



Australian Government
Department of Health and Ageing

CLOSING THE GAP
tackling
Indigenous
chronic
disease

Sentinel Sites Evaluation: Final Report

February 2013

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ABBREVIATIONS

The following abbreviations are used in this document:

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AGPN	Australian General Practice Network
AHS	Aboriginal Health Service
AHW	Aboriginal Health Worker
CCSS	Care Coordination & Supplementary Services
CDSM	Chronic Disease Self-Management
CtG	Closing the Gap
CHAP	Community Health Action Pack
DGP	Division of General Practice
DoHA	Department of Health and Ageing
FTE	Full-time Equivalent
GP	General Practitioner
GPMP	GP Management Plan
HLW	Healthy Lifestyle Workers
ICDP	Indigenous Chronic Disease Package
IHPO	Indigenous Health Project Officer
MBS	Medicare Benefits Schedule
MSOAP-ICD	Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease
NACCHO	National Aboriginal Community Controlled Health Organisation
OW	Outreach Worker
PBS	Pharmaceutical Benefits Scheme
PHC	Primary Health Care
PIP	Practice Incentives Program
QUMAX	Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People
RTC	Regional Tobacco Coordinator
SBO	State-Based Organisations
SLA	Statistical Local Area
SSE	Sentinel Sites Evaluation
TAW	Tobacco Action Worker
TCA	Team Care Arrangement
USOAP	Urban Specialist Outreach Assistance Program

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DEFINITIONS

For the purposes of this report:

- 'Aboriginal Health Service' refers to Aboriginal Community Controlled Health Organisations, state/territory managed Aboriginal Health Services and other non-community controlled Aboriginal Health Services designed primarily to meet the needs of Aboriginal and Torres Strait Islander people.
- 'Aboriginal Health Sector' includes Aboriginal Health Services and NACCHO state/territory affiliates.
- 'Adult health assessments' refers to claims made for Aboriginal and Torres Strait Islander health assessments (MBS items 704, 706, 710 and, after 1 May 2010, 715) by people aged ≥ 15 years.
- 'Clinician' refers to a health professional such as a general practitioner (GP), nurse or Aboriginal Health Worker.
- 'Division of General Practice' may also refer to the Medicare Locals. It is recognised that Divisions of General Practice are at varying stages of transitioning.
- 'General Practice' refers to private General Practices.
- 'General practitioner (GP)' refers to medical doctors based in both private General Practice and Aboriginal Health Services
- 'General Practice Sector' includes private General Practice, Division of General Practice and State-Based Organisations.
- 'Health Service' refers to any primary health care services, including General Practices and Aboriginal and Torres Strait Islander Health Services.
- 'Indigenous' is used when referring to the Indigenous Chronic Disease Package measures as per the usage in Commonwealth Government documents. The term should be read to be synonymous with the phrase 'Aboriginal and Torres Strait Islander people' as used elsewhere in the report.
- 'Measure manager' refers to a Department of Health and Ageing program manager for a specific ICDP measure.
- 'National Framework' refers to the National Monitoring and Evaluation Framework that was developed to guide the ongoing monitoring and evaluation of the Indigenous Chronic Disease Package measures.
- 'Sentinel Site' refers to a geographically defined area that is the focus of 'place-based' Sentinel Sites Evaluation activities.
- 'State-wide organisation' refers to organisations that have state-wide responsibilities such as Divisions State-Based Organisations, Workforce Agencies, NACCHO State/Territory affiliates.

- 'Regional Tackling Smoking and Healthy Lifestyle teams' refers collectively to the following ICDP funded workers: Regional Tobacco Coordinator, Tobacco Action Worker and Healthy Lifestyle Worker.

For the purposes of this report we will continue to refer to DGPs, recognising that by the time of this Final Report all Divisions of General Practices' have transitioned to a Medicare Local.

Where reference is made to data from 'the Sentinel Sites and the rest of Australia', data are aggregated for all the relevant Sentinel Sites, and for the rest of Australia excluding the Sentinel Sites respectively.

GUIDE TO READING THIS REPORT

This report is designed to be useful for people working in a range of roles that may have relevance to the Indigenous Chronic Disease Package (ICDP), and who may have an interest in the findings of the Sentinel Sites Evaluation (SSE). Given the objective of the report to inform wider and ongoing implementation, the managers within the Department of Health and Ageing (DoHA) responsible for implementation of each of the measures are a key target audience. The findings are therefore presented separately for each of the measures.

The report assumes a reasonable level of knowledge about the ICDP and about the measures that make up the ICDP. The report includes references to sources of information about the ICDP in general and about specific measures.

It is clear that the extent to which measures are complementary and mutually reinforcing is a major determinant of the success of individual measures and of the ICDP as a whole. We therefore encourage all readers to engage with the report overall, to understand how measures can be refined and implemented in a way that enhances the overall effectiveness of the ICDP in the variety of settings across Australia.

The report is made up of three sections: the executive summary, main body of the report and appendices.

- The executive summary reflects the key messages from the SSE.
- The main body of the report provides a description of findings over the course of the evaluation in relation to the key objectives of the SSE. The findings for each specific measure area are presented in the order of the design structure of the ICDP, followed by a chapter on the findings of the evaluation of the ICDP as a whole.
- Each of the ‘measure’ chapters provides:
 - **A brief overview of the measure and, based on information provided by DoHA, a summary of the state of implementation of the measure at a national level.** This section provides a brief introduction to each measure, and provides a national context for the findings of the SSE, based on information provided by DoHA.
 - **A description of the findings relevant to the measure based on thematic analysis of the data from the Sentinel Sites.** Key points on each theme are presented as dot points in a box under each theme heading in these chapters. Readers who do not have time or interest in the details of each theme can simply read the dot points, while the text provides more detail for those who want to gain a more detailed understanding of the issues.
 - **An analysis of ‘what works for whom under what conditions’ in relation to each measure.** This reflects the important enablers and constraints to the implementation of the measure within the variety of local contexts in which these measures need to operate. This section of each chapter provides a synthesis of the thematic analysis for the purpose of providing an understanding of how and why each of the measures works in different local contexts. This section should be of particular interest to those with an interest in understanding how each of the measures might be refined to work more effectively in different local service environments.

- **An analysis of progress with implementation in relation to the program logic** for each measure as specified in the National Monitoring and Evaluation Framework (herein referred to as the 'National Framework').¹ This section provides insights into the extent to which expected outcomes and results are being achieved over time, and key issues that need to be addressed and monitored during the process of ongoing implementation of each measure.
- The chapter on the ICDP as a whole is structured in line with the two dot points above, but from a whole of ICDP perspective, and in relation to the outputs and results for the whole of the ICDP (as specified in the National Framework). This chapter provides insight into the higher-level issues that are affecting success with implementation of the overall ICDP in the variety of local contexts, on progress with implementation, and key issues that need to be addressed and monitored during the process of ongoing implementation of the overall ICDP.
- The appendices contain more detailed information on the background, evaluation methods and analysis of the data presented in the main report.

The scope and complexity of the ICDP, the large number of indicators in the National Framework (Appendix A) and the qualitative nature of many of the indicators result in a lengthy report. We have endeavoured to make the report as concise and readable as possible while at the same time dealing with a wide range of important issues in sufficient detail to deliver a meaningful and useful evaluation.

The information presented in this report reflects the best available data at the time of the final evaluation cycle. New data, or refinements to evaluation processes over time, means there are some differences between this and previous reports.

¹ Urbis, ICDP Monitoring and Evaluation Framework, September 2010, <[http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/icdp-monitoring-and-evaluation-framework/\\$file/ICDP%20evaluation%20framework%20vol%201.pdf](http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/icdp-monitoring-and-evaluation-framework/$file/ICDP%20evaluation%20framework%20vol%201.pdf)> (accessed 21 November 2012).

1. EXECUTIVE SUMMARY

1.1. Introduction

The Indigenous Chronic Disease Package (ICDP) was funded over four years from 2009-2013 and represents the Australian Government's contribution of \$805.5 million to the National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander peoples' health outcomes. The funding supported implementation of 14 measures across three priority areas: 1) tackling chronic disease risk factors, 2) earlier detection, improved management and follow-up of chronic diseases in primary health care and 3) expansion of the Aboriginal and Torres Strait Islander workforce and increased capacity of the health workforce to deliver effective care.²

The measures include a range of health promotion and social marketing activities, reforms to existing programs, and new initiatives and funding to increase the size and capacity of primary care services to deliver effective care to Aboriginal and Torres Strait Islander people.

In 2010, the Department of Health and Ageing (DoHA) contracted Menzies School of Health Research (Menzies) to undertake a place-based monitoring and formative evaluation of the Indigenous Chronic Disease Package (ICDP) through the Sentinel Sites Evaluation (SSE) in order to inform ongoing refinements in design and implementation of the package. The SSE is one of a number of evaluations relevant to the ICDP.

1.2. Evaluation process and methods

Twenty-four Sentinel Sites were established through engagement with Aboriginal Health Services (AHS) and the Division of General Practice (DGP) as key stakeholders. Sites were distributed across all states and territories, and across urban, regional and remote locations. Location of sites was determined by DoHA in consultation with Aboriginal and Torres Strait Islander Health Partnership Forums in each state/territory. Ethical approval for the SSE was obtained through a specially established ethics advisory group, and subsequently through the DoHA Ethics Committee.

The SSE comprised five six-monthly cycles of data collection, analysis, interpretation and reporting. Administrative and program data available through DoHA were collated and analysed for all 24 sites. Eight sites were designated as case study sites, with relatively intensive data collection processes, including semi-structured interviews with a range of key informants and community focus groups with community members. Eight sites were designated as enhanced tracking sites, where open-ended interviews were conducted with a smaller range of selected key informants. Clinical indicator data were requested from General Practices and AHSs in the 16 case study and enhanced tracking sites.

Analysis of the data gathered during the evaluation period was designed specifically to address the SSE objectives, including describing ICDP implementation, identifying and tracking change and identifying the constraints and enablers impacting on effective implementation of the ICDP at local level. Findings of the SSE need to be interpreted with an understanding that the sites were not intended to be representative of the range of service settings across Australia.

² For more information on the ICDP [website] <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-ctg-package>> (accessed 24 November 2012).

1.3. Overview of findings

Over the course of the SSE 684 interviews were completed with key informants, 72 community focus groups conducted with a total of 670 participants, and 41 Health Services provided clinical indicator data.

There has been steady progress with the implementation of the ICDP. The SSE has found evidence of activity at a local level for almost all measures across the three priority areas identified above.

1.3.1. TACKLING CHRONIC DISEASE RISK FACTORS

The measures under this priority area were designed to address key risk factors associated with the development of chronic diseases, including tobacco smoking, poor nutrition and lack of exercise. The measure supported the development of community education initiatives, the establishment of a new tobacco and healthy lifestyle workforce, development of lifestyle modification programs and improved access to quit smoking programs.³

National action to reduce smoking rates and reduce risk of chronic disease measures

Regional Tackling Smoking and Healthy Lifestyle teams have been established across the majority of Sentinel Sites, with almost all teams based in AHSs. There was a high level of engagement by the teams in various training activities funded through the measure and considerable activity in development and distribution of toolkits and resources to support the workforce in their roles. There was increasing awareness of the teams over the course of the SSE. Design and delivery of programs and services gained momentum over the course of the evaluation. The program of work delivered by teams varied across sites and included individual patient support, health education and community campaigns, and implementation of smoke free workplace policies. A range of local factors, including organisational capacity and partnerships to provide effective support to the teams, influenced the extent to which teams were able to function effectively.

The key challenges in ongoing implementation include the need to increase awareness of these teams in regional areas, to increase their engagement with the General Practice sector, to increase engagement with and define complementary roles with primary health care clinical teams, and to expand population coverage – including through supporting more local community based initiatives. There is a need for further work to ensure centrally produced resources are suited to local needs in the diverse range of settings where these teams need to work, to evaluate the degree to which the initiatives are integrating evidence based principles and are achieving the intended outcomes, and ongoing refinement of initiatives in the light of this evidence.

Local community campaigns to promote better health measure

There was increasing awareness of grant funding availability (evident in the high number of round two grant submissions), and evidence of project level activities related to the targeted (first round) grant funding. There was no evidence of activity relating to the competitive (second) grant round, as funding

³ For more information on the individual measures that address this priority area see DoHA, Closing the Gap [website] <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/Tackling-Chronic-Disease-Risk-Factors>> (accessed 4 March 2013).

had only recently been awarded. Perceptions of Healthy Community Days were generally positive. There were existing high levels of awareness amongst community members of the risk factors for chronic disease.

The key challenges in ongoing implementation of this measure include the development of strategies to identify and reach particular target population groups; to move beyond education about risk factors to promotion of understanding of personal and population level risks to health, and effective strategies to reduce risk; evaluation of the extent to which the activities funded through the measure are based on best local and international evidence and are achieving their intended outcomes; and ongoing refinement of activities in the light of this evidence.

1.3.2. EARLY DETECTION, IMPROVED CHRONIC DISEASE MANAGEMENT AND FOLLOW-UP CARE

Measures under this priority area were to deliver a comprehensive chronic disease management program through increasing uptake of adult health assessments and follow-up care in a coordinated, accessible and systematic manner. Incentives were provided to encourage Health Services to improve the coordination of health care, and promote best practice management of patients with chronic disease. Support was to be provided to enable Aboriginal and Torres Strait Islander people to actively participate in their own health care. This priority area also included measures to improve access to medicines, multidisciplinary follow-up care and specialist services.⁴

Subsiding Pharmaceutical Benefits Scheme (PBS) medicine co-payments measure

High levels of awareness of the PBS Co-payment measure were evident in urban and regional sites, with lower but increasing awareness in remote sites. Registration for the PBS Co-payment exceeded expectations, and appeared to be encouraged by community demand and practitioners' perceptions of the value of the measure. There was wide variation in uptake of the measure between specific Sentinel Sites and across urban, regional and remote locations, with exceptionally high uptake in a small number of locations. There was no evidence of systematic processes at the local level to ensure that the measure was providing benefit to those in most need.

The key challenges to ongoing implementation include improving understanding and engagement of specialists, pharmacists, hospital staff, and service providers in remote locations in supporting eligible patients to gain access to the benefits of the PBS Co-payment measure. The definition and application of eligibility for the PBS Co-payment should be reviewed and revised in a way that ensures the measure provides benefit to those patients and families most in need.

Higher utilisation costs for Medicare Benefits Schedule (MBS) items measure

Uptake of adult health assessments in the Sentinel Sites increased almost four-fold over the evaluation period, and two-fold in the rest of Australia. There was wide variation in uptake between sites. The highest levels of uptake were in sites where there were high numbers of General Practitioners (GPs) conducting adult health assessments and, to a lesser extent, high numbers of assessments being completed by each GP. There appeared to be limited awareness of the ICDP related follow-up items,

⁴ For more information on the individual measures that address this priority area see DoHA, Closing the Gap [website] <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/Improving-Chronic-Disease-Management-and-Follow-up>> (accessed 4 March 2013).

and limited capacity to take advantage of these items – particularly in those services most in need of support. The number of claims for follow-up services by practice nurses and registered Aboriginal Health Workers (AHWs) was very low, with some increase over the course of the SSE. Uptake of follow-up services by allied health professionals showed a similar pattern.

The key challenges for ongoing implementation include refining the approach to adult health assessments in order to maximise the potential health benefits for patients and populations. Refinements in design should aim to enhance community and population access to health assessments, ensure fit with the variety of primary health care service delivery systems and with health professional perspectives of high quality primary care, and ensure appropriate follow-up care. There is a need to improve systems for ongoing evaluation and refinements of approaches to adult health assessments and follow-up care in order to maximise health benefits to patients and populations.

Practice Incentive Program (PIP) Indigenous Health Incentive measure

There were high levels of awareness of - and registration of Health Services for - the PIP Indigenous Health Incentive in urban and regional sites, with lower but increasing awareness in remote sites. The number of people registered for the incentive increased over the evaluation period, with earlier registration through AHSs, and more recent increases mainly through General Practices. Registration for the PIP Indigenous Health Incentive was largely driven by interest in accessing the benefits of the PBS Co-payment measure, as first-time registration for these measures was generally done at the same time. Almost one third of registered patients did not attend any Health Service sufficiently frequently to trigger a Tier 2 payment, which raises questions about use of and need for health care, and application of eligibility criteria that include patients having a diagnosed chronic disease. Re-registrations for the PIP Indigenous Health Incentive in subsequent years have been limited (between 30 and 40% overall), raising further questions about the design and application of this measure.

In association with this measure, access and uptake of cultural awareness training by General Practice staff increased over the evaluation period, with evidence of General Practices becoming more orientated to Aboriginal and Torres Strait Islander patient needs. There is little clear evidence that funding derived from the incentive payments is being used to enhance systems to provide high quality chronic illness care, and little evidence of a shift to a more planned or coordinated approach to care.

Key considerations for refinement and ongoing implementation of this measure include linking the registration process more directly to care delivery processes and to health benefits to patients and populations, and to support system capability to deliver high quality chronic illness care – specifically including those services most in need of support for system development; enhancing efforts to build the cultural competence of General Practice; and establishing systems for ongoing evaluation and improvement in order to maximise health benefits to patients and populations.

Care Coordination and Supplementary Services measure

The extent of collaborative development of local Care Coordination and Supplementary Services (CCSS) program arrangements varied between sites. While the guidelines emphasised that the funding could be used in different ways to meet local needs, employment of a nurse as a 'Care Coordinator' based in the DGP or Medicare Local (less commonly in an AHS) was the usual model. Recruitment and establishment of Care Coordinators in their role was slow initially. While the program was generally positively regarded, there were substantial difficulties in establishing appropriate processes for referral and transitioning patients through the program, with some concern expressed about equity of access for patients, population coverage, complementarity with other initiatives to enhance coordination of care, role definition and sustainability of the model.

Key challenges for refinement and ongoing implementation include effective integration of Care Coordinators into clinical teams; maximising potential for linkages and complementarity with the other aspects of the ICDP - including through clarifying roles of the Care Coordinator in relation to roles of other members of local primary health care teams, most beneficial use of Supplementary Services funding, strengthening self-management training, and resolving apparent conflicts with ICDP related initiatives to enhance access to specialist care. Reporting frameworks need to be refined to reflect the range of important care coordination activities, linkages and expected outcomes, with development of systems for ongoing evaluation and improvement.

Improving participation in health care through chronic disease self-management measure

Participation in the Flinders Chronic Disease Self-Management (CDSM) training was low in the Sentinel Sites, with resulting low rates of accreditation and no clear trends in awareness of the training. Lack of participation was due to lack of interest in self-management approaches and use of other self-management models. The training did not appear to be effectively reaching staff who were in a position to utilise the skills with patients, and those who attended training were not necessarily in positions to influence uptake of the Flinders CDSM tools and techniques by colleagues. Alternative self-management training models were being used in some sites. In some sites the Care Coordinators - predominately those based in DGPs - took up the Flinders CDSM training with enthusiasm and incorporated self-management principles into aspects of their work.

Key challenges for ongoing implementation of this measure include adaptation and development of models to enable application of effective self-management approaches in everyday service environments, backed by sound evaluation and refinement to maximise potential benefits for patients and populations most in need of support.

Urban Specialist Outreach Assistance Program measure

Access to specialists through the Urban Specialist Outreach Assistance Program (USOAP) varied between Sentinel Sites, influenced by funding allocation processes, availability of services through other programs and availability of specialists who were willing to bulk-bill. AHSs hosted the program in all of the participating sites. Recruitment and engagement of specialists was largely complete at the time of the final evaluation visits with some retention difficulties becoming apparent – this was commonly related to low numbers of referrals and patient attendance for appointments. Where referrals were being made, and patients were attending, the USOAP services appeared to be working well for primary health care services, specialists and for those patients who attended the service. Increased accessibility and confidence in relation to accessing specialist care was noted in respect of some patients that attended AHS-hosted USOAP services. There was a trend towards use of general physicians over super-specialists owing to the greater scope of services they could deliver.

Key challenges for ongoing implementation include strengthening processes for referral (especially from General Practice); for supporting patient attendance at appointments [including through use of Outreach Workers (OWs)]; for orientation of specialists to the organisational culture of AHSs and effective ways of working in these organisations; for enhancing access to specialised equipment and follow-up care and procedures; and development of systems for ongoing evaluation and improvement.

Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease measure

Most eligible sites were accessing program funding by the final evaluation cycle, although implementation was at a fairly early stage. Effectiveness of planning processes in ensuring local needs were addressed was variable, partly owing to limited supply of relevant specialists. Some recruitment strategies put in place by workforce agencies were perceived by AHS interviewees to be overly driven by the availability and interest of visiting health professionals, and were not necessarily responsive to local needs for service delivery. The Medical Specialist Outreach Assistance – Indigenous Chronic Disease (MSOAP-ICD) measure was seen to have resulted in improved patient access to specialists in some sites. However, efficiency was questioned, with low numbers of referrals and low patient attendance for many services. Patient attendance at specialist appointments was influenced by capacity of the host organisation to coordinate visits and support patient attendance (including recall and reminder systems, clinic management, and transport arrangements).

In addition to those identified above for USOAP, challenges for ongoing implementation of MSOAP-ICD include clearer delineation of expectations, roles and responsibilities of the health professional and the host organisation prior to commencement of service delivery; development of effective approaches to enhancing capacity of host organisations to coordinate visits; and adequate resourcing to support patients to attend for specialist care in regional or urban centres.

1.3.3. FIXING THE GAPS AND IMPROVING THE PATIENT JOURNEY

Measures under this priority area aimed to expand the primary care workforce in both AHSs and General Practice, and to encourage uptake of health services by Aboriginal and Torres Strait Islander people.⁵

Workforce support, education and training measure

Staggered recruitment, diversity in skill level, different needs in different work environments and dispersion of OWs presented significant challenges to providing orientation to OWs – especially remote based OWs. Delays in roll out of orientation packages led to opportunities for transfer of learning from more experienced OWs to new workers. There was generally low uptake of funding for individualised training across the sites. Lack of organisational capability to define and source relevant training, uncertainty over contracts, were important barriers to uptake of training.

Uptake of the ICDP funded GP registrar positions in Sentinel Sites was low. There were more posts available than AHSs with capacity to accommodate and provide appropriate supervision, and GP registrars to fill them.

There was little evidence from the Sentinel Sites that the ICDP funded scholarships for professional development of nurses in AHSs and scholarships for nurses undertaking a clinical placement in an AHS had created opportunities not previously available to support training for nurses. The uptake of clinical placements was low, at least partly owing to lack of capacity of AHSs to host and to house students.

⁵ For more information on the individual measures that address this priority area see DoHA, Closing the Gap [website] <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/Workforce-Expansion-Training-and-Support>> (accessed 4 March 2013).

Challenges for ongoing implementation include the need to increase feasibility and desirability of GP registrar posts in AHSs, including development of alternative high quality models of supervision and support to overcome the current shortage of qualified supervisors working in AHSs, high quality infrastructure to accommodate trainees, and support for AHSs to coordinate trainee positions. There is a need to focus ICDP related training, scholarships and placements on strengthening of core competencies for chronic illness care, and to develop systems for ongoing evaluation and refinement to ensure these initiatives are meeting priority needs.

Expanding the outreach capacity of Aboriginal Health Services measure

There were high levels of recruitment to OW positions in AHSs, with some evidence of greater challenges experienced in recruitment and retention in remote sites. People recruited to OW positions varied in their skills and experience, and filled a range of roles depending on their skills and the need of the AHS. AHSs were generally already engaged in efforts to improve their accessibility to communities through various programs. OWs strengthened these efforts, and improved accessibility to communities through a range of activities.

ICDP funded practice managers appeared to fill one of two types of roles: 1) a fairly general role in strengthening operational aspects of the AHS; or 2) a role that was more focused on chronic illness care. In general, if involved in improving quality of chronic illness care, the practice manager had been appointed into an already functioning system rather than setting up new systems or taking the development of an existing system to a higher level.

Challenges for ongoing implementation include development of effective approaches to providing supervision, support, training and mentorship for a workforce with widely differing needs and working in diverse settings; focusing additional 'practice manager' support on enhancing systems to support delivery of high quality chronic illness care; and to develop systems for ongoing evaluation and refinement to ensure these initiatives strengthen the potential for local service delivery systems to achieve population health benefits.

Engaging Divisions of General Practice to improve access to mainstream primary care measure

DGPs were successful in recruiting and, to a large extent, retaining the Indigenous Health Project Officer (IHPO) and OW workforce. These OWs generally had higher qualifications and experience than the entry level specified in the guidelines. OWs appeared to be increasing access to primary care services through assisting patients to navigate the health system, arranging transport, and cultural brokerage role between community members and health professionals. They also appeared to be contributing to improving identification of Aboriginal and Torres Strait Islander patients through encouraging General Practices to make their services more welcoming of Aboriginal and Torres Strait Islander people, and through encouraging community members to self-identify at Health Services.

Challenges for ongoing implementation include strengthening leadership, management and resources to support Aboriginal health teams, and to integrate these teams into the core business of Medicare Locals. Ongoing effort will be required to foster collaboration between the General Practice and AHSs sectors, and to establish systems to evaluate and refine measures in a way that strengthens the potential for local service delivery systems to achieve population health benefits.

1.3.4. THE INDIGENOUS CHRONIC DISEASE PACKAGE AS A WHOLE

While the ICDP is (appropriately) framed as a ‘package’, there appears to be a lack of emphasis on supporting the development and implementation of the measures to ensure the measures function in a complementary way. There was a patchy and generally limited understanding amongst key stakeholders at the local level of the scope or the complementary nature of the ICDP measures.

Specific local contexts appeared to have more significant influence on ICDP implementation than geographic location, although geographic location was associated with some contexts. The wide variation in progress with implementation highlighted the importance of well functioning systems within services and sites. The services and sites where ICDP policies and programs worked well were mostly those that were functioning in relation to chronic illness management and care prior to the ICDP, where there was capacity and readiness to optimise the additional resources available through the ICDP, and where measures could be integrated into existing relatively well functioning service systems. These services and sites were characterised as having strong management and leadership commitment; cultural competency and values; commitment to best practice; and professional experience and local knowledge. Services and sites where implementation of ICDP measures was less successful were characterised as having limited service capacity to engage; diverse and complex delivery contexts; limitations on workforce capacity (including capacity for development) and ability to build linkages; and inability to change.

Current investment is heavily oriented to operate through Medicare funding channels. Many of the services most in need of development, and services providing care to the populations most in need of improved access to high quality care, are not able to benefit from funding that is dependent on having system and service capability to provide and bill for Medicare related items. This means that the funding channelled through these incentives provides benefit to the most developed services, with relatively little benefit to those services or populations most in need of improved systems and access to quality care.

Key challenges for ongoing implementation include the need for stronger emphasis at multiple levels of the system to ensure the measures work more effectively as a package, and to integrate these measures into existing service delivery systems in a way that enhances capability to provide high quality chronic illness care; a need to strengthen systems – and understanding of systems - at local and regional level; and a need to build competence in design and development of systems to deliver high quality chronic illness care, including capability for ongoing evaluation and refinement.

2. INTRODUCTION AND METHODOLOGY

2.1. Introduction

The ICDP is funded over four years from 2009-2013 and represents the Australian Government's contribution of \$805.5 million to the National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander peoples' health outcomes.

In 2010, the Department of Health and Ageing (DoHA) contracted Menzies School of Health Research (Menzies) to undertake a place-based monitoring and formative evaluation of the Indigenous Chronic Disease Package (ICDP) through the Sentinel Sites Evaluation (SSE). The SSE covers much of the first three years of implementation of the ICDP, and is one of a number of evaluations relevant to the ICDP. This final report follows delivery of four interim reports over the course of the evaluation, and covers progress with implementation as of the time of the final evaluation visits in September – October 2012.

2.1.1. SCOPE OF THE INDIGENOUS CHRONIC DISEASE PACKAGE

The ICDP provides funding for fourteen measures across three priority areas: 1) tackling chronic disease risk factors, 2) earlier detection, improved management and follow-up of chronic diseases in primary health care and 3) expansion of the Aboriginal and Torres Strait Islander workforce and increased capacity of the health workforce to deliver effective care.⁶

Each of the three priority focus areas includes a number of specific measures (Table 1.1). The ICDP is managed across seven Divisions of the DoHA with the Office of Aboriginal and Torres Strait Islander Health (OATSIH) having responsibility for overall coordination and governance.

Measures under the ICDP focus on improving the capacity of primary health care (PHC) services to more effectively prevent and manage chronic disease among Aboriginal and Torres Strait Islander people. The measures are delivered through a range of Aboriginal and non-Aboriginal Health Services, including Aboriginal Community Controlled Health Organisations, state and territory government Aboriginal and Torres Strait Islander people specific Health Services, General Practices and other government and non-government organisations that provide and support PHC services used by Aboriginal and Torres Strait Islander people.

⁶ For more information on the ICDP [website] <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-ctg-package>> (accessed 24 November 2012).

Table 1.1: Priority areas, measures and funding under the Indigenous Chronic Disease Package, 2009-2013

Priority area	Key	Measure	Funds allocated 2009-2013 (\$million)
Tackle chronic disease risk factors (Priority area - smoking)	A1	National action to reduce Indigenous smoking rates	\$100.61
	A2	Helping Indigenous people reduce their risk of chronic disease	\$37.53
	A3	Local Indigenous community campaigns to promote better health	\$22.70
Primary health care services that deliver: Improved chronic disease management and follow-up care	B1	Subsidising PBS Medicine Co-payments	\$88.70
	B2	Higher utilisation costs for MBS and PBS Co-payment	\$140.40
	B3	Supporting primary care providers to coordinate chronic disease management	\$115.08
	B4	Improving Indigenous participation in health care through chronic disease self-management	\$18.56
	B5	Increasing access to specialist and multidisciplinary team care	\$70.78
	B6	Monitoring and evaluation	\$39.94
Fixing the gaps and improving the patient journey: Workforce expansion and support	C1	Workforce support, education and training	\$17.74
	C2	Expanding the outreach and service capacity of Indigenous health organisations	\$68.42
	C3	Engaging Divisions of General Practice to improve Indigenous access to mainstream primary care	\$74.72
	C4	Attracting more people to work in Indigenous health	\$7.15
	C5	Clinical practice and decision support guidelines	\$3.14
Total funding			\$805.47

Source: Urbis, ICDP Monitoring and Evaluation Framework, Vol 1, September 2010.

2.1.2. SCOPE AND PURPOSE OF THE SENTINEL SITES EVALUATION

The purpose of the SSE is to assist the DoHA to understand where and why the ICDP is effective at local level, in order to refine ongoing implementation and design of the package.

The specific objectives of the SSE are to:

- monitor the implementation of the ICDP at the local level
- provide baseline data to enable tracking of changes to identify early outcomes
- identify any changes resulting from the ICDP including early outcomes
- provide timely feedback on barriers and enablers impacting on implementation
- contribute to the overall evaluation of the ICDP.

2.1.3. ETHICAL OVERSIGHT

The DoHA established an Evaluation Ethics Advisory Group to provide advice on the ethical conduct of the ICDP evaluation including the SSE. The Evaluation Ethics Advisory Group endorsed the application for the SSE project in October 2010. As a result of constraints on the ability of key members of the Evaluation Ethics Advisory Group to have ongoing involvement in ethical oversight of the SSE, Menzies subsequently submitted an application to the Departmental Ethics Committee to provide ongoing ethical oversight for the remainder of the SSE. The Departmental Ethics Committee granted ethical approval for the SSE in April 2012.

2.2. Overview of the Sentinel Sites

2.2.1. ESTABLISHMENT OF SENTINEL SITES

The SSE has established a total of 24 Sentinel Sites for the purposes of the evaluation. These include urban, regional and remote sites located across the states/territories (Figure 1.1). As indicated in the figure, there are three different types of sites: tracking, enhanced tracking and case study, distinguished by the depth of data collection at each site. The differences between these types of sites and implications are described further in Section 1.3. Appendix B contains site descriptions.

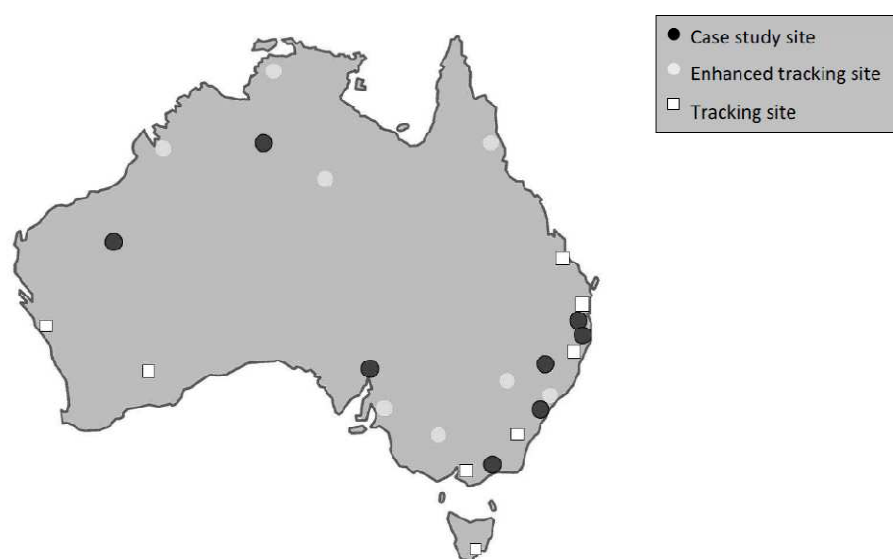


Figure 1.1: Location of Sentinel Sites

Establishment of the sites proceeded in three stages. This was designed to fit with the progressive roll-out of the ICDP in different locations and with the logistical requirements of the implementation of the SSE.

2.2.2. SELECTION AND SPECIFICATION OF SITES

The location of Sentinel Sites was decided by DoHA in consultation with the Aboriginal and Torres Strait Islander Health Partnership Forums in each state/territory. Considerations for these recommendations included the size of the Aboriginal and Torres Strait Islander population, the capacity of relevant organisations to participate, the level of need for improved access or coordination of services and early implementation of ICDP workforce allocations. Establishment of the Sentinel Sites was dependent on the agreement of the key stakeholder organisations [the AHS and the Division of General Practice (DGP)] in each location to participate in the SSE.

Each Sentinel Site is defined by a geographic boundary. The boundary is used to identify the resident population and the service providers that operate within the site for the purpose of understanding and reporting access and availability of services.

Sentinel Site boundaries were defined on the basis of:

- maximising comparability between geographic areas of responsibility for ICDP workers and the geographic areas for which the program administrative data were available
- suitability for reporting of Medicare data
- suitability for reporting population data, based on Statistical Local Areas (SLA) as defined by the Australian Bureau of Statistics (ABS)
- ability to maintain a level of consistency between sites in terms of numbers of Aboriginal and Torres Strait Islander people resident in the site and numbers of key service provider organisations (such as DGPs and AHSs), while at the same time recognising the wide diversity of settings in which Aboriginal and Torres Strait Islander people live.

A key component of the Australian Government's National Health Reforms was the establishment of a new nation-wide network of Medicare Locals from 1 July 2011.⁷ Medicare Locals are PHC organisations built upon the previous DGPs and established to coordinate PHC delivery and tackle local health care needs and service gaps. They are to drive improvements in PHC and ensure that services are better tailored to meet the needs of local communities. The process of transition from DGP to Medicare Local is an important development that has occurred during the course of the SSE. It is particularly important for the SSE because DGPs are key stakeholders in the Sentinel Sites. For the purposes of this report we will continue to refer to DGPs, recognising that by the time of this Final Report all DGPs will have transitioned to a Medicare Local.

⁷ DoHA, 'Your Health' [website] <<http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01>> (accessed 21 November 2012).

2.3. Methodology

2.3.1. OVERVIEW

The SSE has been designed to address the program logic (and associated evaluation questions) of the ICDP as described in the National Framework. The National Framework was developed in early 2010 and reflects information that was available on the policy rationale and expected outcomes of the ICDP at the time of the development of the framework. Key components of the program logic relevant to the SSE are included in the final sections of the chapters on each measure and in the chapter on the whole of the ICDP. The full program logic is included in Appendix A.

The SSE methodology was developed in consultation with DoHA. The methods to some extent were predefined by DoHA through contracts, available data sources from DoHA, site types and also the National Framework. The contract included a requirement for six-monthly cycles of data collection, analysis and reporting for 24 Sentinel Sites spanning urban, regional and remote locations and all Australian States and Territories. Five evaluation cycles were completed between July 2010 and December 2012.

Each evaluation cycle included collection/collation and analysis of the following data sets:

- administrative data provided by DoHA [Medicare Benefit Schedule (MBS), Practice Incentive Program (PIP) Indigenous Health Incentive and Pharmaceutical Benefits Schedule (PBS) Co-payment]
- program data supplied by DoHA
- key informant interviews
- community focus groups
- clinical indicators collected from Health Services.

Appendix C details the evaluation processes, methods and analysis, including limitations, in more depth.

The range of sources relevant to various types of sites are illustrated in Figure 1.2. From the tracking sites, data sources include administrative data and program data, and from the enhanced tracking and case study sites, additional data sources include key informant interviews, clinical indicators and community focus groups.

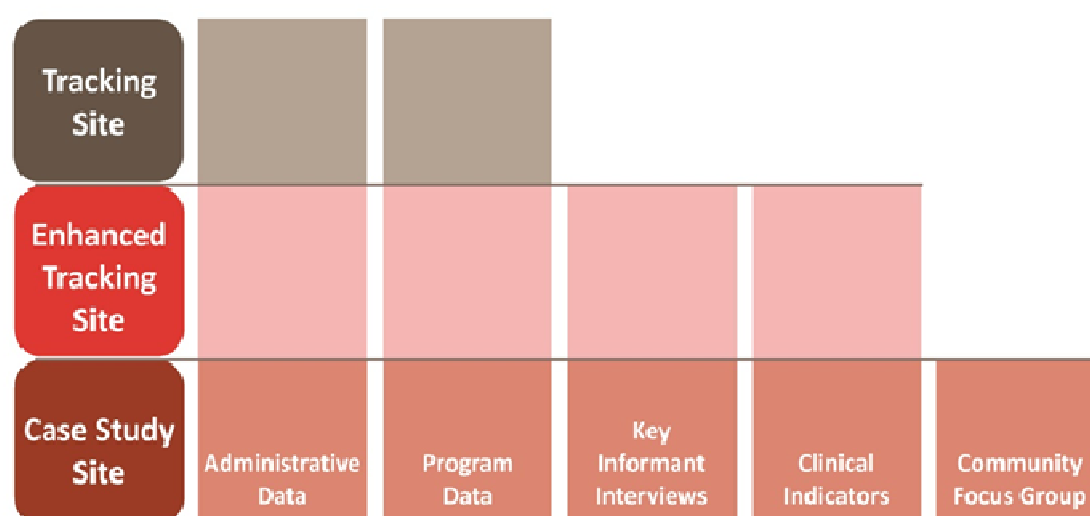


Figure 1.2: Sentinel Sites evaluation processes

For tracking sites, only administrative data and program data were collated, analysed and reported. These data were presented back to the sites, and in this process, some local stakeholders volunteered perspectives on the patterns evident in their data. Although this feedback from tracking sites was not formally part of the SSE methods, these perspectives were found to be useful in understanding emerging patterns in the data.

For enhanced tracking sites, administrative data and program data were enhanced by data collected through annual interviews and discussion groups with key informants. The purpose of interviews and discussion groups was to gain deeper understanding of the patterns in the administrative data and emerging themes. We also sought to obtain clinical indicator data from Health Services in enhanced tracking sites.

For case study sites, interviews with key stakeholders at local and regional levels and community focus groups were conducted every six months in addition to the data collection processes used for tracking and enhanced tracking sites. Interview, focus group and clinical indicator data from case study sites provided more in-depth understanding of the implementation and impact of the ICDP at a local level and complemented the administrative and program data available from all sites.

Each of the data sources and the focus of analysis for each are outlined below.

2.3.2. DATA SOURCES

Administrative data

The aim of the MBS, PBS and PIP analysis was to track the impact of the ICDP on program uptake and chronic disease prevention or treatment item use over time. The data were extracted from the Medicare, PIP and PBS databases.

Aboriginal and Torres Strait Islander population data for the Sentinel Sites and the rest of Australia were based on the 2006 Census. The 2006 census population data were adjusted to account for

population growth using multipliers developed by the Australian Bureau of Statistics for 1991-2021 population projections for Aboriginal and Torres Strait Islander people.⁸

Comparisons between the 2011 Census and the 2006 Census showed particularly large increases in the percentage of the population identified as Aboriginal and Torres Strait Islander people in some sites (Appendix B). This means that uptake of administrative items based on the population projections may be overestimated to varying degrees in different sites (particularly in those with large undercounts of Aboriginal and Torres Strait Islander people in the census data).

The focus of the analysis for administrative data was on the uptake for Aboriginal and Torres Strait Islander people aged ≥15 years in the Sentinel Sites compared to the rest of Australia.

PBS Co-payment measure

The PBS Co-payment measure was introduced in July 2010 to provide reduced-price or subsidised medications to Aboriginal and Torres Strait Islander people with the aim of reducing the financial barrier of access to medications. The data are presented from the first full quarter following implementation of the PBS Co-payment measure (September 2010 – May 2012).

The analysis of these data included:

- trends in uptake of the PBS Co-payment for Aboriginal and Torres Strait Islander people ≥15 years
- trends in the concessional status of patients receiving medications through the PBS Co-payment measure to assess the extent to which the program is reaching the most disadvantaged members of the Aboriginal and Torres Strait Islander community
- trends in the type of medicines supplied through the program including Nicotine Replacement Therapy.

Sentinel Site boundaries in most cases are determined by SLAs. PBS Co-payment data were extracted based on postcodes that in some cases lead to a slight mismatch between PBS data and Sentinel Site boundaries.

Medicare Benefits Schedule data

A number of MBS items are relevant to the ICDP. The introduction of these items predated the introduction of the ICDP. However, several ICDP measures would be expected to influence their uptake and therefore these are included in the SSE. Data are presented for the period March 2009 – May 2012. For the purposes of the SSE, March 2009 - February 2010 is defined as a 'baseline' period.

The analysis focuses on trends in uptake for Aboriginal and Torres Strait Islander people ≥15 years of the following MBS items:

- health assessments (MBS 715)
- follow-up services provided by a practice nurse or registered Aboriginal Health Worker (MBS 10987)
- follow-up allied health services (MBS 81300–81360)

⁸ Australian Bureau of Statistics. Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Canberra: Australian Bureau of Statistics; 2009.

- number of General Practitioners (GP) who claim health assessments
- average number of health assessments billed by GPs.

PIP Indigenous Health Incentive

The PIP Indigenous Health Incentive was introduced in March 2010. It provides incentives to Health Services to increase levels of care provided to Aboriginal and Torres Strait Islander people. Incentives take the form of a range of monetary payments to Health Services for practice registration with PIP Indigenous Health Incentive, for registration of individual Aboriginal and Torres Strait Islander people and for provision of certain services to patients as recorded on MBS billing (Tier 1 and Tier 2 payments).

Data are presented for the period March 2010 – May 2012. As this was a new program, the analysis of these data tracked trends over time in the uptake of this measure following its initial implementation.

The analysis of the PIP Indigenous Health Incentive data focused on trends in:

- uptake of the incentive by Health Services
- uptake of registrations of patients
- triggering of Tier 1 and Tier 2 payments.

Program data

The program administrative data used for the SSE were based on reports provided to DoHA by organisations contracted to provide services relevant to the ICDP and from internal departmental reporting for Sentinel Sites. OATSIH was responsible for coordinating the provision of program administrative data to the SSE team. The timeframes for the program data received varied depending on the implementation stage for each measure and the availability of reports from fundholders.

Where appropriate, the SSE drew on publicly available information to further expand the measure implementation description. We also incorporated information from evaluation visits to sites that took place after the receipt of program administration data from DoHA, where the evaluation visit identified further progress with implementation during the report period.

Key informant interviews

Interviews were conducted with key informants to gain insight into stakeholder awareness and understanding of their perception of issues relevant to the implementation of the ICDP. Interviews were also performed in each evaluation cycle with stakeholders in the Division State Based Organisations (SBO), National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates and Workforce Agencies in each State/Territory where a case study site was located. Interviews in case study sites were semi structured using a mix of open ended questions and responses to closed ended statements. Appendix D provides further detail on interview numbers.

Over 700 interviews (across all site types) were undertaken during the course of the SSE. Overall this included 581 interviews in case study sites, 103 in enhanced tracking sites and 17 in tracking sites (Table 1.2). Some individuals were interviewed more than once in a cycle to gain further depth and understanding of information provided. A number of interviewees were interviewed each cycle about more than one site or ICDP funded position.

In case study sites, a total of 298 different people participated in interviews, with 152 participating in interviews in successive cycles over the evaluation (Appendix D, Table D6). In enhanced tracking and tracking sites, key informants (61 and 17 individuals respectively) provided their perspectives on the reasons underlying change in administrative data during feedback sessions.

Table 1.2: Number of interviews held in Sentinel Sites, by evaluation cycle

Evaluation cycle	One	Two	Three	Four	Five	Total
Overall	46	102	196	158	182	684
Case study sites	46	102	146	145	142	581
Enhanced tracking sites	-	-	50	13	40	103

Note: Site implementation was a three staged process; by the third evaluation cycle all case study sites were established.

Community focus groups

Seventy-two community focus groups were held in case study sites (Table 1.3). The purpose of the community focus groups was to explore community perceptions of change and, where possible, the extent to which this may have been due to implementation of the ICDP. The issues explored included access to health care, tobacco use, life style modification, chronic disease self-management, patient registration, access to medications, access to specialists and care coordination services. Appendix D provides further detail on community focus groups.

A total of 670 attendees (535 individuals) participated in the community focus groups (Table 1.3), with 94 individuals attending groups in successive evaluation cycles (Appendix D, Table D8). The number of participants per group ranged between 4 and 30, with an average of 9 participants.

Table 1.3: Number of attendees at community focus groups held in case study sites, by evaluation cycle

Evaluation cycle	One	Two	Three	Four	Five	Total
Number of attendees	65	80	161	210	154	670
Number of community focus groups held	6	12	17	19	18	72
Average number per group	11	7	10	11	9	9

Note: Average numbers have been rounded up.

Characteristics of focus group participants varied within and between sites. Analysis and interpretation of the data provided in groups included consideration of potential biases of different participant groups.

Clinical indicators

The intended purpose of collection and analysis of clinical indicator data evident in the National Framework was to provide an indication of impact of the ICDP on clinical performance of PHC services located in the Sentinel Sites and on clinical outcomes among Aboriginal and Torres Strait Islander people attending these Health Services.

For the SSE, clinical indicators were extracted from a variety of existing clinical information systems, quality improvement systems or data reports prepared for other purposes in General Practice and AHSs. Appendix E contains analysis of clinical indicator data.

Over the course of the SSE, requests for clinical indicator data were made to 53 different Health Services. In response to these requests, a total of 116 clinical indicator data sets were provided from 41 different services and across the five evaluation cycles. This included 68 data sets from General Practices and 48 from AHSs (Table 1.4).

Table 1.4: Number of Health Services that provided clinical indicator data, by evaluation cycle, and sector

Evaluation cycle	One	Two	Three	Four	Five	Total
Overall	4	13	29	34	36	116
General Practice	0	5	17	22	24	68
Aboriginal Health Service	4	8	12	12	12	48

Note: Health Services that indicated over two evaluation cycles that they did not wish to provide clinical indicators were not approached in subsequent cycles.

For some Health Services data were collected retrospectively and for varying timeframes, depending on existing arrangements for reporting and/or quality improvement systems.

2.3.3. DATA INTEGRATION AND ANALYSIS

Analysis of the data gathered during the evaluation period was designed specifically to address the SSE objectives, including describing ICDP implementation, identifying and tracking change and identifying the barriers and enablers impacting on effective implementation of the ICDP at local level.

The general approach to the data analysis for the SSE Final Report was to continue to use standard case study methods, using methods of analysis that were most suited to the variety of quantitative and qualitative data that have been collected over successive cycles of the SSE for the purpose of addressing the specific evaluation objectives. Quantitative data (from administrative, program, interview and clinical indicator data sources) have generally been analysed using simple descriptive statistics. Qualitative data (from interview and focus group data sources) have been analysed through thematic analysis and thematic synthesis. These analyses have been designed to track the progress over time of the indicators that were specified in the National Framework, and to examine issues that have emerged over the course of the evaluation. The qualitative data were initially coded using descriptive exploratory methods. The interview questions (based on the program logic from the evaluation framework) were used as the data organising framework. Data were arranged within each measure according to factors that enable or present barriers to the implementation of the various ICDP

measures. From these measure specific data sets, text was re-coded using explanatory methods. The purpose of this process is to elicit themes and patterns that help to understand questions of ‘how and why’ these factors impact on the implementation of the ICDP. Special attention was given to capturing Vignettes or stories and quotations that illustrate the emerging themes.

The case study approach was inherent to the design of the SSE, where there were multiple sources of evidence from a range of study sites. Comparative case study methods have been used over successive cycles of the evaluation to increase the understanding of how the ICDP measures have been implemented in different sites, why various approaches have been taken, and what has contributed to the variable progress between sites, and to the variable outcomes and results of implementation. The comparative case study analysis aimed to build an in-depth understanding of progress with implementation of the ICDP measures at a local level through the collection and analysis of data about each site from multiple sources over multiple cycles of the evaluation.

In order specifically to provide more in-depth understanding of the barriers and enablers to implementation for the purpose of informing ongoing and wider implementation (including the role of contextual factors), we used a realist evaluation⁹ approach and drew on systems thinking¹⁰ concepts. The realist evaluation approach aimed to provide insight into the interaction between contextual influences and mechanisms by which the ICDP measures were generating various outcomes across the diverse range of locations in which the ICDP was being implemented. The systems thinking approach aimed to provide insight into how the different ICDP measures were designed to influence various aspects of the complex health system, the emerging patterns of interaction between the measures within the system, and how these interactions were achieving the intended outcomes of the ICDP. Attributing any observed change to specific interventions or influences within a complex intervention and in the context of a complex system is difficult, with inherent and unavoidable uncertainties. More details on the realist evaluation approach and systems thinking concepts are included in Appendix C.

2.3.4. LIMITATIONS AND NOTES ON DATA INTERPRETATION

The broad scope of the ICDP and the primary focus of the SSE on monitoring implementation at the local level in purposively selected sites, mean the SSE does not provide a comprehensive evaluation of the overall program. The main general limitations are outlined below. Appendix C outlines in more detail limitations with each data set.

The Sentinel Sites included in the SSE were not intended to be typical of Australia in general in terms of PHC utilisation or context of implementation. In particular, in interpreting the data provided in this report, the following issues need to be considered:

- The Sentinel Sites all have at least one AHS. The presence of an AHS may mean that these sites have a different pattern of utilisation of General Practices compared to locations without local AHSs.
- Site selection was to some extent based on where ICDP investment was occurring relatively early and/or was more intense. Therefore ICDP measures were likely to be better established in some of these sites than in other locations. The intention of the SSE was to learn from the experience with early implementation for the purpose of informing ongoing and wider implementation.

⁹ Pawson, R and Tilley, N 1997, Realistic evaluation. SAGE publishing.

¹⁰ De Savigny and Adam 2009, Systems thinking, WHO.

- Participation in the SSE may have increased understanding and awareness of the ICDP among local stakeholders. Feedback from sites, particularly the case study sites (where more in-depth data collection occurred) made it clear that the SSE team was an important source of information about the ICDP. In addition, site-specific feedback of data provided early opportunities for locally initiated system improvements. These factors may have influenced how ICDP measures were taken up in the Sentinel Sites compared to other locations. The provision of site-specific feedback to local stakeholder organisations is consistent with Aboriginal and Torres Strait Islander people research values and therefore was considered a core part of the evaluation.
- Owing to the different times that sites were established and the ways in which the routinely available datasets were constructed, the periods covered by different types of data did not always exactly correspond. The timeframes covered by different data sources and implications of any discrepancies are discussed further in Appendix C.
- The administrative data represents the uptake of MBS items for all Health Services within the boundaries of each Sentinel Site and therefore reflect the overall activity of all services within the site. The data are not directly attributable to any specific Health Service. These data include services delivered to patients visiting from outside the site boundaries, and do not include services delivered to patients outside the site boundaries – therefore numbers per population may over- or under-estimate population coverage of service items depending on local patterns of service utilisation.
- The population data used to derive uptake of administrative data items (such as MBS, PBS Co-payment and PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people are based on the ABS projections from the 2006 Census. Comparisons between the 2011 Census and the 2006 Census showed particularly large increases in the percentage of the population identified as Aboriginal and Torres Strait Islander people in some sites. The large increases in population numbers in some sites may indicate relatively large undercounts in the 2006 ABS population projections, and this means that uptake of MBS items based on these population data may be overestimated to varying degrees in different sites (see Appendix C for more detail).
- Data presented in this report reflect billing for MBS items and do not necessarily accurately reflect the provision of clinical care by providers. For example, some providers may be carrying out adult health assessments and follow-up health services or some components of these services without submission of relevant claims to Medicare.

2.4. Overview of Sentinel Sites

The 24 sites taken together provide a rich source of information regarding how the ICDP is implemented in different contexts. Sentinel Sites differed with respect to key factors including the proportion of people identifying as Aboriginal or Torres Strait Islander (ranging for example, from less than 1% in one of the urban sites to 71% in a remote site; based on 2011 census data) (Table 1.5).

The key stakeholder organisations in each site were identified through consultation with DoHA and generally included an AHS and a DGP. In one site there was no active involvement of a DGP and in another two regional sites there were two AHSs. Two urban sites included two DGPs as key stakeholder organisations. Three urban sites also included a regional support organisation for AHSs as a key stakeholder organisation for the SSE.

A summary description of the key site characteristics for all Sentinel Sites by urban, regional and remote location is provided below. Detailed profiles of each of the Sentinel Sites are provided in Appendix B.

Table 1.5: Sentinel Site locations, population numbers and key stakeholder organisations

Site	State	Rurality	Aboriginal and Torres Strait Islander population (2006)	Total population (2006)	Proportion of total population identifying (2006)	% change in Aboriginal and Torres Strait Islander population between 2006 and 2011 census	Key stakeholder organisations
Case study sites							
Bairnsdale	VIC	Regional	764	25 368	3.0%	+ 14.01%	AHS, DGP
Brisbane South	QLD	Urban	4768	302 382	1.6%	+ 11.07%	AHS, DGP
Campbelltown	NSW	Urban	3834	143 076	2.7%	+ 23.3%	AHS, DGP
East Pilbara	WA	Remote	1429	6543	21.80%	+ 41.9%	AHS, DGP
Katherine West	NT	Remote	2126	2795	76.1%	- 2.9%	AHS
Logan/Woodridge	QLD	Urban	4376	173 269	2.5%	+ 24.2%	AHSx2, DGP
Port Augusta	SA	Regional	2303	13 874	16.6%	+ 2.5%	AHS, DGP
Tamworth	NSW	Regional	3710	53 595	6.9%	+ 27.3%	AHS, DGP
Enhanced tracking sites							
Barkly	NT	Remote	1770	3333	53.1%	+ 6.2%	AHS, DGP
Cairns	QLD	Regional	9558	122 234	7.8%	+ 28.9%	AHS, DGP
Darwin	NT	Regional	6233	66 291	9.4%	- 1%	AHS, DGP
Derby	WA	Remote	4031	6507	61.9%	+ 0.6%	AHS, DGP
Dubbo	NSW	Regional	5147	45 964	11.2%	+ 29.8%	AHSx2, DGP

Site	State	Rurality	Aboriginal and Torres Strait Islander population (2006)	Total population (2006)	Proportion of total population identifying (2006)	% change in Aboriginal and Torres Strait Islander population between 2006 and 2011 census	Key stakeholder organisations
Elizabeth	SA	Urban	2777	126 717	2.2%	+ 27%	AHS, DGP
Newcastle	NSW	Urban	12 285	493 466	2.5%	+ 35.7%	AHS, DGP
Swan Hill/Mildura	VIC	Regional	2238	70 452	3.2%	+ 2.2%	AHSx2, DGP
Tracking sites							
Canberra	ACT	Urban	3847	323 326	1.2%	+ 32.2%	AHS, DGP
Dandenong	VIC	Urban	2996	581 191	0.5%	+ 27.2%	AHS, DGPx2
Geraldton	WA	Regional	1836	18 916	9.7%	+ 19.1%	AHS, DGP
Gladstone	QLD	Regional	1481	45 626	3.2%	+ 28.7%	AHS, DGP
Grafton	NSW	Regional	1238	22 812	5.4%	+ 27.5%	AHS, DGP
Hobart	TAS	Regional	5413	189 637	2.9%	+ 17.7%	AHS, DGP
Kalgoorlie	WA	Regional	2135	28 423	7.5%	+ 0.4%	AHS, DGP
North Lakes/ Caboolture	QLD	Urban	4682	216 349	2.2%	+ 47.6%	AHS, DGPx2

Note: Appendix C contains actual numbers from the 2006 and 2011 census data.

Source: Australian Bureau of Statistics, Census, 2006 and 2011.

2.4.1. REMOTE SITES

The SSE included four remote sites, two of which were case study sites (Katherine West and East Pilbara) and two were enhanced tracking sites (Barkly and Derby). All remote sites were located in the north of Australia, Katherine West and Barkly are in the Northern Territory and East Pilbara and Derby are in the north of Western Australia.

The geographic areas covered by remote sites ranged from 47 km² to 371 603 km².

In 2006, total population of sites in remote areas ranged from 2795 to 6543. The total population of two sites (East Pilbara and Derby) increased significantly between 2006 and 2011 census (about 83% and 30% respectively). The total population remained relatively stable in the other two remote sites.

The proportion of the total population in the remote sites identifying as Aboriginal or Torres Strait Islander people ranged from between 22% to 76% in the 2006 Census. Between the 2006 Census and the 2011 Census, the number of people identifying as Aboriginal or Torres Strait Islander increased by 42% in East Pilbara, by 6% in Barkly, by less than 1% in Derby, and decreased by 3% in Katherine West.

2.4.2. REGIONAL SITES

The SSE included 12 regional sites. Three were case study sites (Bairnsdale, Port Augusta and Tamworth), four were enhanced tracking sites (Darwin, Cairns, Dubbo and Swan Hill/Mildura) and five were tracking sites (Geraldton, Gladstone, Grafton, Hobart and Kalgoorlie). Three regional sites were located in New South Wales, two were in each jurisdiction of Queensland, Western Australia, and Victoria and there was one each in South Australia, Tasmania and Northern Territory.

The geographic area of regional sites ranged from 30 km² to 95 576 km². The areas of five sites were less than 630 km² (Bairnsdale, Darwin, Cairns, Geraldton and Grafton) and the areas of the remaining sites (Port Augusta, Tamworth, Dubbo, Swan Hill/Mildura, Gladstone, Hobart and Kalgoorlie) were between 1100 km² and 95 576 km².

In 2006, the total population of sites in regional areas ranged from 13 874 to 189 637. The proportion of the total population that identified as Aboriginal or Torres Strait Islander people in the regional sites in the 2006 Census ranged between 3% and 17%. Between the 2006 Census and the 2011 Census, the number of people identifying as Aboriginal or Torres Strait Islander increased in almost all regional sites, with Dubbo showing the largest percentage increase of 30%.

2.4.3. URBAN SITES

The SSE included eight urban sites, three were case study sites (Brisbane South, Logan/Woodridge Campbelltown), two were enhanced tracking sites (Elizabeth, Newcastle) and three were tracking sites (Canberra, Dandenong and North Lakes/Caboolture). Three urban sites were located in Queensland; two were in New South Wales, and one in each jurisdiction in South Australia, Victoria and the Australia Capital Territory.

The geographic area of urban sites ranged from 242 km² to 4052 km². The areas of five sites were less than 500 km² (Brisbane South, Logan/Woodridge, Campbelltown, North Lakes/Caboolture, Elizabeth)

and of the remaining sites (Dandenong, Canberra and Newcastle) were between 1190 km² and 4052 km².

In 2006, the total population of sites in urban areas ranged from 126 717 to 493 466. The proportion of the total population that identified as Aboriginal or Torres Strait Islander people in the urban sites in the 2006 Census ranged between 0.5% and 3%. Between the 2006 Census and the 2011 Census, the number of people identifying as Aboriginal or Torres Strait Islander increased in all urban sites, with North Lakes/Caboolture showing the largest percentage increase of 48%.

3. NATIONAL ACTION TO REDUCE INDIGENOUS SMOKING RATES (*MEASURE A1*) & HELPING INDIGENOUS PEOPLE REDUCE THEIR RISK OF CHRONIC DISEASE (*MEASURE A2*)

3.1. Description of measures

The aims of the A1 and A2 measures are to reduce smoking rates and increase healthy lifestyle behaviours (quit smoking, improve nutritional choices, appropriate physical activity, access health services) by increasing the awareness of preventable chronic disease risk factors and healthy lifestyle choices amongst Aboriginal and Torres Strait Islander people. A further aim is to increase the capacity of participating Health Services to provide services and activities in order to support Aboriginal and Torres Strait Islander people to reduce their risk of chronic disease. Measures A1 and A2 have had a significant workforce implementation and training component. These measures are addressed together in this report as the workforce was deployed in teams and the measures have similar program logics.

The intention of measure A1 was to expand and up-skill a tobacco control workforce (Regional Tobacco Coordinators (RTC) and Tobacco Action Workers (TAW); and to a lesser extent, existing Health Service staff), who are capable of designing and delivering tobacco control programs based on best available evidence. It was expected that with these initiatives in place, Aboriginal and Torres Strait Islander people exposed to tobacco cessation activities would have a greater awareness and improved understanding of the services available to them and would seek assistance from these services in their attempts to quit smoking.¹¹

Similar to measure A1, measure A2 focuses on expanding and up-skilling a non-clinical workforce that will work to improve healthy lifestyle choices for individuals, families and communities. In addition to the design and delivery of community based activities, the Healthy Lifestyle Workers (HLW) were to refer people at risk of developing chronic disease to Health Services and refer those with an established chronic disease for help in managing their chronic disease. It was expected that by participating in A2 activities, Aboriginal and Torres Strait Islander people would have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean, and that Health Services would offer more support for Aboriginal and Torres Strait Islander people with or at risk of chronic disease.¹²

The key elements of these two measures included:

- **Funding to establish a national network of teams, consisting of Regional Tobacco Coordinators, Tobacco Action Workers and Healthy Lifestyle Workers.** Teams could be hosted in any organisation, including AHSs, DGPs, State Government or non-government organisations. Regardless of where the teams were based, it was intended that services provided by the teams would be accessible to all Health Services within the geographical region. A condition of funding

¹¹ DoHA, National Action to Reduce Smoking Rates Factsheet, <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/national-action-to-reduce-indigenous-smoking-rate/\\$file/DHA6136%20A1%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/national-action-to-reduce-indigenous-smoking-rate/$file/DHA6136%20A1%20Factsheet.pdf)> (accessed 14 December 2012).

¹² DoHA, Helping Indigenous Australians to Reduce Their Risk of Chronic Disease – Factsheet, <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/helping-indigenous-australians-to-reduce-their-risk-of-chronic-disease/\\$file/DHA6136%20A2%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/helping-indigenous-australians-to-reduce-their-risk-of-chronic-disease/$file/DHA6136%20A2%20Factsheet.pdf)> (accessed 14 December 2012).

included the development and implementation of a workplace smoke free policy within 12 months.^{13,14}

- **A funding program to support training and programs of learning and development for the new workforce.** The intention was to build the Aboriginal and Torres Strait Islander health workforce in the medium to longer term along with providing individuals with marketable qualifications and skill sets. Host organisations were responsible for developing tailored training programs together with individual workers, identifying relevant training courses, and applying to DoHA for funding to undertake the training.
- Additional training in brief interventions for around 1000 existing workers, such as nurses and AHWs.¹⁵
- **Funding and resources to support and to undertake community development activities.** Host organisations could apply for up to \$110 000. All organisations with funding allocation for these measures were provided with a range of toolkits and resources. The contents included training and reference materials, such as 'Talkin' Up Good Air', developed by the Centre for Excellence in Indigenous Tobacco Control (CEITC), the 'Healthy Deadly Strong' toolkit developed by the Australian Indigenous HealthInfoNet at Edith Cowan University and the Community Health Action Pack developed by DoHA for the *Live Longer!* campaign.^{16,17,18}
- **Additional resources were made available** including: A plain language guide to Nicotine Replacement Therapy (NRT) 'Medicines to help Aboriginal and Torres Strait Islander people to stop smoking: a guide for Health Workers' and an accompanying consumer booklet, 'Medicines to help you stop smoking'. The guide covered best practice use of all forms of NRT.¹⁹
- **Enhancements to Quitline** smoking cessation services to make the services more accessible and appropriate for Aboriginal and Torres Strait Islander Australians.²⁰
- **Funding was provided to NACCHO to facilitate effective workplace smoking policies.** This project aimed to assist all Aboriginal Community Controlled organisations become smoke free workplaces. A new Smoke Free Support Officer position within NACCHO was created. The funding agreement commenced August 2011 and is due to end on 30 June 2014.²¹

¹³ DoHA, National Action to Reduce Indigenous Smoking Rates, and Helping Indigenous People Reduce Their Risk of Chronic Disease, measure update, 12 August 2011.

¹⁴ DoHA, National Action to Reduce Indigenous Smoking Rates, and Helping Indigenous People Reduce Their Risk of Chronic Disease, measure update, 13 July 2010.

¹⁵ DoHA, National Action to Reduce Indigenous Smoking Rates, Fact Sheet, op cit.

¹⁶ Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report on the Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes - November 2010 <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-gp-kit-annual-progress-report-toc~ctg-gp-kit-annual-progress-report-Implementation-Progress>> (accessed 15 December 2012)

¹⁷ Centre for Excellence in Indigenous Tobacco Control (CEITC) [website] <<http://www.ceitc.org.au>> (accessed 15 December 2012).

¹⁸ Hon Warren Snowdon, MP, New health promotion resource to help close the gap [media release] <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws046.htm>> (accessed 15 December 2012).

¹⁹ Hon. Warren Snowdon, MP, Tackling Smoking and Chronic Disease [media release] <<http://LiveLonger!.health.gov.au/2011/12/13/regional-teams-tackling-aboriginal-and-torres-strait-islander-smoking-and-chronic-disease>> (accessed 15 December 2012)

²⁰ DoHA, National Action to Reduce Indigenous Smoking Rates, Fact Sheet, op cit.

²¹ NACCHO [website] <<http://www.naccho.org.au/health-reform/smoke-free-project>> (accessed 21 November 2012).

3.2. State of implementation – national context

The main achievements of measures A1 and A2 at the time of the final evaluation cycle, at a national level and of relevance to the SSE, are summarised below. This information has been extracted from information supplied by DoHA over the course of the evaluation period. The national level achievements are described in relation to the core components of the measures.

3.2.1. A NATIONAL NETWORK OF REGIONAL TACKLING SMOKING AND HEALTHY LIFESTYLE TEAMS

DoHA representatives consulted with the National Tobacco Control Technical Reference Group and the Indigenous Health Partnership Forums in each state and territory to determine the regions for workforce implementation, and other aspects of the program such as the approach to brief interventions.

In March 2010, Dr Tom Calma was appointed as the National Coordinator for Tackling Indigenous Smoking.²²

In November 2010 DoHA reported a redesign of the workforce element of these measures resulting in the workforce being deployed in teams to create a more concentrated effort in each region (herein referred to as 'Regional Tackling Smoking and Healthy Lifestyle teams'). This refinement meant the first stage of workforce roll out was slower than initially expected.

The majority of funding agreements nationally for Regional Tackling Smoking and Healthy Lifestyle activities (including variations to OATSIH funding agreements) were executed by February 2011. Nationally, the majority of organisations funded for these teams were AHSs.

The workforce of RTC, TAW and HLWs was funded in a staged roll out over 57 regions plus the ACT (21 regions plus ACT in 2010-2011, a further 19 funded in 2011-2012 and 17 in 2012-2013).

3.2.2. TRAINING AND PROGRAMS OF LEARNING AND DEVELOPMENT

Generally, two types of training, or support for training, were made available: workforce induction and orientation workshops; and a program of learning and development tailored for individual workers (to facilitate access to more formalised training leading to qualifications – particularly Certificate III or Certificate IV – and in recognition of experience and skills).

Three induction and orientation workshops have been held. A common purpose of these training events was to provide orientation to roles, to showcase available resources and programs, and to build networks across the new workforce. Induction training had two streams; 'Talkin' Up Good Air' and Smoke Check brief intervention training; and Living Stronger Training.²³ A 'Welcome Workshop' for Regional Tackling Smoking and Healthy Lifestyle teams was held in Canberra in December 2010, and a second information sharing workshop was held in December 2011. The workshop also included

²² Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report, op cit.

²³ DoHA, The Indigenous Chronic Disease Package in 2010-11 Annual Progress Report

<<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-2010-11-annual-progress-report~key-outcomes-2010-11~tackling-chronic-disease-risk-factors>> (accessed 8 October 2012).

organisations that were about to receive funding for workers and other stakeholders, such as some of the NACCHO affiliates and Quitline workers. The DoHA reported high attendance at these workshops.

Additionally, Regional Tackling Smoking and Healthy Lifestyle teams were invited to participate in the Live Longer Conference held in October 2012, along with successful round one and round two Local Community Campaign grant recipients (see Chapter 4).

Organisations employing Regional Tackling Smoking and Healthy Lifestyle teams had been funded to support those workers through Vocational Education and Training courses. Each worker had to develop a training plan. Job descriptions identified minimum entry and achievement levels: TAW and HLW aiming for Certificate II (initially as entry level), III or higher, and RTCs working towards Certificate IV at minimum. Training plans were to reflect these goals if required.²⁴

DoHA reported that training for the RTCs and TAWs was planned to be provided by the Centre for Excellence in Indigenous Tobacco Control (CEITC). This training was to draw on the centre's resource 'Talkin' Up Good Air' as well as specific modules developed about how to be a Tackling Smoking worker. As of July 2012, six training events had occurred (Cairns, Freemantle, Darwin, Nhulunbuy and two in Victoria) and CEITC were to undertake more activity after this date. On 27 September 2012 a NACCHO e-communique announced CEITC were inviting AHSs throughout Australia to register their interest in hosting or participating in the two day training workshop for TAWs or HLWs in tobacco control. CEITC reported workshops were scheduled for the last few months of 2012 in Launceston, Darwin, Alice Springs, Broome and Brisbane. The two day workshops replaced the 'Talkin' Up Good Air' one day workshop and propose to be more comprehensive by focusing on Aboriginal and Torres Strait Islander specific smoking cessation, community development, work plan and project development, event planning, evaluation and smoke free work place policy development.^{25,26}

In July 2012 DoHA reported that QUIT SA had been funded to provide the Quitskills training across Australia. Quitskills is a nationally accredited program on smoking cessation that is based on three units of competency from a Certificate IV in Population Health (assess readiness for and effect behaviour change; provide information on smoking and smoking cessation; provide interventions to patients who are nicotine dependent). This training has been specifically tailored for Aboriginal Health Workers and other people working in Aboriginal organisations. DoHA states that this may be a good way for TAWs to address their vocational education training needs. As of July 2012 training had occurred in Port Augusta/Whyalla.²⁷

Smoking cessation training, including brief intervention training, has been provided to other health and community workers, with the aim of reaching 1000 trainees over the period of implementation. In 2010-2011 DoHA reported over 200 workers were trained nationally. The DoHA reported that funding was provided to Quit Victoria to deliver brief intervention training in Victoria and NT. These involved group sessions with workers drawn from across the country. In July 2012 this activity was reported as completed.²⁸

²⁴ Ibid.

²⁵ NACCHO Media, Training workshop opportunity for Aboriginal Tobacco Action Workers throughout Australia, 27 September 2012 [NACCHO Communique].

²⁶ Centre for Excellence in Indigenous Tobacco Control (CEITC) [website] <<http://www.ceitc.org.au/training>> (accessed 10 October, 2012).

²⁷ QUIT SA [website], <http://www.quitsa.org.au/asp/register_for_training.aspx> (accessed 9 October 2012).

²⁸ DoHA, The Indigenous Chronic Disease Package in 2010-11 Annual Progress Report, op cit.

The Flinders Human Behaviour & Health Research Unit was funded in 2012/2013 for the Flinders Closing the Gap program to be expanded to include the Flinders Tobacco Cessation Training Module. This module, developed as stand-alone training to people who have completed the Flinders Closing the Gap program, was designed to be incorporated into all future training. Funding for this training is through Measure B4, Helping Indigenous People Self-Manage Their Risk of Chronic Disease (see Chapter 9). The training was available to the Regional Tackling Smoking and Healthy Lifestyle workforce.²⁹

3.2.3. RESOURCES AND FUNDING TO SUPPORT IMPLEMENTATION

ICDP developmental research was completed in October 2010. This informed the development and implementation of the 'Break the Chain' advertising campaign launched in March 2011. This campaign included Australia's first national Aboriginal and Torres Strait Islander focused anti-smoking advertising using national media (television, radio and print). The campaign ran parallel with the National Tobacco Campaign, the Australian Government tobacco control social marketing activity.³⁰

Regional Tackling Smoking and Healthy Lifestyle teams had access to funding for local community development programs or resources. In 2010-2011 DoHA reported that 13 organisations were provided with regional campaign grants and sponsorship to deliver social marketing activities through their Regional Tackling Smoking and Healthy Lifestyle teams. These included the 'Deadly Choices' program in South East Queensland and the Djurali program in Campbelltown.³¹

In 30 June 2010 DoHA reported that Edith Cowan University (HealthInfoNet) had been contracted to develop the 'Healthy, Deadly and Strong' resource packs. These were expected to be produced in early March 2011.

The 'Healthy Deadly Strong' toolkit was launched in December 2011 and distributed to all teams. It contained fact sheets on available resources, how to access them and appropriate use. Topics covered include nutrition, physical activity, alcohol, smoking, diabetes, kidney and heart health.³²

The HealthInfoNet News, 13 September, 2012 announced the Australian Indigenous HealthInfoNet launch of an online portal to support HLWs. The portal sought to compliment the existing resources that have been developed for HLWs by the HealthInfoNet, the 'Healthy, Deadly and Strong' toolkit and guide. Features of the portal are downloadable copies of the toolkit and guide and key facts and resources relating to lifestyle factors and preventable chronic diseases. There is portal access through the HealthInfoNet website, plus links to the Closing the gap Tackling Chronic Diseases and DoHA websites.³³

Other resources for the Regional Tackling Smoking and Healthy Lifestyle teams included the Community Health Action Pack (CHAP) and the plain language guide to NRT.

The CHAP was distributed to each team in December 2011. The CHAP booklets were also made available for download electronically from the *Live Longer!* website. This resource is discussed in

²⁹ Flinders Human Behaviour & Health Research Unit, The Flinders Closing the Gap Program [website] <<http://www.flinders.edu.au/medicine/sites/fhbhru/atsi-ccm/new.cfm>> (accessed 15 October 2012).

³⁰ DoHA, The Indigenous Chronic Disease Package in 2010-11 Annual Progress Report, op cit.

³¹ Ibid.

³² HealthInfoNet News, New online resource for Australia's Indigenous Healthy Lifestyle Workers [website] <<http://www.healthinonet.ecu.edu.au/about/news/1029>> (accessed 8 October 2012).

³³ Ibid.

Chapter 4. More copies of the CHAP booklet were planned to be distributed to Regional Tackling Smoking and Healthy Lifestyle teams and the second round of Local Community Campaigns grant recipients sometime after July 2012.

With the widespread awareness and use of NRT and the need to ensure good quality information and education for AHWs, the Tobacco Technical Reference Group recommended the development of a plain language guide to nicotine replacement therapy. The handbook 'Medicines to help Aboriginal and Torres Strait Islander people stop smoking: a guide for Health Workers', and an accompanying consumer booklet, 'Medicines to help you stop smoking', were launched in late 2011 as a free resource. The guide covers best practice use of all forms of NRT with an emphasis on the nicotine patch listed on the PBS for Aboriginal and Torres Strait Islander people, which can be obtained free under the Closing the Gap scheme.³⁴ DoHA report that the entire first print-run of five thousand copies were distributed within a few weeks and reordering was available.

Organisations with Regional Tackling Smoking and Healthy Lifestyle workforce allocation were to be provided with a tool kit as a starting pack for the workforce, with training materials and references. The pack was designed to be built on by the funded organisation. The contents of the kit were determined by a reference group and were to include training and reference materials, such as 'Talkin' Up Good Air' and the 'Healthy, Deadly and Strong' toolkit.

Healthy Community Days had initially been rolled out as part of the Local Community Campaigns program (see Chapter 4). In August 2011 the DoHA reported that the Regional Tackling Smoking and Healthy Lifestyle teams were being encouraged to apply for funding to run Healthy Community Days. In July 2012 the DoHA reported that it had become a part of new funding agreements to have Healthy Community Days on World No Tobacco Day.

3.2.4. QUITLINE ENHANCEMENT

In the period 2009-2010, funding was provided for the enhancement of Quitlines in all states and territories except Tasmania and the Northern Territory. In 2010-2011 DoHA reported that funding was in place for enhancement of Quitlines servicing all states and territories.^{35,36}

Data obtained from the progress reports to DoHA available for this evaluation report (most as at 31 May 2012, one as at 29 February and one at 30 April 2012) show that services were at differing stages of enhancement. Changes to the Quitline services included the employment of Aboriginal Enhancement Officers/Liaison Officers, employment of Aboriginal and Torres Strait Islander counselling staff, upskilling existing Quitline counsellors' cultural competencies and understanding of specific target groups, the commencement of routine collection of Aboriginal and Torres Strait Islander status of Quitline callers, consultation and development of culturally safe resource and support/referral processes, Quitline enhancement representatives visiting AHS's to raise awareness and upskill health professionals in the use and referral to the enhanced Quitline, providing tours of Quitline centres for AHWs as a way of upskilling and familiarising with the processes, developing Quitline referral partnerships with Health Services in specifically identified areas of high Aboriginal populations such as the NT remote service '100 Quit Club', and marketing of the new orientation of the service. DoHA reports that the Quitline

³⁴ The Hon. Warren Snowdon MP, media release, <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws057.htm>> (accessed 21 November 2012).

³⁵ Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report, op cit.

³⁶ DoHA, The Indigenous Chronic Disease Package in 2010-11 Annual Progress Report, op cit.

services were being encouraged to work with the Regional Tackling Smoking and Healthy Lifestyle teams. One service reported it had developed a list of all AHSs and RTCs and TAWs in the state and added them to the referral list.

3.2.5. NACCHO SMOKE FREE PROJECT

The progress reported from 30 June 2011 - 1 July 2012 included:

- The NACCHO Smoke Free Project officer commenced in November 2011.
- NACCHO Tackling Smoking Advisory Committee was created and was made up of representatives from NACCHO state and territory affiliates, Quitline Victoria, and CEITC. As of July 2012 they had met twice.
- NACCHOs smoke free workplace policy was launched on 31 May 2012.
- The NACCHO board intensive tobacco leadership program was being developed with the first workshop planned for 2-5 September 2012. The workshops are planned to be hosted throughout Australia for all member services – CEOs and Board members to June 2014.
- NACCHO emailed a survey to all member services to identify the number of services that had implemented smoke free workplace policies.
- The priorities for 2012-2013 were reported to be the Intensive Tobacco Leadership workshops, supporting AHSs to effectively develop and implement smoke free workplace policies, and to assist with culturally secure social media campaigns.

3.3. Findings from Sentinel Sites

3.3.1. PROGRESS WITH RECRUITMENT AND POSITION ADAPTATIONS

KEY POINTS

- Expansion of the tobacco and healthy lifestyle workforce has generally progressed well.
- By the final evaluation cycle, Regional Tackling Smoking and Healthy Lifestyle teams had been established across the majority of Sentinel Sites.
- Some local adaptations were made to the measure design to facilitate recruitment to positions.

Overall, data from the Sentinel Sites indicated that recruitment to Regional Tackling Smoking and Healthy Lifestyle teams was largely on track across urban, regional and remote sites, with 20 of the 24 sites having coverage by these teams in the final evaluation period. Sixty-four percent of those positions overall were filled, down from 74% in the preceding evaluation cycle, but this generally reflected an expansion in new positions not yet filled. The lack of appropriately skilled applicants and high turnover of staff continued to be issues of concern in several sites in remote, regional and urban locations.

Allocation of Regional Tackling Smoking and Healthy Lifestyle teams

Over the period of the evaluation the Sentinel Sites had an increase in the number of sites in which funding for Regional Tackling Smoking and Healthy lifestyle teams have been invested (from around 60% to up to 83% sites represented). In the final evaluation period there were four remote sites, nine regional and seven urban sites where funding had been allocated (noting that three of the urban sites were in an area covered by the same organisation and team). The majority of positions were allocated to AHSs in Sentinel Sites, as was intended in the design of the measures. Only one regional site had a team allocated to a state government health service.

Initially, the funding approach had been to allocate a complement of four staff to a Regional Tackling Smoking and Healthy Lifestyle team: one RTC, one TAW and two HLWs (with the exception of one urban site: one TAW, one HLW). Over the evaluation period, there has been further investment of TAW positions to the teams; one additional TAW in the 2011-2012 year and then again in the 2012-2013 year. This resulted in 15 of the Sentinel Sites being covered by a team with three TAWs allocated by the final evaluation period (includes the three urban sites covered by the same team in the total of 15).

Recruitment was similar for urban and regional sites in the latter three evaluation cycles, with most teams complete, or close to complete by the final evaluation cycle. At the final evaluation cycle, six of the seven urban sites had nearly full recruitment (three sites were covered by one team) and the remaining site had a half filled team (with some staff turnover in existing positions and some new positions under recruitment). Of the nine regional sites that had been allocated positions, six had near full recruitment, two were new teams undertaking recruitment and one team had low recruitment across all evaluation periods. The four remote sites had two nearly full teams, and two low to half filled teams. Difficulty with recruitment was the main constraint in establishing teams for these two sites.

Recruitment progress

Table 3.1 presents the state of allocation and recruitment to positions. The dates of the DoHA reported data do not align well with the evaluation cycles, and information from DoHA reports have been supplemented with information obtained at the time of the site visits, as described in table notes and Appendix C.

These positions generally have responsibility for geographic regions larger than the areas encapsulated by specific Sentinel Sites. In three urban sites one organisation was funded for the team that covered a large region, including the three sites. It should be noted that the positions for these three urban sites are only counted once in this table. In the final evaluation period, the organisation had been funded for a second team. This allowed the organisation to expand the number of positions, with one large team operating across the region. Not all workers referred to in this table were operating in the Sentinel Sites. At least two remote and one regional site had team members allocated to different organisations, some outside the sites.

Table 3.1: Regional Tackling Smoking and Healthy lifestyle team allocation and recruitment in Sentinel Sites, March 2011 - October 2012

Evaluation cycle	Two	Three	Four	Five
Number of Sentinel Sites with workforce allocation/Total number of Sentinel Sites	11/18 ^a	17/24 ^b	18/24 ^b	20/24 ^b
Overall % positions filled	55% (23/42)	69% (40/58)	74% (55/74)	64% (67/105)
Overall % RTC position uptake	50% (5/10)	86% (12/14)	80% (12/15)	83% (15/18)
Overall % TAW position uptake	55% (6/11)	60% (9/15)	68% (19/28)	50% (25/50)
Overall % HLW position uptake	57% (12/21)	66% (19/29)	77% (24/31)	73% (27/37)

^a The first evaluation cycle is not included as only stage 1 sites had been engaged (n=8) and no recruitment data had been available. In the second evaluation cycle there were 18 sites with signed participation agreements. From the third evaluation cycle onwards all sites had been established (n=24).

^b In evaluation cycles 3, 4 and 5 three urban sites were covered by the one Regional Tackling Smoking and Healthy Lifestyle team. The team has been counted once for the three sites. In evaluation cycle 3 it was a single team of 4 positions, by evaluation cycle 4 it was a team of five recruited staff and the final team had expanded to two teams working together as a team of 10 recruited positions. Varying numbers of the team members provide services across the region depending on the program needs.

Notes: The data are presented as 1.0 position equals 1.0 FTE or less. (e.g. 1.5 FTE recruited is recorded as two positions filled). The intention is to show the investment in a site as positions allocated and recruited, not actual numbers of people employed (as there can be more than one person per FTE).

All DoHA sources have been updated to reflect site visit findings, up to four months after the DoHA data source.

Source: DoHA, ICDP workforce tables for periods 15 March 2011, 30 June 2011, 31 December 2011 and 30 June 2012, and interview data (up to October 2012).

Regional Tobacco Coordinator positions

The overall recruitment status of RTCs to Sentinel Sites over the last three evaluation cycles has been relatively stable with an average of 83% RTC positions filled. Only three RTC positions were vacant at the time of the final evaluation, one of which was a new allocation.

Tobacco Action Worker positions

The trend in overall TAW positions shows there has been an increase in the number of positions in existing teams over the last three evaluation cycles, plus new teams established in three sites. Between the third and final evaluation periods there had been 35 TAW positions allocated in Sentinel Sites. In the final evaluation cycle, of the vacancies for all positions (n=38) in the Regional Tackling Smoking and Healthy Lifestyle teams, the majority (25/38) were TAWs. Sixteen of the vacant TAW positions were new allocations for the 2012-2013 year and not yet filled, one was previously filled but vacant in the final evaluation period and eight had not been filled over the evaluation (two in one site that had been allocated in 2010).

The relatively lower recruitment for these positions, averaging 59% over the last 3 periods, is partly due to newly allocated positions that had not yet been filled.

Healthy Lifestyle Worker positions

Over the last three evaluation periods, on average, 72% of HLW positions were filled. Of the 37 HLW positions allocated, 10 positions were vacant in the final evaluation cycle with four of those newly allocated. Despite recruitment attempts, four positions in two sites had never been filled and have remained vacant since being allocated in 2010. The majority of other sites had full recruitment of HLW positions across the evaluation period.

Local adaptations to positions to overcome recruitment challenges

Despite considerable progress in recruitment over, some specific challenges were noted. The most commonly reported reason for delays or difficulty in recruiting was the time taken for funding for the positions to be available to the employing organisations, the small pool of suitably skilled people to draw on and the availability of people with interest and skills in delivery of tobacco control programs.

To overcome some of these recruitment barriers and to better suit local contexts, host organisations in a number of Sentinel Sites adapted the RTC, TAW and/or HLW positions or requirements for these positions or implemented certain recruitment strategies. The local adaptations identified over the evaluation period included:

- Pooling of (or supplementing) funding from different sources to support establishment of more generalist positions. For example, in a remote site, the AHS pooled state and commonwealth Closing the Gap funding to create generalist health promotion positions. Furthermore, in a regional site, funding for ICDP positions (OW and HLW) was pooled and position descriptions changed, to reflect a broader role in supporting families to access Health Services.
- Specification of non-smoking applicants to support role modelling in Tackling Smoking roles. Although this is not a specific requirement from DoHA's perspective, at least one site felt that it was important and had adopted this in their selection criteria. In some sites non-smoking status was not considered to be an essential selection criterion, as this was perceived to be unrealistic, potentially limiting the pool of applicants, given the high smoking rates amongst the local population.
- Dual-roles/positions (Regional Tackling smoking and/or healthy lifestyle role combined with clinical duties into one position). In three Sentinel Sites, it appeared that Tackling Smoking and/or Healthy Lifestyle positions also had a clinical aspect to their role. It is possible that the reason behind combining these positions was to fit with skills of best available candidates for the role. However, there is some concern over the ability of workers to carry out clinical roles as well as the defined responsibilities of the positions. For example, it was evident from information

gathered at interview in a non-remote site that, due to clinical demands, the TAW had been unable to spend time doing tasks in the tackling smoking role. This was also evident at a remote site, where the interview did not take place because the worker had yet to commence in the tackling smoking aspect of her role. For these workers, the clinical role seemed to have the potential to ‘overshadow’ the role of Regional Tackling Smoking and Healthy Lifestyle positions, perhaps reflecting the priorities of the organisation or staff that may be in supervisory positions within the organisation, or the particular background of the worker.

- Using the funding allocation to fund workers in positions where other funding had ceased. For example, in a remote site, funding for an existing program ceased and workers from that program were appointed to HLW positions. This enabled ongoing employment of the workers and continuity in programs delivered in the community.
- Targeted or staggered recruitment to positions. For example, in one remote site, the AHS delayed recruitment processes for the TAW and HLW positions until the RTC position was established to create a mentoring or supervisory team structure. Recruiting local people to the new positions was also an important consideration for program effectiveness (see Vignette below).

Vignette – Local people to facilitate successful community based health promotion

The AHS in a remote site prefers to recruit local people to Tobacco Action Worker and Healthy Lifestyle Worker positions. A suggested recruitment strategy for the region has been to run a ‘Healthy Lifestyle Summit’ where community and health professionals come together and are informed of the healthy lifestyle worker role and healthy lifestyle message.

Experience indicates that it takes several years for workers from outside the community to effectively engage community groups in determining health promotion priorities and strategies, and to facilitate activities with potential to change health behaviours and lifestyles.

‘It takes at least a year to develop the relationship with the community and for community to trust, as for years people having been going out to community and asking questions and researching and taking away intellectual property from community. It’s at least another year to start to be effective and the third year just as they are effective the funding [usually] runs out.’
(AHS, program manager)

Local adaptations of the Regional Tackling Smoking and Healthy Lifestyle teams had implications for training and other capacity issues, including requirements to build a broader range of skills and knowledge to support health promotion, for people working in these positions and for their managers.

3.3.2. SKILLED AND EQUIPPED TOBACCO AND HEALTHY LIFESTYLE WORKFORCE

KEY POINTS

- There was a high level of engagement in various training activities across the Regional Tackling Smoking and Healthy Lifestyle teams.
- Where it had been accessed, training was generally valued by interviewees.
- There has also been considerable activity in development and distribution of toolkits and resources to support the workforce in their roles.
- The important influence of high-level support for individual workers became evident in the later evaluation cycles.

An important prerequisite for the design and delivery of smoking cessation and healthy lifestyle programs and services is an adequately skilled and equipped workforce. To achieve this, these measures supported a range of training and professional development opportunities for the new tobacco and healthy lifestyle workforce and for existing workers such as nurses and AHWs, together with access to funding, toolkits and other resources.

The staged rollout and time taken to recruit to new positions meant that it was too early to assess satisfaction with training in the first two evaluation cycles. In the later evaluation cycles, steady progress had been made with recruitment and interviewees were better able to comment on the training and the extent to which the training had equipped staff with knowledge and skills to fulfil their roles.

A relatively small number of workers have accessed and participated in brief intervention training. It was therefore not possible to gather substantive information on the extent to which these workers were satisfied and/or felt that the brief intervention training provided them with the necessary skills to fulfil their roles.

Satisfaction with training for new workforce

By the time of the final evaluation period, there was a high level of engagement by Regional Tackling Smoking and Healthy Lifestyle teams in the various training activities. This appeared to be facilitated by the dedicated funding made available to host organisations to cover travel and accommodation costs for these workers. In the final evaluation period when asked whether *‘training provided to ICDP workers has equipped them with skills to fulfil roles’*, 85% (17/20) of RTCs, TAWs and HLWs either strongly or partly agreed with this statement.

Regional Tackling Smoking and Healthy Lifestyle team members generally felt the training activities, particularly the workshops, had been useful and practical. The workshops were valued in building confidence and ability to talk with the community, particularly about smoking and physical activity; and for the opportunity to network and hear about what other workers were doing.

‘Lots of show and tell – it’s really good to learn about how other teams have worked, showing the know-how.’ (AHS, regional site)

'We have been able to access huge amounts of training - we have been treated so well ... The induction was invaluable as I came back knowing just what was expected. Expectations [were] clearly identified and this was helpful as this is a new role for the organisation.' (AHS, urban site)

Some considered the 'show and tell' style workshop as less valuable, possibly because the content was not at the level of what was required of the positions.

'I didn't think it was training, it was just packages that they were showing you. It was more information sharing. We need more on-the-job skill development.' (AHS, urban site)

As the Regional Tackling Smoking and Healthy Lifestyle teams became established there was a general consensus among individual workers and their managers about the need for on-the-job training. This was to ensure an appropriate level of skills and understanding was developed in relation to the varied skills of individual workers and their professional roles and responsibilities. The additional funding made available for individualised programs for learning and development was considered particularly important in supporting workers to achieve standard competencies as well as further accredited training.

'When we recruit, their skills do not match the requirements of the job. Even though the selection criteria do match it does not flow on to the jobs. Good things about the team is that there is funding to do individual professional development training as required.' (AHS, urban site)

'A population health diploma [has been] commenced by both HLWs and this was identified through the training plan developed as part of the funding agreement.' (AHS, urban site)

Further training implications appeared to be linked to the design of the workforce and to the adaptations of these positions that were made to suit local contexts (as described in the section above). One intention of the workforce redesign was to deploy workers in teams to facilitate a regional approach for working together. A number of interviewees commented on the importance of taking a team approach to training.

'This strengthens the team capacity to carry out the duties or the role and provide support to each other.' (AHS, urban site)

'So that we get a better understanding of each of the 'pillar's rather than just staying concentrated in specific areas of activities. It would be a much better environment to work as a team.' (AHS, urban site)

For those workers in positions that had been created through a pooling of funds (e.g. generalist positions) and those in a 'dual role' position (i.e. both clinical and health promotion components) there were expectations to attend different orientation workshops (for other ICDP workers, e.g. OWs). This meant time away from their role and family and was of particular concern to these workers as it presented barriers to their ability to attend training opportunities.

Awareness and perceptions of funding and resources to support development of programs and activities

Alongside the workforce training element under these measures, there has been considerable activity in the development and distribution of toolkits and resources. All organisations with funding allocation

for these measures were provided by DoHA with a range of toolkits and resources to support the Regional Tackling Smoking and Healthy Lifestyle teams in their roles.

Awareness of the toolkits and resources available under these measures increased over the course of the evaluation, particularly among workers who had attended the workshop where these toolkits and resources had been promoted. However, it was difficult to ascertain the extent to which these toolkits and resources were being used or have assisted in the development of evidence based programs and services. Whether or not these national resources were meeting an existing need was also unclear. It appears that lack of resources may not be a major issue, and that locating locally relevant resources and understanding how they can be applied and sustained in varying contexts is a greater challenge for the effective implementation of these measures.

'There's plenty [of resources]. People don't realise what's out there. It's about knowing where to look and how to get them.' (AHS, remote site)

'I have a store room full of flip charts, posters and resources ... The investment in resources doesn't make the difference, it is about long term projects that have stable workforce, which is hard in a remote context, to engage community so it can carry on through workforce turnover, and is an approach that the community wants.' (AHS, remote site)

'The information needs to be simplified for Aboriginal people.' (AHS, remote site)

'Any educational resources can be used but they need to be culturally suitable.' (AHS, remote site)

Policy level leadership and practical support

The important influence of high level leadership and support in steering the implementation of the Regional Tackling Smoking and Healthy Lifestyle initiatives became evident in the fourth and final evaluation cycles. Across Sentinel Sites, interviewees made specific reference to the National Coordinator, Dr Tom Calma (by name) and the DoHA Measure Manager, commenting on their leadership and ongoing practical support for the Regional Tackling Smoking and Healthy Lifestyle teams. Communication between workers and the National Coordinator and/or Measure Manager, was particularly evident (and helpful) in cases where individual workers felt unsupported or were lacking direction at the local level.

'I found out through talking to Tom Calma and the department and others that it is not the way the program is meant to run.' (AHS, regional site)

'... Tom Calma said we are not [involved in] clinical service delivery therefore this qualification does not really match the job description.' (AHS, urban site)

An AHS in a regional site was proposing to create generalist positions from the TAW and RTC funding. However, following discussions with the National Coordinator, the TAW and RTC roles in this site remained focused on tackling smoking.

'This is what Tom Calma wanted and we did not want to upset him.' (AHS, regional site)

3.3.3. DESIGN AND DELIVERY OF TOBACCO CONTROL AND HEALTHY LIFESTYLE PROGRAMS AND SERVICES

KEY POINTS

- The design and delivery of tobacco control and healthy lifestyle initiatives was slow initially, gaining momentum once Regional Tackling Smoking and Healthy Lifestyle teams were established in the Sentinel Sites.
- Programs and services varied and included individual patient support, health education and community campaigns, and implementation of smoke free workplace policies.

A major role envisaged for the Regional Tackling Smoking and Healthy Lifestyle teams was to design and deliver smoking cessation and healthy lifestyle programs and services in their local communities. The effectiveness of the workforce in being able to achieve this was dependent on a number of factors including the length of time in the position, skills and experience of individual workers, workforce leadership and support, and the availability and accessibility of locally relevant tools, resources and training.

Findings from the early evaluation cycles indicated many workers were in the ‘meet and greet’ stage and there was limited program activity. By the fourth and final evaluation cycles it was evident there were a range of activities being supported and delivered at a site level. It was not possible within the scope of the SSE to ascertain the degree to which these initiatives integrated evidence-based principles.

3.3.4. STRATEGIES WITHIN HEALTH SERVICES TO SUPPORT PATIENTS

Brief interventions, referrals to Quitline and support programs, raising awareness of medications available on PBS (e.g. patches) and encouraging patients to have regular health checks were common strategies used by Health Services to support patients in their attempts to quit smoking and lead a healthier lifestyle.

The need for greater access to face-to-face support for smoking cessation for Aboriginal and Torres Strait Islander people, particularly in remote communities, emerged during the evaluation. Whilst Quitline could potentially play a role in one-to-one support for smoking cessation, it is plausible that face-to-face support may be more effective and appropriate for some Aboriginal and Torres Strait Islander communities. Interviewees consistently indicated that this service was not being accessed by members of remote communities, due to language barriers and low telephone ownership. We have noted that a number of participants indicated they had called the Quitline but no one had got back to them or they were dissatisfied with the support. In a regional site, there were examples of ICDP workers facilitating patient access to Quitline by calling on behalf of patients.

‘No-one is going to ring up Quitline. Aunty needs someone to sit and support to give up smoking.’ (DGP, regional site)

‘If someone wishes to give it up it is their choice, if they want to make that choice with medication or patches, or I can ring Quitline for them.’ (AHS, regional site)

Culturally appropriate and supportive tobacco counsellors (face-to-face) was considered an important service for assisting Aboriginal patients in their attempts to quit smoking. An interviewee noted that the role of the Regional Tackling Smoking and Healthy Lifestyle team is one that requires *‘incredibly supportive counselling services’*. There are indications that in some cases the TAW/RTC are offering this type of support.

3.3.5. COMMUNITY BASED INITIATIVES

Services and programs developed and implemented by the Regional Tackling Smoking and Healthy Lifestyle teams have progressed steadily across sites and over the evaluation period, with the exception of sites where there have been delays in recruitment or changes in staffing. The program of work delivered by teams varied in the Sentinel Sites. Some examples of the diversity of work conducted in relation to the ICDP Tackling Smoking and Healthy Lifestyle measures included:

- **Social marketing activities:** raising community awareness of healthy lifestyle choices using nationally and locally developed campaign materials at events such as health expos, Healthy Community Day events (see Chapter 4) NAIDOC and Close the Gap celebrations.
- **Health education and skill development:** activities aimed at improving knowledge and understanding of healthy lifestyle choices and developing healthy lifestyle skills. Examples include smoke check brief intervention and smoking cessation programs, cooking and walking groups, ‘Deadly Choices’ program and traditional Aboriginal and Torres Strait Islander games.
- **Smoke-Free Workplaces:** Strategies to support AHSs implement their smoke-free policies. In one AHS, staff that leave the building to smoke are required to cover the organisational logo on their uniform. In this and in other AHSs, QUIT groups are being organised for staff and patients. Smoke-free workplaces are discussed further below.

The range of existing tobacco control and healthy lifestyle initiatives (funded at both state and national levels), made it difficult for interviewees and community focus group participants to tease out whether the initiatives they were aware of were funded and delivered through the ICDP Tackling Smoking measure or through some other initiative.

This context of multiple initiatives at local level suggests that there may be some benefit in ensuring complementarity of measures A1 and A2 in relation to these other initiatives, recognising that these other initiatives are subject to their own funding timelines and shifting priorities in the funding agencies.

It was difficult to ascertain the extent to which the interventions implemented at community level were in accordance with best practice. There were some examples of how Regional Tackling Smoking and Healthy Lifestyle workers engage with community, such as the ‘Talking not Telling’ story below.

Some key informants also highlighted the cultural importance of establishing relationships between community and individual workers.

‘... me being from the south west, this is not my country. I don’t come from here so it’s very important for me to meet with the Aboriginal Elders first – particularly the Chairman and get his approval as they are a very traditional community.’ (AHS, remote site)

Vignette - Talking not telling

An urban Healthy Lifestyle Team is finding a ‘talking not telling’ approach effective when working with young people in an eight-week school program about Smoking and Healthy Lifestyle. They use conversation, interactive activities and communication games to talk about nutrition, chronic disease, sexual health, substance abuse, physical activity and smoking. Young people have the choice to participate.

‘There are young people who are asking or talking about quitting smoking which has been a great outcome ... Once they know that you are there to help not just to deliver and go away that’s when the building of trust happens.’

Some people in the wider community question the effectiveness of the approach used in schools. *‘I wonder if they listen?’*

However the team, comprising young workers, attributes much of the program’s apparent success to the way it engages with young people. *‘Communication is the key in building this trust ... [and they] support the fact that [we use] positive message such as, it is ‘deadly not to smoke’, it is ‘deadly to eat good food’.’*

The relatively small number of positions, large distances and large service populations were consistently raised as issues impacting on the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams. These issues were identified by a number of stakeholder interviewees as the major challenges for the Regional Tackling Smoking and Healthy Lifestyle teams, in relation to how to implement a program and to have effective reach across a large area.

‘I think it is too much to expect [teams] to go out [across the region], even though they might not think that. Looking at it, you just go ‘wow’ to achieve the goals that COAG and Government would like them to achieve. I don’t think it is possible, just because of the sheer distance and the capacity of staff to do that work.’ (AHS, regional site)

‘This will be a challenge and I am sceptical of the impact the workers will make on a remote satellite clinic.’ (NACCHO, remote site)

‘[For] all the team to cover a huge geographic area and Aboriginal and Torres Strait Islander population is a challenge.’ (AHS, urban site)

The large geographic area to cover has required the teams to limit service delivery to particular parts of the area they are funded to cover. The lack of team capacity was evident in one urban site where it was perceived that programs were not responsive to community needs.

‘Our mob’s missing out. They seem to do a lot more of the big events, promotional events where you’ve got celebrities. Need to provide local community stuff to have a real impact on kids and families. Not the one off stuff.’ (Community focus group, urban site)

Vignette – extending reach

One urban Regional Tackling Smoking and Healthy Lifestyle Team highlighted the limitations of their health promotion program to facilitate change, because of the expectation for them to cover a large, densely populated region with a single team, and described some of the strategies they are using to maximise their impact in the face of this challenge.

‘In the Deadly Choices program at school we may be able to accommodate only 30 people where we should be covering more. At community days we [see] around 200 people, when we should be getting at least 500.’

A number of strategies are being used to reach more people. A trainee is being mentored by the team coordinator; a lesson guide is available to guide school presentations. Community and sporting days focus on activities and resources that are easy to show people and engage them to talk about chronic disease, effects of smoking and how to stay active for at least 30 minutes a day - diagrams, smoking and activity stations, pamphlets and a trailer with a big screen TV.

The organisation running the program is linking its work with other healthy lifestyle and training programs for Aboriginal and Torres Strait Islander people that are offered by the city council, state government and the NACCHO affiliate.

Interventions to support smoke free workplaces

Over the course of the evaluation, there was an increasing trend in the percentage of stakeholder interviewees who either partly or strongly agree with the statement, *‘workplaces have implemented smoke-free workplace policies as a result of the new tobacco workforce’*; from 30% (7/23) in the third evaluation cycle to 74% (25/34) in the final evaluation cycle. This was particularly influenced by interviewees from the Aboriginal Health sector, with 96% (23/24) agreement with this statement among AHS interviewees in the final evaluation cycle. This high level of agreement is consistent with the development and implementation of a workplace smoke-free policy being a condition of funding for these organisations.

Concern over the number of Health Service staff who smoke (including board members) presented challenges to gaining support for and enforcement of smoke-free policies. Key informants highlighted that more programs were needed to support Health Service staff and strategies to create non-smoking environments and workplace culture.

‘Services still have too many workers who smoke around services. Need more training and policies to reduce smokers in Health Services and to enforce non-smoking environment.’ (AHS, urban site)

‘A smoke-free workplace requires such a big shift in culture. When I first started here six and a half years ago, 50% of the workforce would have smoked. We are currently down to about two per cent, that’s been a massive smoking culture change and largely due to the smoking policy we did have in place; that came well before the ICDP.’ (AHS, regional site)

‘Smoke free workplaces are becoming more common – that is the way it is and get used to it. Supported from the top down, staff have to accept that’s it.’ (NACCHO affiliate, regional site)

Vignette - Smoke free Workplaces

An AHS in a regional city has used measure A1 funding to support their existing smoking cessation efforts and to fully implement a smoke free workplace policy. Success has led to plans to use A1 and A2 funding to take strategies to other services in the region.

Prior to the ICDP (in 2009), staff were consulted about establishing a smoke free workplace policy. While this policy was challenging to implement, when RTC funding became available the environment was conducive to implementing the 'Our Space' smoke free policy and rolling it out to community/patients. As a result, the approach was taken that staff should lead by example before such a policy could apply to patients. Smoking cessation programs were delivered internally under 'time to quit' funding through the substance misuse program.

'As professional health workers we need to set an example if we wish to tackle chronic disease and close the gap. We cannot educate our people and tell people to quit smoking and here we are smoking. It is about internally let's work together [to quit] and ... then take message to community and roll it out.'

In the 12 months that a Regional Tobacco Coordinator and Tobacco Action Worker have been employed they have engaged with the service's network of sites, using A1 funding to market the 'Our Space' concept and to offer support and assistance to reduce the number of people smoking. They work closely with two Healthy Lifestyle Workers (A2 measure funding) who support people who have quit to adopt healthy lifestyle practices. They plan to promote the approach to other AHSs in the region through a train the trainer model.

'[We] have a large area to cover so will ... sell the idea to the site first through networking and linking and communicating. Focus on areas where the AHS wishes to engage, start where strengths are [and] assist where needed ... One thing in favour of the project being successful and rolling out to a large area is that the budget is healthy. With a workforce of five or six people and budget ... a lot can be achieved.'

Organisation and management characteristics

Key organisational and management factors emerged as being important in the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams. These factors included an adequate level of organisational stability, adequate supervision of staff, particularly in sites where workers were required to cover large geographic areas, and good team functioning.

Organisations with clear structure and purpose, and a stable workforce in a supportive working environment, were in a better position to implement the measures more effectively. More advanced programs of work were evident in organisations with good supervision and where individual team members have clearly described and understood their roles and responsibilities.

'We're all on the same page, and this adds capacity to the system.' (AHS, urban site)

In the final evaluation cycle, when most of the Regional Tackling Smoking and Healthy Lifestyle teams were established in Sentinel Sites, 90% (18/20) of interviewees either strongly or partly agreed that having the workforce deployed in teams provided a supportive environment for workers. There was no clear difference in responses across remote, regional and urban locations.

A supportive supervisory structure enabled workers to link with others who have established credibility in the community and to cover communities that are separated by large geographic distances.

'It's unrealistic to think a new non-Aboriginal person will be able to make much of a difference unless she works closely with our Health Promotion Officers who have established credibility.' (AHS, remote site)

Where clear direction and leadership were lacking, the capacity of Regional Tackling Smoking and Healthy Lifestyle teams' to design and implement a comprehensive program of work was inhibited.

'The previous RTC was responsible for the tobacco part of it. I just had to focus on the nutrition side – so I don't know much about the tobacco programs.' (AHS, regional site)

'I'm just going off my job description. Feels like we just sink or swim.' (AHS, remote site)

'I've basically just come into the position and learning everything myself as well and I know the Healthy Lifestyle Workers are the same. I do weekly meetings with the HLW over the phone just to see how she's going and what she's doing. I don't want her to feel like I felt; coming into the position with not having any support. We don't want to be left in the lurch. [Organisation] are lucky that people are staying in their position.' (AHS, remote site)

3.3.6. AWARENESS OF THE REGIONAL TACKLING SMOKING AND HEALTHY LIFESTYLE WORKFORCE

KEY POINTS

- There has been growing awareness of the Regional Tackling Smoking and Healthy Lifestyle positions overall and across sites. Awareness was greater in urban sites and remote sites than in regional sites.
- Despite awareness of the Regional Tackling Smoking and Healthy Lifestyle teams increasing, at the time of the final evaluation cycle there continued to be limited awareness of these positions, particularly in regional sites and particularly amongst General Practice staff.
- These patterns of awareness were consistent with recruitment progress, challenges of achieving high population coverage, and the focus of work of these teams.
- Awareness of the Regional Tackling Smoking and Healthy Lifestyle teams amongst Health Service staff across sectors is relevant to the effectiveness of these measures, as these workers have a role in developing partnerships and supporting Health Services to deliver smoking cessation and healthy lifestyle activities and/or facilitating appropriate referrals.

Since the commencement of the SSE, there has been growing awareness of the Regional Tackling Smoking and Healthy Lifestyle positions overall and across sites (Table 3.2). Awareness appears consistent with greater numbers of people being recruited to these positions and increasing knowledge of the ICDP more generally across the Sentinel Sites.

Over the course of the evaluation, awareness of Regional Tackling Smoking and Healthy Lifestyle positions was greater in urban sites and remote sites than in regional sites. Lower awareness in the

regional sites reflects difficulties with recruitment and staffing changes. The difference in awareness levels of these positions between urban, remote and regional sites was less marked in the final evaluation cycle.

In Sentinel Sites, the vast majority of Regional Tackling Smoking and Healthy Lifestyle teams were based in AHSs, and as expected, interviewees from AHSs were generally more aware of the positions compared with interviewees from private General Practice or DGPs. Responses to the question ‘are you aware of the following positions ... [name]?’ are summarised in Table 3.2 below.

Table 3.2: Trends in managers’ and clinicians’ awareness of Regional Tackling Smoking and Healthy Lifestyle workforce (% who responded ‘yes’), overall and by sector

		Evaluation cycle		
		Three	Four	Five
Are you aware of a Regional Tobacco Coordinator position that is responsible for providing services in this Sentinel Site? MS, CS ^a	Overall	55% (n=64)	78% (n=54)	76% (n=45)
	Aboriginal Health Sector	60% (n=30)	88% (n=25)	86% (n=28)
	General Practice Sector	50% (n=34)	69% (n=29)	59% (n=17)
Are you aware of a Tobacco Action Worker position that is responsible for providing services in this Sentinel Site? MS, CS ^a	Overall	36% (n=64)	52% (n=54)	72% (n=46)
	Aboriginal Health Sector	40% (n= 30)	68% (n=25)	82% (n=28)
	General Practice Sector	32% (n=34)	38% (n=29)	56% (n=18)
Are you aware of a Healthy Lifestyle Worker position that is responsible for providing services in this Sentinel Site? CS, MS ^a	Overall	43% (n=60)	64% (n=53)	74% (n=46)
	Aboriginal Health Sector	52% (n=29)	64% (n=25)	82% (n=28)
	General Practice Sector	35% (n=31)	64% (n=28)	61% (n=18)

^a Type of interview respondent, see Appendix C for listing of interview types and respondent types.

n = number of people who responded. Included in the denominator are the respondents who indicated ‘don’t know/can’t say’.

Aboriginal Health Sector includes: AHS, NACCHO State and Territory affiliates.

General Practice Sector includes: General Practice, DGP and Division SBOs.

Over the course of the evaluation, including in the final cycle, there remained some GPs who were simply not aware of the positions, with a typical response being ‘I’m not aware of any of healthy lifestyle workforce positions.’

Lack of engagement with General Practice was also evident in interviews with staff of DGPs in a number of sites and staff of the SBOs who indicated that they were aware of the positions, but there had been minimal or no contact between this workforce and private General Practices. In some cases, interviewees were confused about areas of program responsibility, service delivery and links with state-based workforce. This was particularly evident in sites implementing the Healthy for Life program and where there had been significant investment in a state-based tobacco workforce.

‘I don’t know what has happened with this workforce. I know the positions are RTC, HLW and TAW and these have been given to the ACCHO sector to manage, but I don’t think they must be established yet, as we haven’t heard anything about status of plans to integrate with other ICDP funded workers or how General Practitioners will be able to access the services.’ (SBO, regional site)

'I know there are a couple of lifestyle worker positions that work out of the DGP, and I know that there are a couple of positions at the Aboriginal Health Service. The ICDP positions at the DGP work very well with the state-based healthy lifestyle positions.' (DGP, regional site)

3.3.7. BETTER ACCESS TO RESOURCES TO SUPPORT SMOKING CESSATION AND HEALTHY LIFESTYLE ACTIVITIES IN HEALTH SERVICES

KEY POINTS

- Regional Tackling Smoking and Healthy Lifestyle teams have had a limited role in increasing access to smoking cessation and healthy lifestyle resources in General Practices, with most work focused in AHSs.
- This appears to be related to lack of awareness of the roles (including their intended scope or responsibilities more generally), lack of communication and/or collaborative working relationships, including capacity to engage with clinicians, to support working across large geographic regions or populations, owing to workload in the AHSs.
- Healthy community days were identified as an opportunity to improve links between the healthy lifestyle and clinical teams.

The National Framework indicates that one of the intentions of measures A1 and A2 is to ensure that Health Services have access to evidence-based resources to support smoking cessation and healthy lifestyle activities. At a local level, provision for this is primarily through the services and support offered by the Regional Tackling Smoking and Healthy Lifestyle teams. There is also national support available through enhanced Quitline, national social marketing campaigns and availability of NRT through PBS; access to these components of the measures is discussed below and in the following sections.

Linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams

There was generally limited evidence of linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams. Interviews with GPs indicated that limited awareness of these workers was a barrier for the development of collaborative working relationships or an ability, on their part, to access support from the teams. Clinicians suggested some contact by the teams and possibly media or other means of communication would better enable them to make appropriate referrals.

'It makes it difficult to work together when you don't know who they are. I've had no communication, any offer to meet and greet or to work collaboratively.' (DGP, regional site)

'It would be good if they can keep us up-to-date of what they are doing, that would be fine. If they can send us emails, or pamphlets to remind us so that we can put them on the notice board that would be more beneficial and people can be more aware.' (GP, urban site)

By the final evaluation period, despite increased awareness of the Regional Tackling Smoking and Healthy Lifestyle teams, linkages between GPs/clinicians and the Regional Tackling Smoking and Healthy Lifestyle teams were still limited.

'[There is] more work to be done on linking with the other sections of Health Service such as tobacco and healthy lifestyle teams. We are looking to develop a system to do this. They previous have functioned a little bit independently.' (AHS, regional site)

There was evidence that the use of social networking media such as Facebook and Twitter had generated some interest and enquiries for GP services within the community. This has also created interest to develop events and programs for particular community groups.

Referrals between clinicians and the services offered by Tackling Smoking and Health Lifestyle teams, was an issue for patients, who reported a lack of support programs and follow-up in their efforts to quit smoking. For example, health service providers 'talk about smoking' or patients were prescribed Nicotine Replacement Therapy (NRT) but then there was no ongoing support.

'Doctors do support you and nurses support you, but when you come home and start again ... there is no practical support medium to long term.' (Community focus group, regional site)

'The AHS gives out tablets and patches but then when I go home there's no support from clinic staff.' (Community focus group, regional site)

'The AHW, doctors and nurses speak about smoking and tell you that you have to do it [give up], that's not support. Need support not be told what to do.' (Community focus group, urban site)

In one regional site, the Healthy Lifestyle Worker is an accredited dietitian and there was a perception that clinicians in the AHS were referring to the position more often as due to the ability to offer dietetic services rather than general advice and support. The HLW in this site also noted that generally referrals from GPs for services offered through the healthy lifestyle programs were not being received.

'Doctors refer patients to see me one on one probably because I am an accredited dietitian rather than a healthy lifestyle worker – so ticking two boxes. Generally the doctors are not referring patients to healthy lifestyle programs such as community kitchen or exercise group.' (AHS, regional site)

Vignette - Referral pathways

A large AHS in a regional site have found that having the Healthy Lifestyle team referral form outside the computer system was a barrier to clinical staff referring their patients to the Healthy Lifestyle team. This is being overcome by building an electronic template and ensuring access to the computer system by all teams in the Health Service.

'If a [patient] is identified as a smoker they are asked if they want to do something about it. The plan is that [an electronic] referral will immediately be sent to [the Healthy Lifestyle Team]. We will see if [members of] the tobacco team [are] available on the spot.'

Thus an improved computer system will be able to opportunistically link patients with Tobacco and Healthy Lifestyle Workers.

Awareness and uptake of nicotine replacement therapy

Awareness of the availability of NRT patches and medication was high among community focus group participants. PBS Co-payment measure data also showed increasing uptake of NRT during the period of ICDP implementation. The extent to which advice and prescription of NRT is integrated into evidence-based behaviour change communication campaigns was not able to be ascertained in this evaluation.

Specific comments were made about *'patches and tablets'* in community focus groups with some community members referring to *'champix'*. Key informants also spoke about the availability of NRT on the PBS and considered this as a positive step in supporting a larger group of patients in their attempts to quit smoking.

'Now that these are on PBS, people don't have to miss out.' (DGP, regional site)

'The [community activities] have had a great impact on people's interest to stop smoking. I have had patients who came to me saying 'I have heard that patches are available through PBS – [I] would like to do this ...' (AHS, urban site)

A review of the uptake of NRT through an examination of the PBS Co-payment measure data showed that over the period of implementation of ICDP, there has been an overall general upward trend in number of Aboriginal and Torres Strait Islander people prescribed NRT (Figure 3.1).

The number of NRT prescriptions per 1000 Aboriginal and Torres Strait Islander people aged ≥ 15 years increased about three-fold between September - November 2010 and March - May 2011, with no further increase to March - May 2012. There was a slight seasonal dip in September 2011 - February 2012 for both regional Sentinel Sites and the rest of Australia (Figure 3.2). A greater number of NRT prescriptions per 1000 people were given for Sentinel Sites than for the rest of Australia throughout the period. There were no NRT prescriptions recorded in remote Sentinel Sites, as NRT should be available under S100 supply arrangements in remote locations. The changes in NRT PBS item number prescriptions are difficult to interpret in the context of new items becoming available in 2011.

The number of NRT prescriptions per 1000 Aboriginal and Torres Strait Islander people aged 55 or more was approximately twice that for those aged 15 to 54 years, with similar patterns between Sentinel Sites and the rest of Australia (Figure 3.3).

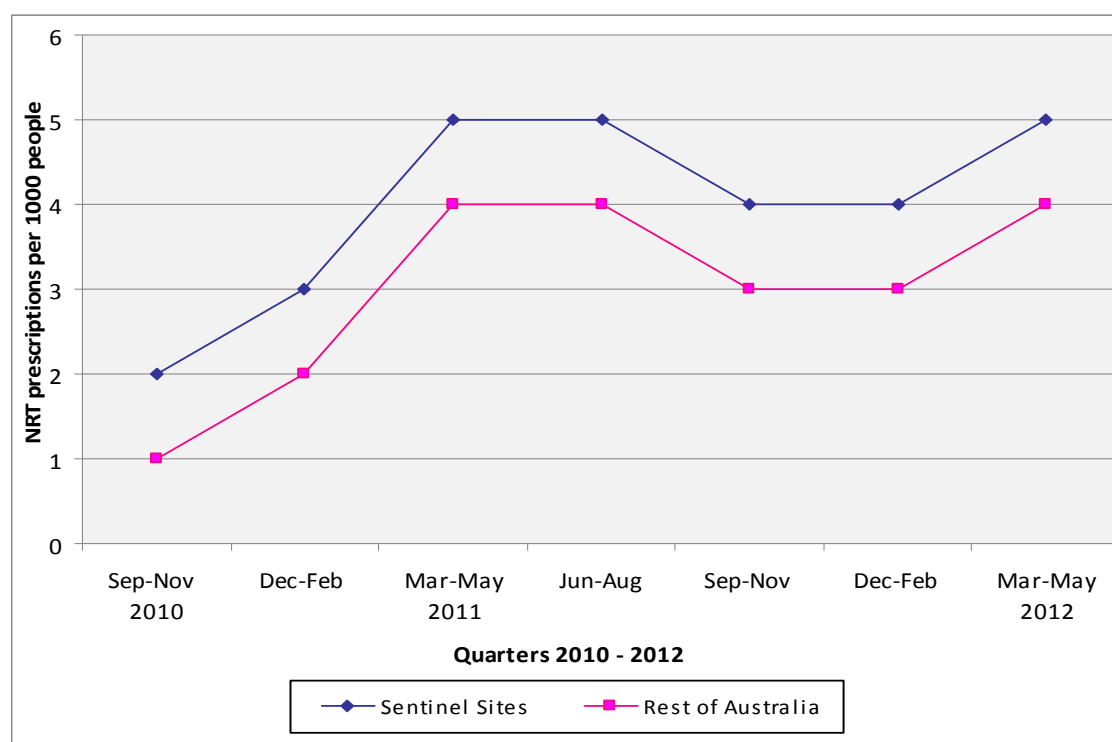


Figure 3.1: Number of prescriptions for nicotine replacement therapy per 1000 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia by quarter, September 2010 – May 2012

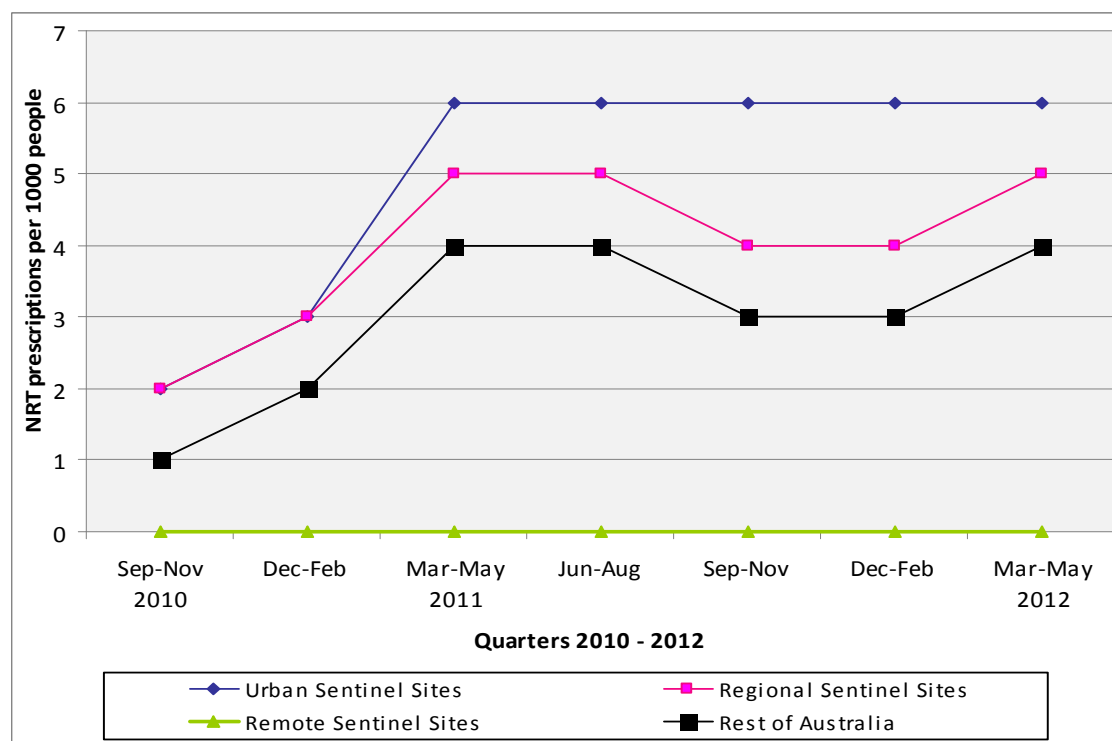


Figure 3.2: Number of prescriptions for nicotine replacement therapy per 1000 Aboriginal and Torres Strait Islander people aged ≥ 15 years by remoteness of Sentinel Sites and the rest of Australia and quarter, September 2010 – May 2012

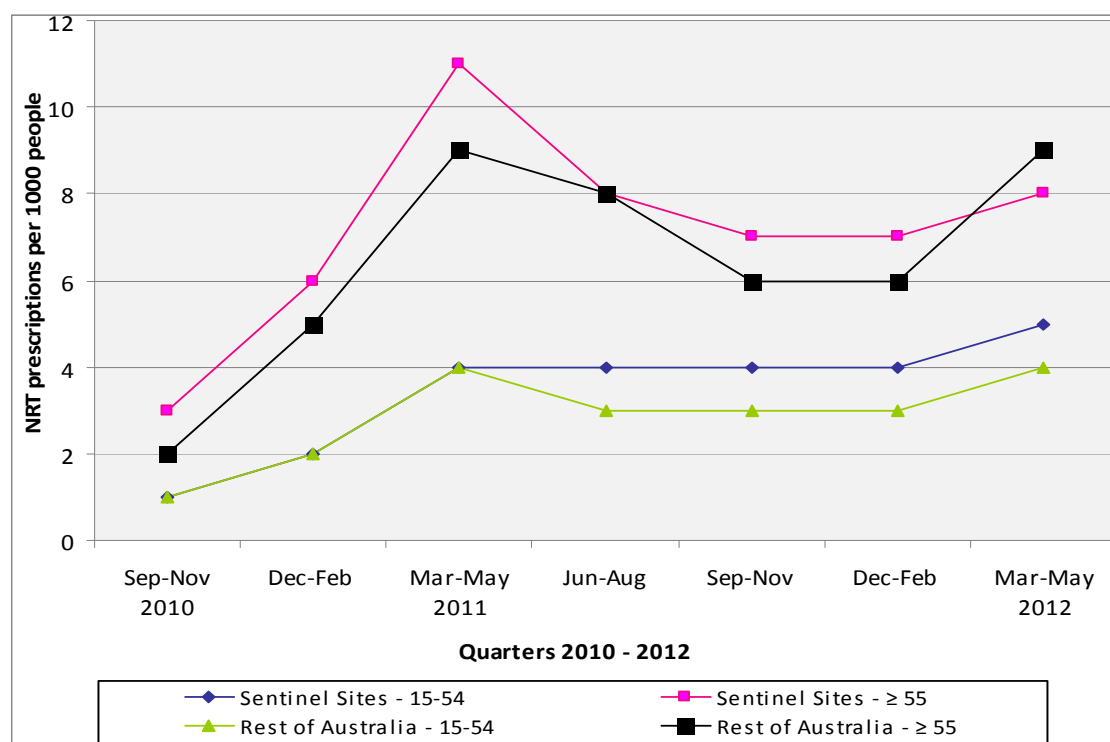


Figure 3.3: Number of prescriptions for nicotine replacement therapy per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by quarter and age, September 2010 – May 2012

3.3.8. BETTER ACCESS TO SMOKING CESSATION AND HEALTHY LIFESTYLE RESOURCES FOR COMMUNITIES

KEY POINTS

- A range of community-level activities in relation to these measures were evident, including social marketing events, group work and one-to-one support to motivated patients.
- Some of these activities involve linkages or brokerage between patients and other resources, for example, Regional Tackling Smoking team calling Quitline on behalf of patients who experience barriers to doing it themselves.
- These activities take place in the context of a range of other pre-existing tobacco control and healthy lifestyle initiatives at both state and national levels.
- Community focus group discussions indicated a generally high level of community awareness of the workforce.

Community awareness of the Regional Tackling Smoking and Healthy Lifestyle teams has increased over the evaluation, in some sites more than others.

Community focus group discussions showed community members in remote sites to be less likely than those in urban and regional areas to be aware of the Regional Tackling Smoking and Healthy Lifestyle team and programs and services. This is consistent with stage of program implementation in remote sites and the limited awareness among the private General Practice sector, described above. Regional

Tackling Smoking and Healthy Lifestyle teams appear not to have extended their reach to the patients of General Practices in their regions. Youth community focus groups also showed lower awareness.

The level of awareness of the teams appears to be influenced by the length of time workers had been in positions and the extent to which programs have been delivered in communities. As indicated above, at the time of the third evaluation cycle, workers were newly recruited and many were in the 'meet and greet' phase and there was little evidence of program activity. In the later evaluation cycles, several community focus group participants were able to name individual workers and describe some healthy lifestyle and tobacco related initiatives (although, not all were ICDP funded programs). This was particularly evident in community focus groups held in urban sites.

3.3.9. COMMUNITY AWARENESS, UNDERSTANDING, HEALTH SEEKING BEHAVIOURS AND SMOKING STATUS

KEY POINTS

- Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation. Pre-existing programs, including national social marketing campaigns and promotion related to plain packaging legislation, appears to have contributed to the high levels of awareness.
- There has been a general increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles, as reflected in clinicians' responses.
- Over the course of the evaluation, self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.
- At Health Service level, there was a notable lack of recording of smoking status in clinical information systems, with implications for identifying 'target' groups and monitoring effectiveness of community based activities

Changes in awareness and understanding

Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation. Existing programs, including national social marketing initiatives and promotion related to plain packaging legislation, were identified by community focus group participants in earlier evaluation cycles and these appear to have contributed to the high levels of awareness in the community of the risks of smoking and healthy lifestyle behaviours. Community focus group participants spoke of smoking, poor nutrition and lack of exercise and their consequences, including problems with heart, lungs, throat and stomach. Participants appeared to be well aware of the health issues and risks associated with chronic disease, stating '*Yeh, we live it*'.

Changes in help seeking behaviours

There has been a general increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles. Over the course of the evaluation, clinicians were asked to respond to a series of statements regarding their perceptions of community health seeking behaviours related to these measures. The proportion of clinicians agreeing with the statement '*there has been increased interest from patients to seek support to implement healthy lifestyle choices in the past six months*' has shown a general trend of increase across the evaluation period with some decline evident

in the fourth evaluation period before increasing in the final evaluation period. A similar trend was evident in the proportion of clinicians agreeing with the statement *‘there has been increased interest from patients seeking support to quit smoking in the past six months’*. To the extent that the decline in agreement with these statements in the fourth evaluation period may be real, the change may reflect a better understanding about the complexities of behaviour change, and this should inform a more solid platform for planning and program implementation.

Table 3.3: Trends in clinicians perceived changes in client behaviour (% who responded ‘strongly agree’ or ‘partly agree’), overall and by rurality

	Rurality	Evaluation cycle				
		One	Two	Three	Four	Five
Over the past six months there has been an increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking.	Overall	57% (n=16)	52% (n=33)	56% (n=25)	40% (n=20)	80% (n=20)
	Remote	71% (n=7)	20% (n=5)	50% (n=8)	33% (n=3)	80% (n=5)
	Regional	50% (n=4)	59% (n=17)	33% (n=6)	40% (n=10)	50% (n=2)
	Urban	40% (n=5)	55% (n=11)	73% (n=11)	43% (n=7)	85% (n=13)
Over the past six months, there has been an increased interest from Aboriginal and Torres Strait Islander people seeking support to implement healthy lifestyle choices.	Overall	13% (n=16)	39% (n=33)	65% (n=23)	55% (n=20)	65% (n=20)
	Remote	43% (n=7)	60% (n=5)	75% (n=8)	67% (n=3)	60% (n=5)
	Regional	50% (n=4)	29% (n=17)	50% (n=4)	50% (n=10)	50% (n=2)
	Urban	40% (n=5)	46% (n=11)	64% (n=11)	57% (n=7)	69% (n=13)

^a Clinician interview used, see Appendix C for listing of respondent types.

n = number of people who responded to statement. Included in the denominator are the respondents who indicated ‘don’t know/can’t say’.

A greater percentage of clinicians in the Aboriginal health sector strongly or partly agreed to these statements related to Aboriginal and Torres Strait Islander people seeking support.

In the final evaluation cycle, 47% of interviewees strongly or partly agreed to the statement *‘the availability of support provided through the HLWs has led to more adult health assessments, GP Management plans or team care arrangements’*. There has been an increasing trend in agreement with this statement over the evaluation period. Across the evaluation cycles a greater proportion of interviewees in urban and remote sites agreed with the statement, compared with interviewees in regional sites. This may reflect recruitment progress and/or relatively less focus in these aspects of care by HLWs in regional sites compared to urban and remote locations. Limited capacity of the HLWs or an existing capacity within services (and therefore no need for the HLW to take on this role) were cited as reasons for the perception that HLWs had not led to increased adult health assessments, GP Management plans or Team Care Arrangements.

Over the course of the evaluation, self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.

'There are supports available, but you make it work if you want to ... we still go around and smoke ... you got to help yourself, the will power ... knock off yourself to give up smoking.'
(Community focus group, regional site)

'Awareness is there. There has been some behaviour change, but its up to the individual.'
(Community focus group, regional site)

Some participants went so far as saying that this is the reason they don't feel the need to go to the clinic for help.

'Stop smoking programs need to respect that it's my business and people can make their own choices.' (Community focus group, regional site)

One of the strategies to increase motivation to change identified by informants was to target younger age groups in order to put pressure on parents – a positive impetus for change, based on parents concern about the effects of their behaviour on young children (e.g. secondary smoke) and the respect of their children. This strategy is consistent with a growing body of literature showing that relationships between people, within families and communities, take precedence over other influences, such as an individuals' knowledge of chronic disease, on health behaviours.

'It's not just about educating the kid. That kid could go home and educate the parent and that's a big thing that doesn't happen. There are a lot of kids that come to youth group that have spoken about things that happen. They want their families to change, their parents to do this and do that and smoking does come up. They want their parents to quit smoking.' (Community focus group, urban site)

Given the stage of implementation of these measures, the complex long-term nature of behaviour change and challenges of attributing impact to specific public health initiatives, it could not be expected that these measures have had a significant role in achieving change in levels of smoking (or healthy lifestyle behaviours more generally) at this stage.

Changes in smoking status

At Health Service level, there was a notable lack of recording of smoking status in clinical information systems. Documentation of smoking status is an important step in the implementation of brief interventions and smoking cessation measures in Health Services. This lack of documentation has implications for identifying 'target' groups and monitoring effectiveness of tobacco control activities.

Enquiring about and recording smoking status is an important first step in the implementation of brief interventions and smoking cessation measures in Health Services. A number of General Practices and AHSs provided clinical indicator data on smoking status. Whilst these data have serious limitations, they do give a sense of the extent of under-documentation and accuracy of documentation of key indicators, including smoking status. More general limitations to the clinical indicator data are described in Appendix E.

In the final evaluation period, 12 AHSs and 24 General Practices provided clinical indicator data. Data were analysed for Health Services with over 100 Aboriginal and Torres Strait Islander patients identified on their clinical information system. Amongst these Health Services, the majority (26/28) provided data on smoking status of their patients. This is higher than the proportion that provided data on smoking status in previous evaluation periods.

For those AHSs and General Practices that provided clinical indicator data on smoking status, 51% and 72% of patients respectively had smoking status recorded (Table 3.4). Amongst the sub-set of patients with diabetes, 77% of AHS patients and 82% of GP patients had smoking status recorded. Rates of 'current smoking' reported for patients of both sectors combined were around 35%. This is higher than for the Health Services that provided data for the fourth evaluation period, where the corresponding figure was 30%. This difference is likely to be in large part due to the additional services providing relevant data for the final evaluation period, and the difference in recorded smoking status between these services and the services that provided relevant data for the fourth evaluation period. These differences, and the wide variation between both AHSs and General Practices in the recording of smoking status and the proportion of patients identified as smokers, highlight the sensitivity of these clinical indicator data to changes in the range of services that provide relevant data. In the fourth evaluation period, limitations of these data as a result of under-documentation of smoking status were highlighted. While this continues to be a limitation, the extent of under-documentation is considerably less.

The limitations of currently available clinical indicator data for monitoring smoking rates is also highlighted by the difference between the rates reported through these clinical information systems on smoking rates amongst the general Aboriginal and Torres Strait Islander population of close to 50%.³⁷ The reported rates through the clinical indicator data are nevertheless considerably higher than reported rates for the general Australian population of around 15%.³⁸

Encouraging primary health care services to improve the accuracy and completeness of recording of smoking status could be a useful focus of work for the Regional Tackling Smoking and Healthy Lifestyle teams as a means to encourage appropriate targeting, delivery and monitoring of smoking cessation, such as brief interventions, and broader tobacco control activities.

Table 3.4: Clinical indicators provided by Health Services for Aboriginal and Torres Strait Islander people

Indicator	Aboriginal Health Services				General Practice			
	Mean	n	Min	Max	Mean	n	Min	Max
Proportion of all patients who have had their smoking status recorded in the past 12 months	51.3%	10	15.0%	91.1%	71.8%	16	33.8%	96.1%
Proportion of all patients who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	30.7%	5	9.6%	51.5%	32.2%	16	13.4%	54.8%
Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months	76.8%	3	50.0%	91.9%	82.1%	16	0.0%	100.00%
Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	30.4%	3	21.6%	35.1%	28.2.0%	16	0.0%	66.7%

Note: n= number of services.

³⁷ AIHW 2011. Substance use among Aboriginal and Torres Strait Islander people. Cat. no. IHW 40. Canberra: AIHW. <<http://www.aihw.gov.au/publication-detail/?id=10737418268>> (accessed 7 June 2012).

³⁸ AIHW 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

3.3.10. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Dedicated workforce with team structures and strategic focus required for implementation and was enabled by high level flexibility for local adaptation and a feeling of being a 'collective' workforce. Organisations needed to have the values and capacity to provide support and ability to tailor the workforce structure and focus of work to meet local context imperatives.
- Workers were more effective when they had existing connections or ability to develop connections with the community, access to training and professional development, good working relationships with staff within the organisation and across other service providers, and willingness to work outside normal working hours (to support Healthy Community Day events).
- Pre-existing skills of individual workers helped to activate measure implementation, but could operate as constraints when coupled with competing demand for their skills (e.g., for the clinical skills of AHWs recruited to teams where host organisations had high clinical workloads)
- Generally, a history of health promotion activities (including workers and programs or services) meant that organisations were better positioned to implement the measures at a site level, while a perceived lack of organisation and/or sector role in health promotion limited engagement with A1 and/or A2 measure activities.
- Improved health promotion capacity of the general primary health care workforce supported implementation of these measures and was activated by collaborative activity between clinical and Regional Tackling Smoking and Healthy Lifestyle teams.
- Community demand for more follow-up support indicated a need for greater integration of smoking cessation services with evidence-based behaviour change programs.
- Health Service system constraints in documenting and monitoring brief intervention and smoking status had implications for identifying 'target' groups and monitoring effectiveness of community based activities.
- Enabling linkages that emerged were joint training and networking opportunities for ICDP workers, and development of multidisciplinary team approaches to chronic disease self-management, that involved Regional Tackling Smoking and Healthy Lifestyle workers.
- Constraints to complementary linkages included the wide range of initiatives, stakeholders and service providers in local areas, lack of collaboration between sectors and/or organisations and lack of awareness or clear role definitions for different workers. Vast geographic distances and large service populations were also constraining factors

Effective implementation of this measure as envisaged in the program logic would enable services to support a skilled and equipped workforce to deliver, enhance access and increase demand for evidence based programs and services that reduce risk factors for chronic disease. This chapter has outlined a range of enablers and constraints that influenced the extent to which implementation could be achieved at local level.

The main mechanisms through which this measure appeared to achieve change are described below, and shown in the central boxes in Figure 3.4. Enablers and constraints related to each of the main mechanisms are also shown in the figure, and described in the accompanying text.

Constraints		Mechanisms		Enablers
•Geographic coverage and/or large service population •Not all positions filled or unsuitable person in job role •Lack of local orientation and support •Individuals working in silos	→	Dedicated workforce with team structures and strategic focus	←	•Funding and availability of workers to establish team •Flexibility in guidelines for recruitment •Shared understanding of individual & team roles •Policy and regional level leadership and accessible support (e.g. RTCs, National Tobacco Coordinator, Measure Manager)
•Perceived lack of organisation and/or sector role in health promotion •Acute care focus or clinical demand •Lack of management capacity to lead or create supportive environment for workers	→	Organisational environment with values and capacity to provide support	←	•Ability to absorb new resources and adapt to changes •Organisation has clear understanding of needs and priorities •Good management and supervision of workers
•Inability to attend training •Isolation of workers •Timeliness of availability of resources •Perceived lack of relevance and value of resources	→	Capability of the new health promotion workforce	←	•Access to adequate and quarantined funding •Team training, on-the-job and networking opportunities •Worker co-location •Skills of workers to develop positive relationships with key target groups •Motivation and commitment of individual worker •Capacity to identify and support individual worker training needs suited to context
•Lack of perceived benefit or understanding of health promotion among general primary health care workforce •Limitations of clinical information systems to support and monitor access to relevant range of services	→	Health promotion capacity of the general primary health care workforce	←	•Collaborative activity between clinical and Regional tobacco and healthy lifestyle teams •Availability of NRT on PBS •Clinical information systems capture access to a range of relevant services

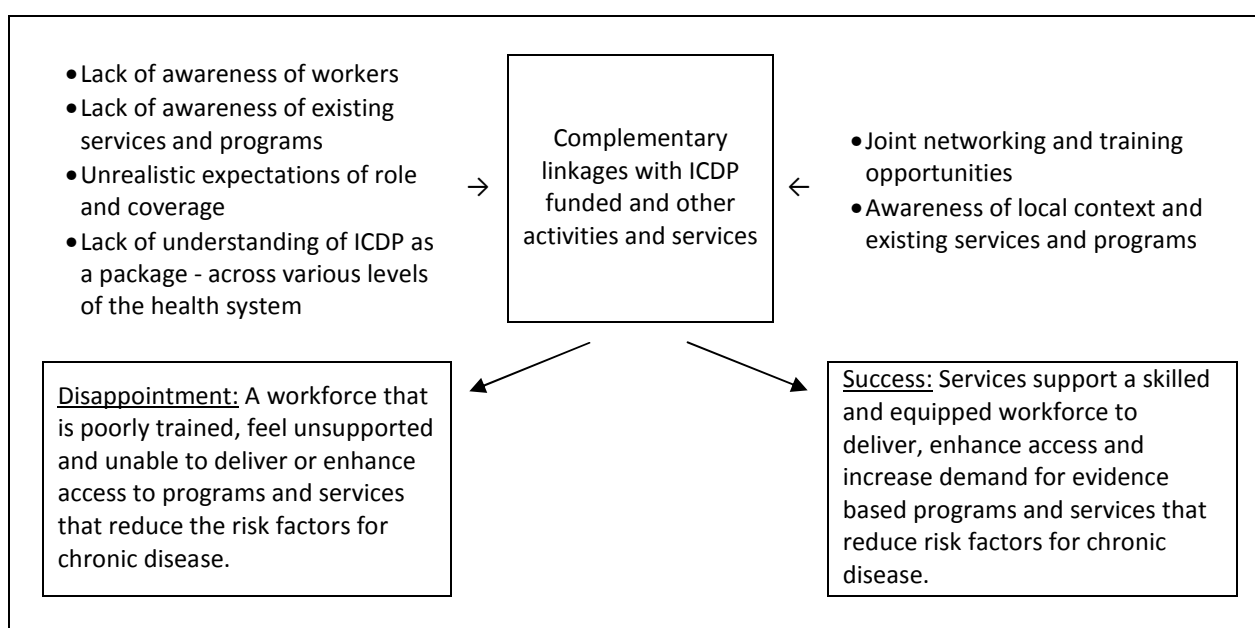


Figure 3.4: Enablers and constraints to effective implementation of the National Action to Reduce Aboriginal and Torres Strait Islander Smoking Rates and Helping Aboriginal and Torres Strait Islander People Reduce their Risk of Chronic Disease measures

Dedicated workforce with team structures and strategic focus

The establishment (i.e. recruitment and retention) of a dedicated workforce with team structures and strategic focus was a key mechanism through which Measures A1 and A2 could achieve the aim of designing and delivering a range programs and services to reduce risk factors for chronic disease in Aboriginal and Torres Strait Islander communities. In the Sentinel Sites, it was apparent that establishment of this workforce was influenced by a number of factors. Key factors were the way the measures were implemented; the ability of the host organisations to integrate the new workforce; and the characteristics of the individual workers.

Since the A1 and A2 Measures included a significant and new investment in positions and a plan to deploy these positions in regional teams, the collective capacity of workers in these teams would be expected to be a key factor in influencing the design and delivery of local programs and services, and indeed this was evident in the Sentinel Sites. In host organisations with an established Regional Tackling Smoking and Healthy Lifestyle Team (i.e. individual workers recruited to allocated positions), as envisaged in the design of the measure, there was greater likelihood that these teams were able to design and deliver a broader range of smoking cessation and healthy lifestyle programs and services and subsequently offer more support for the local targeted population when compared with host organisations with less collective capacity (i.e. not all Tackling Smoking and Healthy Lifestyle positions filled).

Flexibility in program implementation at a high level was also an enabler for establishing a dedicated workforce. Funding and policy changes at a national level enabled workers with similar roles to form teams. The appointment of Dr Tom Calma, as the National Coordinator for Tackling Indigenous Smoking was associated with positive effect. Dr Calma played a key role in promoting the national agenda whilst influencing the establishment of site level workers, particularly the Tackling Smoking workforce. He created a feeling among workers of being part of something greater – a ‘collective’ workforce. While position descriptions for the new workforce – RTC, TAW, HLW – were prescribed at the national level,

there was some scope for adaptation. This enabled host organisations to negotiate modifications to roles and selection criteria with DoHA to suit local contexts.

Factors related to the characteristics of the individual workers also enabled the establishment of this new workforce. These included existing connections or ability to develop connections with the community (often in relation to Indigenous identity and cultural obligations) and the ability to tailor the focus of work and/or the approach to deploying workers in order to meet community needs and/or local context imperatives. Individual worker capacity was often enhanced through access to training and professional development (see related mechanism below). Other enablers associated with establishing the new workforce included prior and good working relationships with staff within the organisation and across other service providers (see mechanism related to complementary linkages described below), and a willingness to work outside normal working hours (for example, on weekends to support Healthy Community Day Events).

Pre-existing skills of individual workers was a factor that activated the mechanism. For example, some clinically qualified workers recruited from within host organisations or from a predominately clinical role (e.g. Aboriginal Health Workers; Allied Health staff) experienced difficulty engaging in Tackling Smoking or Healthy Lifestyle Worker roles because of two factors. This was particular an issue in settings where high clinical workloads within host organisations placed ongoing demands on their clinical skills. Lack of full engagement could also be influenced by limitations in health promotion knowledge and skills. To some extent, training and professional development opportunities were able to counter limitations in worker skills and knowledge, but where organisational structures and support were lacking, including, for example local orientation processes; this appeared to be a constraint to the effective implementation of community based smoking and healthy lifestyle activities (see discussion related to organisational environments below).

A dedicated Tackling Smoking and Healthy Lifestyle team with a strategic focus was difficult to achieve in contexts where there were limited numbers of suitably qualified/or eligible individuals who were interested in these positions; large geographic areas and/or large service populations; unsuitable people recruited to positions or where individual workers operate in silos. To some extent, where such factors impacted significantly, the flexibility in the measure design and program implementation enabled host organisations to overcome these barriers, for example, adaptations to position descriptions and recruitment processes to suit local circumstances and further funding for additional workers (i.e. Tobacco Action Workers) in the last three evaluation periods. It was evident that certain organisational environments were not only more likely to activate a dedicated workforce with team structures and strategic focus, but also, organisational environments with values and capacity to provide support needed to be operating at a site level for the workforce to effectively design and develop the programs and services as envisaged in the program design.

Organisational environment with values and capacity to provide support

Even when generous funding was made available, particular characteristics of host organisations were important influences on the extent to which the new and existing workers could effectively engage in, and deliver A1 and A2 measure activities at a local level. The new Regional Tackling Smoking and Healthy Lifestyle workers needed to design and implement new initiatives as well as work in partnership with communities and local service providers and to build on existing programs and services. At an organisational level, this required a clear vision of how the measures, including the new workforce, should work and a strategic approach to training, learning and development to achieve a workforce capable of designing and delivering tobacco and healthy lifestyle initiatives based on best available evidence.

For many host organisations, the organisational development dimension of integrating a non-clinical workforce (Regional Tackling Smoking and Healthy Lifestyle team) into a predominately clinical environment was challenging. It was evident that in organisations with strong leadership coupled with effective corporate management including the ability to establish structures and processes were more likely to facilitate workers to engage in A1 and A2 activities using team approaches. These structures and processes fostered more support for individual workers and validated their role within the broader function of the organisation. Supportive organisational environments, where health promotion is valued by people at different levels in the organisation, emerged as an important enabler for worker retention, satisfaction and facilitated a shared understanding of roles within teams and across the organisation. This also often resulted in more well developed programs of work. In contrast, in organisations without clear direction and leadership or structures that promote collaboration with only a few (or one) and often marginalised Tackling Smoking and Healthy Lifestyle workers that value health promotion, workers expressed feelings of isolation and a lack of direction for their day to day role, thereby limiting their capacity to design and deliver new initiatives.

Generally, a history of health promotion activities (including workers and programs or services) meant that organisations were better positioned to implement the measures at a site level, as demonstrated by the regional support organisation in an urban site and where existing workers and/or programs continued (due to availability of funding through these measures) after alternative funding came to an end. Where there was a perceived lack of organisation and/or sector role in health promotion, there was limited engagement with A1 and/or A2 measure activities.

Capability of the new health promotion workforce

The capability of the new health promotion workforce was identified as a key mechanism through which these measures were able to achieve change at a local level. Dedicated funding for a program of learning and development enabled new workers to develop a range of relevant knowledge and skills and to access resources (i.e. funding and tools to support practice) which gave the workforce the necessary capacity to design and deliver local community based activities.

Organisations with commitment to, and leadership in, creating an environment conducive to workforce learning and development were more likely to improve the capability of the new health promotion workforce. In these organisations, there was greater capacity to determine worker training needs, arrange access to workforce development (including on-the-job and networking opportunities), and provide practical support for new staff through planned supervision, team based approaches to learning which was facilitated by worker co-location.

As already highlighted (above), pre-existing staff competency was a significant factor that activated this mechanism – this was most evident when workers with prior health promotion experience and/or professional training were recruited to Regional Tackling Smoking and Healthy Lifestyle worker roles and where individual workers were intrinsically motivated and committed to community based work.

Some factors that enabled the new positions to respond to local needs simultaneously constrained the capability of the new workforce to work effectively. Local modifications to the roles of Regional Tackling Smoking and Healthy Lifestyle workers resulted in differing expectations, confusion and lack of clarity of workers roles. Without a clear and shared understanding of worker roles, partnerships with other health professionals and local service providers were also difficult to establish. Additionally, a program of learning and development that was relevant and accessible for individual workers was more challenging to achieve (for example, where roles of OW and HLW were combined).

Despite a range of system-wide resources made available to support the RTC, TAW and HLW workforce, their introduction, in September 2011, was well after orientation and role establishment for many of these workers. This impacted on workforce capability. During the final two evaluation rounds a number of people in these roles were still not aware of the online resources or had not utilised them, on occasions because of the timing of publication, but more frequently because workers were uncertain how best to use them for planning community health promotion activities.

Improved health promotion capacity of the general primary health care workforce

The A1 and A2 measure components had the potential not only to increase capacity of organisations by increasing the number of positions and developing the knowledge and skills of a new workforce, but also through improving health promotion capacity among the existing health workforce.

While this is an important mechanism that needs to be operating to support Indigenous Australians in their attempts to quit smoking and to adopt healthy lifestyles, there were few examples where this mechanism was being successfully activated across the Sentinel Sites.

Where there was collaborative activity between clinical and Regional Tackling Smoking and Healthy Lifestyle teams, this mechanism was more likely to be activated. Clinicians needed to be aware and also see the potential benefit of services and health promotion programs for improving patient outcomes. Collaboration was evident in sites where health checks were incorporated in Healthy Community Day events and where clinicians perceived the workers in these positions as credible (for example, a HLW was also an accredited dietitian). Clinicians also valued the availability of NRT on PBS for improving their capacity to provide support to patients. However, community demand for more follow-up support indicated a need for greater integration of smoking cessation services (such as NRT and brief intervention) with evidence-based behaviour change programs (see complimentary linkages).

It was evident that there were also Health Service system constraints to activating this mechanism. Systems for documenting and monitoring brief intervention and smoking status were clearly lacking in Health Services' clinical information systems. This lack of documentation has implications for identifying 'target' groups and monitoring effectiveness of community based activities.

Complementary linkages with ICDP funded and other activities and services

Responsive program leadership at a high level was a key enabler to activating complementary linkages with ICDP funded and other activities and services. This was evident through policy changes at a national level related to combining Measures A1 and A2 (establishing Regional Tackling Smoking and Healthy Lifestyle teams) and later in the evaluation, incorporating the Healthy Community Day events element of A3 measure. Collectively, this provided a comprehensive, system wide approach to increasing awareness and reducing risk factors for chronic disease.

While the risk factor reduction measures (A measures) did not include any activities that were directly targeting linkages with chronic disease prevention and management measures (B measures) or workforce expansion and support (C measures), some linkages between different ICDP measures did emerge. For example, ICDP workers jointly attended training and networking opportunities or attended training that had not been intended by the measure design (for example, Regional Tackling Smoking and Healthy Lifestyle workers participate in OW orientation). There were also examples of more system wide changes, such as developing multidisciplinary team approaches to chronic disease self-management, that involved Regional Tackling Smoking and Healthy Lifestyle workers (see Chapter 9). Where these occurred, this was an enabler for developing linkages between different components of the ICDP.

A particular challenge to programs implemented under this measure is how to work in a complementary way with the range of initiatives underway and the range of stakeholders and service providers in the local area. This mechanism was more likely to be activated in contexts where there were opportunities to show case work (for example, the Live Longer! conference) and where there was a prior history of working together (for example, where funding was used for the continuation of existing programs).

The common constraints identified for complementarity with ICDP funded and other activities and services included a lack of collaboration between sectors and/or organisations and a lack of awareness or clear role definitions for different workers. This made teamwork and partnerships more difficult. Vast geographic distances and large service populations was also a constraint to activating this mechanism because workers had to prioritise programs of work to certain areas and/or population groups.

3.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 3.5). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 3.5: Summary of key findings in relation to the program logic – National Action to Reduce Aboriginal and Torres Strait Islander Smoking Rates and Helping Aboriginal and Torres Strait Islander People Reduce their Risk of Chronic Disease measures

	Summary of key findings from SSE
Outputs for year 1 and beyond	
RTCs and TAWs are recruited. HLW positions are filled.	Recruitment to RTC, TAW and HLW positions has generally progressed well. There has been a progressive increase in the number of funded positions over the course of the evaluation, with a particularly marked increase in the number of TAW positions. Where there are vacant positions this is generally because newly allocated positions are yet to be filled. There are a small number of sites that continue to experience difficulty with recruitment to these positions. Some services had overcome difficulties with recruitment by adapting positions to suit local circumstances. There is a clear need to proactively support local adaptation of positions in a way that addresses local needs in relation to the measure objectives.
Training is well received and well regarded HLW are equipped for roles through training	Perceptions of the training were generally positive, particularly with regard to the networking and information sharing opportunities. There is a need for further work on clarifying the competencies required for these roles, and enhancing access to training programs that address the specified competencies.

	Summary of key findings from SSE
Design and delivery of enhanced or new smoking cessation services, programs and communication activities Participation in A2 activities is high.	High level leadership and the development of regional teams have been a positive influence on program delivery and communication activities. A range of new resources have been developed and distributed. Awareness of the resources was variable, and the extent to which the resources were meeting local needs was unclear. It appears that supporting the effective application of available resources by local teams is now a greater priority than the development of new resources. There is a lack of information on levels of participation (or population coverage) in relation to these measures, specifically including the extent to which programs are reaching those most in need. More importantly, there is a lack of information and of systems for monitoring, evaluating and enhancing the quality of programs being implemented at the local or regional level. It is clear that the large geographic areas and/or the large size of populations to be covered by the teams is a major constraint on achieving high levels of community participation in program activities. In addition to the need to enhance participation through continuing to build the new workforce, supporting grassroots community developments and enhancing synergies with other complementary programs is likely to encourage community participation.
Expected early results for years 2 – 4	
Better access to smoking cessation resources, services and materials for health professionals. Primary Health Care services involved in A2 are able to offer more support for Indigenous Australians with or at risk of chronic disease.	Following the early evaluation cycles where teams were still being established, more recent evaluation cycles indicate that a range of activities are being supported and delivered at the local level, including brief interventions, support for access to Quitline, provision of information on NRT, social marketing and health education and skill development. There is a continuing need to enhance availability of locally relevant counselling services, particularly where phone support does not meet local needs. There is a strong indication that the new teams have been a positive influence on the implementation of smoke free workplaces (particularly in the AHS sector), although high levels of smoking among staff and board members continues to present a challenge to effective implementation. There is some evidence that services are actively supporting smoking cessation efforts among staff.

	Summary of key findings from SSE
Research, monitoring and evaluation is being used to inform future smoking cessation communication activities and program development	Monitoring and evaluation processes show an emphasis on reporting on contractual requirements with limited attention to monitoring and reporting quality of health promotion activities. There is also limited evidence of effective support or use of systems that enhance both the quality of health promotion as well as quality of reporting. Providing reports that demonstrate compliance with contractual requirements do not necessarily provide meaningful information that can be used for the purpose of informing future activities and programs and/or evidence based strategic planning, monitoring and evaluation at the local health service or regional level. Furthermore, the potential of health service clinical information systems to provide meaningful data on smoking status and trends is constrained by patchy state of development of clinical information systems, lack of staff capability to use data for population health purposes, and lack of systems to provide data at a regional level.
Participating services are smoke-free workplaces or implementing smoke-free policies.	See above
Individuals and communities in contact with measure A1 are more aware of health risks associated with smoking, of resources available to help them quit or cut back and more inclined to seek assistance as part of quit attempts. Participants in A2 activities have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean.	There appeared to be a high level of awareness of risk factors among community members, and this predated the ICDP. In the final evaluation cycle clinicians indicated an increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking. Individual motivation and broader structural barriers were highlighted as constraining efforts to quit, indicating the need for a broad social determinants approach that reduces structural barriers and enhances self efficacy.
Expected medium term results for years 4+	
The health workforce is better informed and resourced to promote smoking cessation among Indigenous Australians Health Services are better able to provide increased options and tailored support for Indigenous Australians with or at risk of chronic disease seeking to improve or manage their condition	There are clear indications that the measure is having a positive impact on the capacity of the health workforce to promote smoking cessation among Indigenous Australians, and to provide increased options and tailored support in the prevention and management of chronic conditions. However, there is a need to enhance the potential for adaptation to meet local community needs and to enhance community engagement.

	Summary of key findings from SSE
Demand for Indigenous smoking cessation programs and support services is strong Increased participation in health lifestyle activities and positive changes towards healthy lifestyle behaviours amongst Indigenous Australians	As indicated above, in the final evaluation cycle clinicians reported an increase in interest in seeking support to quit smoking by Aboriginal and Torres Strait Islander people. In comparison to the indication of increased interest in seeking support to quit smoking, clinicians indicated a lower level of interest in seeking support to implement healthy lifestyle choices in the early evaluation cycles. This increased in the third evaluation cycle, but does not show any further increase in the most recent cycles. These data are based on small numbers of interviews, and there are no established systems to monitor indicators of this type on a broader scale or over the longer term.
Key predictors of quitting smoking have increased among Indigenous Australians	As indicated above, there is a lack of established systems to monitor 'predictors of quitting'.

3.4.1. KEY FINDINGS

This section provides a summary of the key findings in relation to the National Action to Reduce Indigenous Smoking Rates and Helping People Reduce their Risk of Chronic Disease measures.

Progress with recruitment and position adaptations

Expansion of the tobacco and healthy lifestyle workforce has generally progressed well, with Regional Tackling Smoking and Healthy Lifestyle teams established across the majority of Sentinel Sites. The vast majority of positions were allocated to Aboriginal Health Services.

Some local adaptations were made to the measure design to facilitate recruitment to positions, for example recruitment to RTC before recruiting to other positions and amendments to position descriptions to meet local context imperatives.

Skilled and equipped tobacco and healthy lifestyle workforce

There was a high level of engagement in various training activities across the Regional Tackling Smoking and Healthy Lifestyle teams and this appeared to be facilitated by the dedicated funding made available to host organisations. Where it had been accessed, training was generally valued by interviewees.

A relatively small number of workers accessed and participated in brief intervention training. This made it difficult to gauge the extent to which the training provided the necessary skills for workers to fulfil their roles.

There has also been considerable activity in development and distribution of toolkits and resources to support the workforce in their roles. Awareness of the resources was variable, and the extent to which the resources were meeting local needs was unclear.

The important influence of high-level support for individual workers became evident in the later evaluation cycles.

Design and delivery of tobacco control and healthy lifestyle programs and services

Design and delivery of programs and services gained momentum over the course of the evaluation. The program of work delivered by teams varied across sites and included individual patient support, health education and community campaigns, and implementation of smoke free workplace policies. It was not possible to ascertain the quality or effectiveness of these initiatives, including the degree to which these initiatives integrated evidence based principles.

The range of tobacco control and healthy lifestyle initiatives implemented at a local level made it difficult for interviewees and community focus group participants to tease out whether the initiatives they were aware of were funded and delivered through ICDP or through some other initiative.

The length of time in positions, skills and experiences of individual workers, workforce leadership and support (including adequate supervision), and availability and accessibility of locally relevant tools resources and training were important factors influencing the effectiveness of the workforce in being able to design and deliver programs and services. Small numbers of positions, large distances and large service populations were also issues impacting on the effectiveness of the workforce.

Awareness of the Tackling Smoking and Healthy Lifestyle workforce

There has been growing awareness of the Tackling Smoking and Healthy Lifestyle positions overall and across sites. Awareness was greater in urban sites and remote sites than in regional sites. However, there continued to be limited awareness of these positions, particularly in regional sites and particularly amongst General Practice staff. Some confusion emerged as to areas of program responsibility, service delivery and links with state based workforce.

These patterns of awareness were consistent with recruitment progress, challenges of achieving high population coverage, and the focus of work of these teams and increasing knowledge of the ICDP more generally across sites.

Better access to resources to support smoking cessation and healthy lifestyle activities in Health Services

Regional Tackling Smoking and Healthy Lifestyle teams have had a limited role in increasing access to smoking cessation and healthy lifestyle resources in General Practices, with most work focused in AHSs.

This appears to be related to lack of awareness of the roles (including their intended scope or responsibilities more generally), lack of communication and/or collaborative working relationships, including capacity to engage with clinicians, to support working across large geographic regions or populations, owing to workload in the AHSs.

There was generally limited evidence of linkages between Regional Tackling Smoking and Healthy Lifestyle teams and clinical teams. Healthy Community Day events were identified as an opportunity to improve links between the healthy lifestyle and clinical teams.

Better access to smoking cessation and healthy lifestyle resources for communities

Generally, there were high levels of community awareness of the workforce, social marketing initiatives and some smoking cessation services including Quitline and NRT.

A range of community-level activities were evident, including social marketing events, group work and one-to-one support to motivated patients. These activities take place in the context of a range of other pre-existing tobacco control and healthy lifestyle initiatives at both state and national levels.

The need for greater face-to-face and practical follow-up support for smoking cessation emerged. Whilst awareness of NRT availability and Quitline was high amongst community members and a small but general upward trend in NRT prescriptions was observed, there was a lack of support programs and follow-up services. Some activities involved linkages or brokerage between patients and other resources, for example, Regional Tackling Smoking team calling Quitline on behalf of patients who experience barriers to doing it themselves.

Community awareness, understanding, health seeking behaviours and smoking status

Awareness of risk factors for chronic disease among community focus group participants was high prior to ICDP implementation.

There has been a general increasing trend over the course of the evaluation in perceived changes in client behaviour towards healthier lifestyles, as reflected in clinicians' responses.

Over the course of the evaluation, self-motivation was consistently noted as key for people to quit smoking and adopt healthier lifestyles.

At Health Service level, there was a notable lack of recording and monitoring of smoking status in clinical information systems, with implications for identifying 'target' groups and monitoring effectiveness of community based activities.

3.4.2. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Continue working with Health Services to create and/or strengthen supportive workplace environments to host teams of Regional Tobacco Coordinators, Tackling Smoking and Healthy Lifestyle workers. Provide support to establish good team structures, including suitable supervisory arrangements and articulating roles and responsibilities amongst team members, and develop a strategic focus of work that meets local context imperatives and skill sets of individual workers.
- b) Provide support to Health Services to plan, implement, evaluate, document and share findings of successful (and lessons from) tobacco control and healthy lifestyle programs and services. This could be achieved by encouraging Health Services to use health promotion quality improvement tools that include assessment of systems to support best practice. Support development of resources to assist Health Services in strengthening systems for health promotion, aligned with quality improvement processes and including support to meet staff training needs identified through these processes.
- c) Continue a funding program to support training and programs of learning and development for this workforce. Work with stakeholders in each jurisdiction to ensure the roles of the Regional Tackling Smoking and Healthy Lifestyle teams are clarified and align with recognised health promotion competencies. Further work is needed to enhance access to training programs that address these specified competencies.
- d) Consider increasing investment in evidence-based initiatives that improve self-motivation and quit attempts. Strategies that have been effective in de-normalising smoking include broad social marketing campaigns (not health education), reduction of tobacco industry marketing (for example, plain packaging and banning retail displays) and smoke free promotion of spaces and events (for example, smoke free workplaces). Smoke free laws, tax and price increases (including the promotion of such) are also effective means for changing social norms.
- e) Consider strengthening systems that support greater integration of clinical services with evidence-based behaviour change programs at a local level. Support development of partnerships between clinical Health Services, the Regional Tackling Smoking and Healthy Lifestyle teams and community based organisations and organisations with a mandate to support health promotion, that ensure community members have better access to a range of services and are supported and enabled in their efforts to lead healthier lifestyles and manage their chronic disease more effectively. Better systems for capturing smoking behaviours (including smoking status and consumption), brief interventions and community based initiatives are important for monitoring progress and informing development of future activities at national, regional and local levels

4. LOCAL ABORIGINAL AND TORRES STRAIT ISLANDER CAMPAIGNS TO PROMOTE BETTER HEALTH (MEASURE A3)

4.1. Description of measure

The Local Community Campaigns to Promote Better Health measure aims to give Aboriginal and Torres Strait Islander people a better understanding of the risk factors involved in chronic disease and knowledge of how lifestyle choices and quality primary health care services can help prevent or better manage chronic disease. This was to be achieved through the delivery of locally generated and relevant health promotion initiatives that target Aboriginal and Torres Strait Islander people at risk of chronic disease, including groups that have low engagement with Health Services.

Key elements of the measure included:

- **A research project to gain an in-depth understanding of attitudes and perspectives** within Aboriginal and Torres Strait Islander communities, used to inform appropriate and better practices in social marketing in Indigenous communities.
- **A Local Community Campaign grants program** to support community designed and delivered initiatives. The grants are intended to complement national activities under the 'Get Active, Eat Good Tucker, Live Longer!' banner.
- **Funding to support national Healthy Community Day events** – a series of local Aboriginal and Torres Strait Islander events held in urban, rural and remote communities, to deliver healthy lifestyle messages, driven by the community.
- **The development of a range of national support strategies** under the 'Get Active, Eat Good Tucker, Live Longer!' banner including a national website (Live Longer!) and the Community Health Action Pack (CHAP) to assist local communities and Regional Tackling Smoking and Healthy Lifestyle teams to deliver locally generated chronic disease prevention activities.^{39,40} Funding was also made available to support NACCHO affiliates and SBOs across Australia to undertake projects related to the promotion of relevant MBS items.

It was anticipated that locally generated campaigns would be based on the nationally developed evidence based social marketing initiatives and resources. Through local partnerships, consistent health messages and promotions would be reinforced, extended and localised, leading over time to gradual improvements in people's behaviours, including greater uptake of Health Services.⁴¹

³⁹ Live Longer! website, <<http://LiveLonger!.health.gov.au>> (accessed 13 December 2012).

⁴⁰ Cox Inall Ridgeway, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Background paper, 8 February 2011.

⁴¹ Ibid.

4.2. State of implementation – national context

At the time of the final evaluation cycle, information provided by DoHA indicated that the main achievements of the program at a national level (and of relevance to the SSE) are summarised below. The national level achievements are described under the four core components of the measure: social marketing research, community grants, 'Healthy Community Day' events and program supports.

4.2.1. SOCIAL MARKETING RESEARCH

- A research project, completed in June 2010, was conducted to gain an in-depth understanding of attitudes and perspectives within Aboriginal and Torres Strait Islander communities. The findings highlighted that mainstream health messages designed around 'warnings' and 'consequences' were not working for Aboriginal and Torres Strait Islander communities, yet misconceptions in regard to chronic disease prevention existed, coupled with the social acceptance of health harming behaviours such as smoking tobacco. The research identified that Aboriginal and Torres Strait Islander people needed to be the drivers of messages for their own communities to make them relevant.⁴²
- The Local Community Campaigns (LCC) program was designed to provide a comprehensive approach to health messages that would engage Aboriginal and Torres Strait Islander people. Based on the findings of the social marketing research, a consultant was to develop and support engagement strategies comprising grants, Healthy Community Days and an interactive website. The program sought to focus on four key healthy lifestyle messages encouraging Aboriginal and Torres Strait Islander people to give up smoking, eat healthy food, take regular exercise and have regular medical check-ups.⁴³
- Cox Inall Ridgeway, a specialist Indigenous communications consultancy, was appointed in October 2010 to work in consultation with the DoHA to further develop and implement the LCC program.

4.2.2. LOCAL COMMUNITY CAMPAIGN GRANTS

- Stakeholder engagement meetings were held in Cairns (December 2010), Darwin (January 2011), Broome and Perth (February 2011), and Melbourne and Sydney (March 2011). These briefings served to inform AHSs, Aboriginal and Torres Strait Islander media organisations, academic institutions and other community organisations about the grants process and encourage participation. A briefing paper was made available with examples of potential projects and organisations that might consider undertaking Healthy Community Days and grants as envisioned.⁴⁴
- There had been two grant rounds during the evaluation. The first round was targeted: community and media organisations were identified by consultants, Cox Inall and Ridgeway, on

⁴² The Hon. Warren Snowdon, MP, National Live Longer Roadshow Kicks off to Improve Health of Indigenous Australians, 11 April 2011 [media release] <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws014.htm>> (accessed 12 September 2012).

⁴³ Ibid.

⁴⁴ Cox Inall Ridgeway, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Background briefing papers, December 2010 and 8 February 2011.

the basis of their capacity to utilise and implement the grant effectively. The second round was open and competitive: invitations to apply were advertised and promoted and any organisation could submit a project proposal for consideration by the DoHA.⁴⁵

- In June 2011 the targeted round of LCC grants were awarded, with 38 projects funded across urban, regional and remote Australia.
- The competitive round of grants was opened in June 2011, closing on 30 September 2011. There was a strong response, with DoHA receiving over 300 grant applications (3 times the number expected). The processing of applications delayed the announcement of the awarding of 34 grants as intended in April 2012. The announcement was made in September 2012.⁴⁶
- Most of the open grant projects were planned to run to May 2013. At the time of compiling this report there were no plans for a third funding round. The DoHA reported plans to produce a narrative description of the first and second round grant project activity in 2013.
- As of July 2012 the DoHA reported that visits were being conducted to some of the grant sites for support and profiling of activities.
- A national conference with LCC grant recipients was held 22-24 October 2012, in order to facilitate attendance by grant recipients from both rounds.

4.2.3. HEALTHY COMMUNITY DAY EVENTS

- It was anticipated that 60 Healthy Community Day events would be achieved by June 2012 with the consultant team aiming to have up to 30 held by June 2011.⁴⁷ Forty-eight Healthy Community Days were held throughout the period from April - December 2011. From 18 August 2011 it was made mandatory for host Health Services to offer health checks or screening as part of the Healthy Community Day activities. No particular type of health screening was specified as it depended on the capacity of the organisation. Whilst not obligatory, the DoHA expected Health Services to offer follow-up to the screening. From 2012, the 'Healthy Community Day' events element of this measure was incorporated into Measures A1 and A2 program design. Annual World No Tobacco Day is a targeted date for Healthy Community Day events.
- The development of the campaign brand 'Get Active, Eat Good Tucker, Live Longer!' by consultants Cox Inall Ridgeway and Carbon Media aimed to provide a consistent look and feel for national-level activity; however communities were encouraged to develop their own branding for local activities.

⁴⁵ Cox Inall Ridgeway, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Briefing paper, December 2010.

⁴⁶ The Hon. Warren Snowdon, MP, Communities Tackle Chronic Disease to Live Longer 14 September 2012 [media release] <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-ws-ws015.htm>> (accessed 13 December 2012).

⁴⁷ The Hon. Warren Snowdon, MP, National Live Longer Roadshow Kicks off to Improve Health of Indigenous Australians, 11 April 2011 [media release] <<http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws014.htm>> (accessed 12 September 2012).

- The LCC briefing paper stated that events would be developed with the assistance of the Regional Tackling Smoking and Healthy Lifestyle teams and their host organisations. Indigenous media organisations would also be approached to participate in or support the Healthy Community Days.⁴⁸

4.2.4. PROGRAM SUPPORTS

Live Longer! Website

- The Live Longer! campaign was launched by Minister Snowdon on 11 April 2011 to coincide with the first Healthy Community Day.
- The Get Active Live Longer! Website provided information about the Local Community Campaigns program and the local activities of grant recipients, and hosts an online version of the Community Health Action Pack (CHAP). The website was launched in September 2011.
- The DoHA report that new content was uploaded to the website on a regular basis. New stories on individual grant projects were scheduled to be published on the website regularly – pending consent and approvals by organisations. Twitter communication between website users was encouraged and included sections for news and media updates⁴⁹. As at September 2012 there were 45 Healthy Community Day events presented on the website to enable sharing.⁵⁰

Community Health Action Pack

- The CHAP was launched on 6 September 2011 with an electronic version made freely available on the Live Longer! Website. The CHAP was designed to assist people working in Aboriginal and Torres Strait Islander health to better design, develop and deliver health promotion projects addressing the needs of their local communities. Feedback from a workshop held with Regional Tackling Smoking and Healthy Lifestyle teams in May 2011 was used to refine the CHAP.
- The CHAP had limited hard copy distribution. The first distribution included the CHAP manual, flip camera and a small anatomical model. It was distributed to 29 host organisations for Regional Tackling Smoking and Healthy Lifestyle teams and the targeted round one grant recipients. The DoHA reported in September 2012 that an updated distribution plan would send CHAP manual packages to all grant recipients, stakeholders and Members of Parliament/Senators.
- As at September 2012, the CHAP components of the website were structured to reflect the revised version of the resource.
- The DoHA were invited to speak at the June 2012 'Live longer Stronger Chronic Disease Conference' run by the NSW NACCHO affiliate. The DoHA presented the CHAP in a concurrent session on strategies for prevention of chronic disease. Delegates included Aboriginal Health Workers from AHSs across NSW. The DoHA reported there was a positive response to the resource with many requests for the publication.

⁴⁸ Cox Inall Ridgeway, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Background paper, 8 February 2011.

⁴⁹ Live Longer! website <<http://LiveLonger!.health.gov.au>> (accessed 12 December 2012).

⁵⁰ Ibid.

- A licence agreement has enabled the Queensland NACCHO affiliate to use the CHAP for face-to-face training with health professionals working in Aboriginal and Torres Strait Islander Primary Health Care.
- The DoHA reported that, as at early September 2012, there had been 180 requests for the revised CHAP.

Promotion of MBS items

The DoHA LCC program had also funded NACCHO affiliates and SBOs across Australia to undertake projects related to the promotion of relevant MBS items (such as adult health assessments). Funding concluded in 30 June 2011 with all activities and promotions having been undertaken in all states and territories. Some organisations worked collaboratively:

- In Queensland, there was collaboration around activities between the SBO, NACCHO affiliate and the Improvement Foundation.
- In Victoria, the NACCHO affiliate agreed to reassign their funding to the SBO and worked with them, providing expertise.
- The South Australian and Tasmanian affiliates undertook collaborative activity.

An overview of the projects identified the following similar approaches: the development of locally relevant resources and posters alerting and identifying MBS items and pathways of care; up-skilling through academic detailing and community and health provider events and training; social marketing; quality improvement and information technology initiatives. Some areas promoted Aboriginal and Torres Strait Islander specific MBS items and chronic disease items, whereas others focused particularly on adult health assessment items. Some organisations included a focus on data quality, recall reminder and auditing. Others improved access to cultural awareness training. In regards to training, the Victorian NACCHO affiliate identified a need for, and provided, training in motivational interviewing to improve AHW confidence in promotion of health behaviour change.

4.3. Findings from the Sentinel Sites

The findings presented here are based predominately on data collected during the fourth and final evaluation periods and from a small number of case study sites and, to a lesser extent, enhanced tracking sites. Due to the design and the early stage of implementation of this measure, together with the nature of the SSE, the availability of data at the local site level has been limited, particularly during the first three evaluation periods.

It should also be noted that a separate and more in-depth national evaluation is being undertaken for this measure.

4.3.1. LOCAL CAMPAIGNS TO PROMOTE BETTER HEALTH - PROGRAM REACH

KEY POINT

- Over the evaluation period, 21 Sentinel Sites had exposure to at least one Local Community Campaign activity.

Overall, a total of 21/24 Sentinel Sites had exposure to at least one LCC activity over the period of the SSE (Table 4.1).

The LCC activities were delivered by organisations targeted on the basis of their capacity to develop and implement the activities successfully.

At the commencement of the final evaluation cycle, notifications of successful round two (open, competitive) grant recipients had yet to be announced (announcements were made after four of eight case study evaluation site visits had been completed). The DoHA indicated that the announcement delay was due to the unexpectedly large number of applications.

Table 4.1: Local community campaign activity in Sentinel Sites 2010-2012

Sentinel Site	Rurality	Healthy Community Days	Local Community Campaign - targeted grant	Local Community Campaign - open grant	NACCHO affiliate or SBO activity
Barkly	Remote		✓ ^a		✓
Brisbane South	Urban		✓ ^b		✓
Cairns	Regional	✓			✓
Campbelltown	Urban	✓	✓		
Canberra	Urban			✓	✓
Dandenong	Urban				✓
Darwin	Regional		✓		✓
Derby	Remote		✓		
Dubbo	Regional	✓		✓	✓
Elizabeth	Urban	✓		✓	✓
Geraldton	Regional	✓		✓	
Gladstone	Regional				✓
Hobart	Regional				✓
Kalgoorlie	Regional		✓		
Katherine West	Remote	✓	✓		✓
Logan/Woodridge	Urban		✓ ^b		
Newcastle	Urban	✓	✓		
North Lakes/Caboolture	Urban	✓	✓ ^b		
Port Augusta	Regional				✓
Swan Hill/Mildura	Regional	✓		✓	
Tamworth	Regional	✓			

^a Darwin grant project has activity in the Barkly site.

^b Media program has a Brisbane wide reach.

Sources:

DoHA, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health update, Healthy Community Day events in Sentinel Sites to 31 December 2011.

Live Longer! [website] <<http://Live Longer!.health.gov.au>> (accessed 13 December 2012).

DoHA, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health update, MBS promotional activities – SBO and NACCHO. Sites listed as identified in the reports.

Notes: Healthy Community Days data were only available up to 31 December 2011, NACCHO and SBO activities funding ended June 2011. The Local Community targeted grants were funded in June 2011-2013 and the open grants commenced September 2012 for one year. This table excludes the Sentinel Sites of Port Augusta, East Pilbara, and Grafton as no Local Community Campaign activities were identified for those sites.

4.3.2. AWARENESS AND UPTAKE OF LOCAL COMMUNITY CAMPAIGN GRANTS PROGRAM

KEY POINTS

- There was an increasing awareness of grant funding availability and some evidence of project level activities related to the targeted (first round) grant funding.
- Access to grant funding was seen to be partially dependent on organisational capacity to apply for funding and local stakeholders perceptions of capacity to effectively utilise funding.
- There was no evidence of local activity implementation from the Sentinel Sites of round two grant related activity, due to a delay in the announcement of grant recipients for the open grant round, and therefore the commencement of projects.

The targeted LCC grants were operational in nine of the 24 Sentinel Sites. These included five urban, two remote and two regional Sentinel Sites (representing twelve grant recipients). One grant potentially affected three urban sites around Brisbane due to the geographical location and nature of the project (media campaign) and these sites are included in the Table 4.1. The open round of grant funding was awarded to six organisations and covered five additional Sentinel Sites; two urban and three regional sites

The use of targeted funding varied between the sites. In some cases the funding was used to support or expand existing initiatives, and in other cases, new one-off or occasional outreach events were implemented. At the local level, the funding covered a diverse range of activities and messages that target Aboriginal and Torres Strait Islander people across the sites. Grants mainly focused on increasing awareness or knowledge, and community engagement and/or participation in healthy lifestyle choices activities and management of chronic disease risk factors. Five of the programs included the creation of opportunities for lifestyle change with community gardens, sports and exercise activities and one program included delivery of low cost fresh food to those less likely to access this.

While the community grants program was open to any organisation, in the Sentinel Sites, grant recipients were predominantly either Aboriginal community based organisations or AHSs. In the open grant round a Medicare Local in one Sentinel Site was a grant recipient.

At a local level, our findings indicated that there was limited awareness of the LCC grants from the DGP sector. In a regional site the IHPO was aware of the grants after receiving information via the DGP 'email list serve' and also through attendance at workshops. The IHPO felt the limited uptake by the DGP could be due to a lack of perceived relevance of the grants to the role of the organisation.

'Need and opportunity don't always match. The Division didn't feel this as part of their role.'
(SBO, regional site)

Differing organisational capacity effecting ability to access and implement grant program

Access to the grants program was at least partially dependent on organisational capacity to apply for funding and/or stakeholder perceptions of local capacity to effectively utilise funding. For example, in

the DGP sector, organisational disruption due to the transition to Medicare Locals was identified as a temporary barrier to the development of an application.

‘We have looked at local community grants and we were keen to apply, making sure that we ... have the resources to carry out what we are applying for. We thought we probably don’t have enough resources, as in people at the moment, so we are ... doing a joint one between the three divisions that will become part of the Medicare Locals - but with the transition phase and everything that is going on we have put that on hold at the moment.’ (DGP, regional site)

Organisational contexts also affected the ability to apply and implement grants in a positive way. For example, interviewees from the regional support organisation in an urban site had dedicated resources which enabled the organisation to take a lead role in preparing grant applications, including consulting with other AHSs as part of the process. This organisation was a successful round one grant recipient.

4.3.3. IMPLEMENTATION AND PERCEPTIONS OF HEALTHY COMMUNITY DAY EVENTS

KEY POINTS

- Healthy Community Day events are in early stages of implementation - the first national Healthy Community Day was held in April 2011.
- By the final evaluation cycle, Healthy Community Days had been held in 10 Sentinel Sites.
- Perceptions of Healthy Community Day were generally positive, although some challenges were highlighted regarding identifying and reaching particular target population groups.
- During the period of the evaluation, the Healthy Community Day events element of this measure was transferred to the Regional Tackling Smoking and Healthy Lifestyle programs.

During the evaluation period, Healthy Community Day events were held in ten Sentinel Sites (five regional sites, four urban sites and one remote site). The strategies used to promote healthy lifestyle messages varied across sites. For example, in one urban site, high profile role models (local footballers Preston Campbell and Dean Withers) and a trailer with health promotion messages were used to raise community awareness of healthy lifestyles. In a regional site, the Regional Tackling Smoking and Healthy Lifestyle team held a ‘Healthy Fun 4 Everyone’ community expo, which was used as an opportunity to promote the importance of self-identification as Aboriginal and/or Torres Strait Islander. The expo included games and activities, free health information and check-ups, morning tea and lunch. In remote sites, local community events used movie nights and community open days at the AHSs to raise community awareness of healthy lifestyles. These activities were often scheduled to coincide with relevant national events such as Harmony Day, Closing the Gap celebrations and World No Tobacco Day.

Interviewees in some case study sites felt the Healthy Community Days were important for raising awareness of new and existing Health Services and to encourage people to have health checks.

‘The team organised some community days where they introduce and promote PIP-IHI and other CTG programs.’ (AHS, urban site)

‘[Host organisation] has big links to the community, health messages get across, we see faces at community days that you don’t see at appointments so it stretches out.’ (AHS, urban site)

In remote sites, communities appeared to conduct Healthy Community Day style events more regularly, often to align with other national and international celebrations, and these events were taken as opportunities for combining healthy lifestyle messages to community populations more broadly.

'[We have been] holding stalls on International Women's Day and Close the Gap Day.' (DGP, remote site)

'We use the existing community events to raise the awareness of adult health checks, for example; [community name] Sports Festival and [community name] Freedom Day.' (AHS, remote site)

Overall perceptions of the Healthy Community Day events were generally positive across Sentinel Sites. Some community focus group participants could recall the events and main healthy lifestyle messages. Additionally, community focus group participants spoke of broader social marketing campaigns, such as World No Tobacco Day. They also referred to media publicity surrounding the legislation for plain packaging of tobacco products.

By the final evaluation cycle, the DoHA had made health checks a requirement for each local Healthy Community Day. In one urban site, a registration card was developed as a strategy to encourage people to participate in each activity at Healthy Community Day events. Nurses from the local AHS were available to conduct health checks during the day. The initiative used social networking media to promote the event including websites, Facebook and Twitter. Interviewees in this site commented that these communication mechanisms were particularly popular with younger people. In a regional site, an approach titled 'Pit Stop' was used to encourage men to have health checks.

'Each of the men went through a series of checks including a 'Chassis Check' for waist measurements and diabetes risk, 'Oil Pressure' for blood pressure, blood glucose and cholesterol, and 'Exhaust' for lung health and smoking advice.' (AHS, regional site)

Vignette - Incorporating health checks in local health promotion campaigns

A regional support organisation providing Tackling Smoking and Healthy Lifestyle activities is working with local AHSs to encourage Aboriginal and Torres Strait Islander people to undertake comprehensive adult health assessments and to register with Health Services.

Health checks have been incorporated into the Healthy Community Days, coordinated by the Regional Tackling Smoking and Healthy Lifestyle team. A partner Health Service provides a mobile outreach clinic van, which is staffed by a GP and nurses from the local AHS clinic. On the day of the event, people register to have a health check in the van. They are asked which AHS or General Practice they attend and personal contact details.

Patients who attend a different AHS to the health check provider, or who have a regular General Practice, receive basic screening for blood pressure, height and weight measurements.

Patients who do not have a regular General Practice and agree to become patients of the site AHS receive a full health check, which includes a follow-up appointment for urine and blood tests at the AHS clinic, and referrals as needed.

'Everyone who registers for a health check on the day receives a follow- up call from the AHS.'

The SSE identified a number of challenges to implementing and fostering engagement in Health Community Days.

‘The struggle is getting everyone on board from a community - it’s not always known [about] all organisations in a particular part of the community. We overcome this by not going in and telling people what to do, but we go in and say ‘this is what we can do, how can we help?’ We also get people involved in all the planning.’ (AHS, urban site)

Additionally, concerns were raised about whether or not the community campaigns and events were optimally targeted, particularly for reaching specific at-risk groups in the community.

Local community members suggested that smaller, targeted initiatives, particularly aimed at young people, may be more effective than large public events.

‘... [d]oing stuff at the grass root level it would be more of an impact, [not] ... the big events, promotional events where you’ve got celebrities. It was a big event and [the program] only had a little stall. Kids really didn’t get into there and be educated about it ... It’s just another stall ... adults just walked straight past. They could be coming to do big promotion to youth group here ... come on Friday night.’ (Community focus group, urban site)

An unintended consequence of offering incentives for health checks at Healthy Community Days emerged in one urban site during the final evaluation cycle. Concern was raised that the incentives could potentially lead to community members undertaking unnecessary or multiple health checks.

‘The ‘giveaways’ are used in exchange for doing the ‘mini health checks’ and to register [people] for CtG and ask them to come to the clinic. Some of them were already signed up at their General Practice, they already had health checks, and they were thinking why [not] do it again ..., and they all got confused.’ (DGP, urban site)

4.3.4. AWARENESS AND PERCEPTIONS OF PROGRAM SUPPORT STRATEGIES

KEY POINTS

- At a national level, a range of program support strategies have been developed and implemented to raise awareness and support local communities to undertake Healthy Community Day events and Local Community Campaigns.
- Initial delays in the development, and subsequently the availability, of the CHAP and Live Longer! website were reflected in lower levels of awareness early in the evaluation period.
- By the final evaluation cycle, there was evidence from the Sentinel Sites that awareness of the national support strategies had generally improved, although it was patchy within and across sites.
- While awareness had improved, there was little evidence from the Sentinel Sites of the use and effectiveness of these resources in supporting on-the-ground activity. Some challenges with distribution of resources were noted and in some cases the packs were not seen to be relevant to local context and needs.

No clear trend in awareness of the centrally supplied resources and communications to support the Local Indigenous Community Campaigns and Healthy Community Day events emerged over the course of the evaluation cycles (see Table 4.2). Initially, interviewees made reference to the time-lag in

availability of the national resources and the subsequent impact on local service delivery. Comments included, *'I haven't seen them yet'* (AHS, remote site); *'they should have come out a lot earlier, then it was too late'* (AHS, regional site); and *'resource roll out is not timely...timeframes are often short and organisations are under the hammer'* (AHS, regional site). Timeliness in receiving resources was a particular issue for sites where the ICDP funded workers had been established.

Table 4.2: Trends in awareness and perceptions of centrally supplied resources (% who responded 'strongly agree' or 'partly agree'), overall

Evaluation cycle	Two	Three	Four	Five
Are you aware of the availability of resources for supporting the development of local health campaigns? CS, MS ^a	42% (n=71)	55% (n=62)	60% (n=47)	62% (n=47)
Resources supplied at a national level have been helpful to implement the local health campaigns. MS, CS ^a	43% (n=30)	50% (n=40)	40% (n=42)	57% (n=30)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

The development of the support resources and associated distribution plans was slower than anticipated and, as expected, resulted in limited awareness of their availability in the early stages of measure implementation.

Over the course of the evaluation, a range of stakeholder engagement and Regional Tackling Smoking and Health Lifestyle team workshops were held, two rounds of grant funding had been announced, the Live Longer! website had been launched and the CHAP was distributed. By the time of the final evaluation cycle, these communication strategies, together with visits by the SSE team, appear to have contributed to improving levels of awareness of the resources (including clarity of the resources supplied under this measure) amongst some stakeholders in the Sentinel Sites.

The CHAP has been purposefully distributed to the Regional Tobacco and Healthy Lifestyle teams. Despite this, awareness of the CHAP and Live Longer! website amongst these workers was not consistent across Sentinel Sites. This may be a reflection on the length of time workers had been employed in these roles (issues of recruitment and retention), attendance at training and orientation days (where the resources have been promoted) and/or the distribution process. Additionally, awareness of the resources was greater in the AHS than General Practice sectors. This was likely to be related to the placement of the Regional Tackling Smoking and Healthy Lifestyle teams in AHSs and greater proportion of Aboriginal health sector LCC grant recipients.

'... unless they are distributed correctly, staff don't receive them and cannot use them.' (AHS, regional site)

The need for local implementation guidelines and practical support for nationally developed resources

It is difficult to gauge the benefit of the CHAP in supporting communities undertake local community campaigns in Sentinel Sites. It was envisaged that the national level resources, particularly the CHAP and Live Longer! website, would be used to support the design and development of local community

campaigns and Healthy Community Events and subsequently improve the effectiveness of these initiatives. Due to the delay in the CHAP and Live Longer! website development and their subsequent availability, it would be expected that many local community campaigns and Healthy Community Day events had been designed and, in some cases, implemented without support from the national resources. This was supported by our findings that there was little evidence of use and uptake of the CHAP or Live Longer! website across Sentinel Sites, including by those with targeted grant funding.

SSE findings also indicated that there were mixed views on the quality and adequacy of the available resources. In particular, remote site stakeholders expressed concern that the national resources required local adaptation to ensure the process and resources were applicable and appropriate to local community needs, including the need to replace words with pictures and to make resources more visually appealing.

'Resources have been quite good, some of them could have been better, more pictorial, as some are very wordy.' (AHS, remote site)

'A barrier has been that the campaigns come to us pre-designed and even though they are designed for the Aboriginal community they still often come with too complex language, cluttered with too many messages. I have a store room full of flip charts, posters and resources but they are all too complex for the remote context where education is poor and English is often second language.' (AHS, remote site)

In the final evaluation cycle, an increasing number of interviewees across sites spoke about their preference to develop and/or use locally developed resources over national resources, including the CHAP, to support the development of initiatives. Specifically, comments about the lack of use of the CHAP and national resources included that they were not using them because they were uncertain on how to use them, or because they used pre-existing resources.

'We are doing our own things anyway. We tend not to use them.' (AHS, urban site)

'We use more local based resources than national.' (AHS, urban site)

'I have had a look but I couldn't see how I could use it to do my job, so I moved on.' (DGP, urban)

These findings suggest that there is a plethora of resources available, either existing materials and/or the funding to develop new materials, to assist and support communities and Health Services to develop and implement campaigns and Healthy Community Day events.

It became apparent over the course of the evaluation that a lack of guidelines or practical support for how available resources could be used more effectively had inhibited practical implementation at a site level. For example, a preference to develop local resources may be due to lack of skills of how to engage with existing resources for them to be used and/or adapted for local use. This was evident at one regional site when a member of the SSE team spent time with a worker from the Regional Tackling Smoking and Healthy Lifestyle team following their interview, to illustrate how the CHAP could be used to support existing programs and develop new initiatives. To further illustrate the need for practical guidance, in a remote site, an interviewee commented on the value of Live Longer! website for sharing initiatives, however, suggested that more detailed information on projects would be helpful.

'The site was not bad. ... There is often an overview of an event but would like to see more details about the types of things that people are doing ... [and] what people do.' (AHS, remote site)

These findings from the Sentinel Sites were consistent with findings from DoHA of low utilisation of the CHAP. As part of the grants program, the recipients report on aspects of their program development. In response to the question, *'Did you use the CHAP to assist in developing your health promotion initiatives?'*, none of the grant recipients in Sentinel Sites reported that they had used the CHAP template. Some had reviewed it and were hoping to use it in the next stages of planning, others found it was not useful or relevant to the project, or too structured and formal when used in partnerships and with community. One project had not recruited the staff who would use it and one recommended the availability of future help to use the CHAP. One project used the CHAP camera.

4.3.5. EXISTING HIGH LEVELS OF COMMUNITY AWARENESS

KEY POINTS

- Overall in the Sentinel Sites, there were existing, high levels of awareness amongst community members of the risk factors for chronic disease throughout the evaluation period, but less awareness of the link between healthy lifestyle and the importance of regular health check ups in developing or managing chronic diseases.
- The SSE was not able to gauge the impact of the measure activities at a population level within the sites.
- Population level effects are unlikely to have been achieved at this early stage of ICDP implementation, because health behaviour change requires long-term and strategic programs, and because of the short time frame for most of these newly funded projects and their limited reach.

SSE community focus group discussions highlighted a pre-existing level of awareness of the key messages of chronic disease risk factors and the importance of healthy lifestyles. Over the course of the evaluation cycles, community and key informants also identified a number of barriers to making healthy lifestyle choices, including a lack of support staff in clinics, perceived financial costs, lack of personal motivation, and poor access to programs and services.

The existing high levels of community awareness are evidence that non-ICDP (or prior) activity, both nationally and locally, have been having an impact on the knowledge and understanding of risk factors for chronic disease amongst Aboriginal and Torres Strait Islander people. Evidence from the SSE suggests a lot of health promotion work continues to focus on raising awareness with less effort made to address environmental, structural and individual barriers - such as those identified by community focus group members - to making healthy lifestyle choices.

4.3.6. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Awareness of grants, adequate time, resources and skilled personnel to carry out community consultations, write the funding application and support implementation were necessary for organisations to engage with the grants program.
- Delayed timing of resource distribution and their lack of utilisation constrained development and implementation of locally developed campaigns.
- In some sites, organisations considered locally developed health promotion resources necessary to reach target audiences.
- In some sites, instability or transitioning structures in host organisations inhibited organisations from applying for grants, due to lack of certainty about future resources and support.
- The partnerships and complementary linkages required for health promotion were enabled by prior working relationships, previous experience in social marketing, networking and information sharing opportunities.

Effective implementation of this measure as envisaged in the program logic would result in a greater understanding among Aboriginal and Torres Strait Islander people of the risk factors for chronic disease and how quality primary health care services can help prevent or better manage chronic disease.

As is evident through the analysis presented above, progress with implementation of the different elements of the measure varied across Sentinel Sites. This variation in progress with implementation is due to a complex mix of local, regional and national influences, some of which vary over time. The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective implementation can be achieved and the influences that enable and constrain the operation of these mechanisms.

Our analysis has identified two broad mechanisms through which the measure appeared to achieve change in different contexts. These are shown in the central boxes in Figure 4.1 below. Enablers and constraints related to these mechanisms are shown in the figure, and described below.

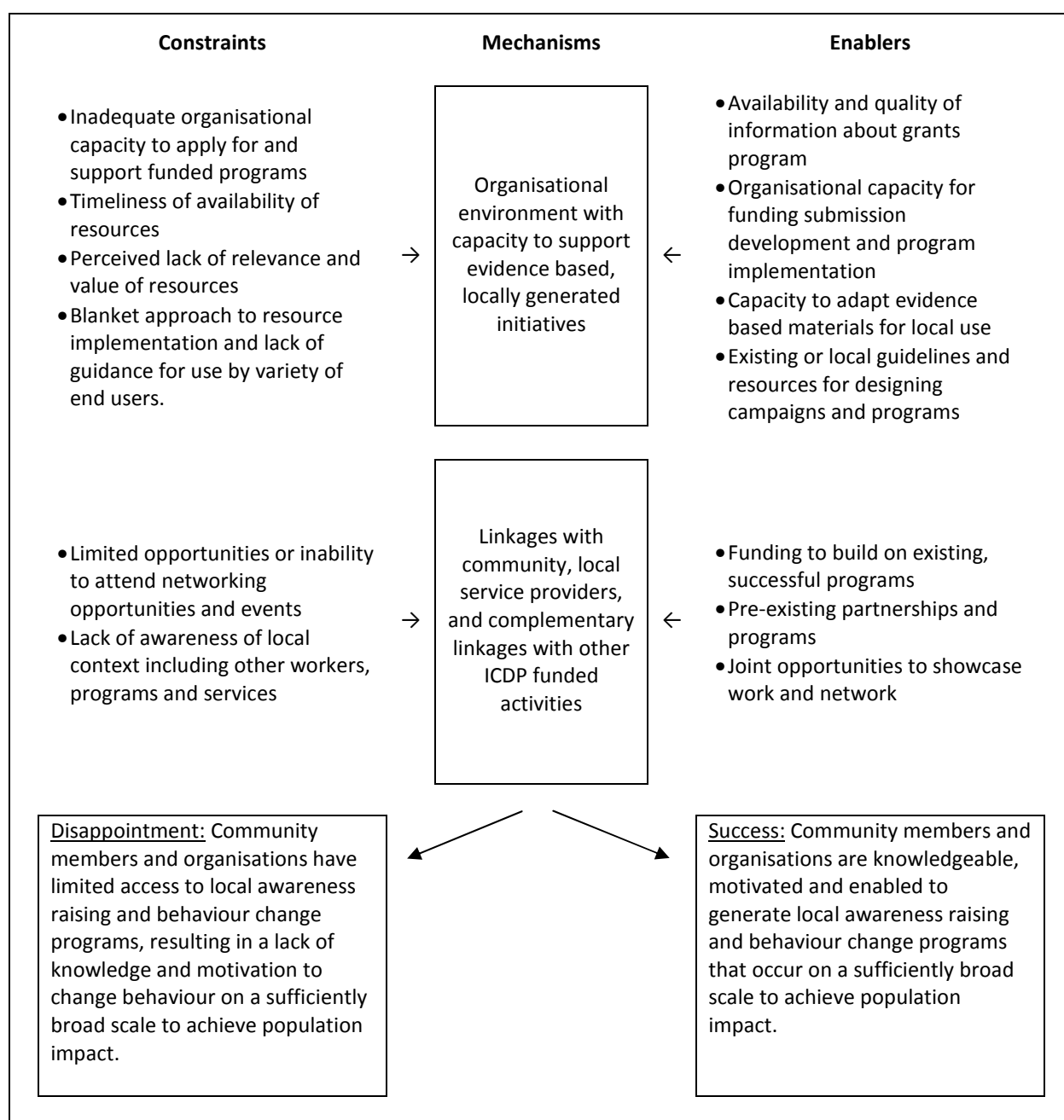


Figure 4.1: Enablers and constraints to effective implementation of the Local Aboriginal and Torres Strait Islander Campaigns to Promote Better Health measure

Organisational environment with capacity to support locally generated initiatives

The extent to which the goal of developing and delivering locally generated campaigns, including Healthy Community Day events, could be achieved was influenced by organisational characteristics, particularly the capacity to engage with the grants program and national support strategies, and to develop and implement programs. The ability to apply for the grants was enabled (or constrained, where capacity was lacking) by firstly, an awareness of the grants program and subsequently, having the necessary time, resources and skilled personnel to carry out community consultations and to write the funding application and if successful, to support the implementation of the program. While implicit in the measure design, adequate organisational capacity appeared a criterion for grant recipients, at

the least for round one grants (targeted) and more implicitly in round two (open and competitive, and presumably successful applications were based on capacity to undertake local community campaigns). To some extent, making available a range of resources was aimed at supporting community organisations to develop and implement evidenced based and locally relevant community campaigns, but the timing of resource distribution and their apparent lack of use (related to perceptions of their limited applicability or uncertainty on how to use them) were barriers to effective implementation. In some sites, organisations developed their own or utilised existing resources, with a perception that this would ensure the process and resources were applicable and appropriate for local community needs.

In addition to the converse of the above enabling factors, local context that hindered the development of locally generated initiatives was host organisation instability. For example, where DGPs were transitioning to Medicare Locals there was uncertainty about capacity to implement the program if a funding submission was successful. This appears to have prevented the organisation from engaging with the grants program.

Linkages with community, local service providers, and complementary linkages with other ICDP funded activities.

It was evident that partnerships and complementary linkages for health promotion was a key mechanism through which this measure could deliver consistent and locally appropriate messages that improve community understanding of risk factors for chronic disease and how Health Services can help prevent and manage chronic disease. The role of the measure in facilitating partnerships and linkages was explicit in the measure design including making partnerships a requirement for grant program funding; incorporating health checks in Healthy Community Day events and by organising a range of information sharing strategies (e.g. Live Longer! website, conferences and stakeholder engagement workshops). The extent to which these strategies resulted in greater linkages at a local level was influenced by a number of factors.

Linkages with local service providers was seen to be enabled through prior relationships, formed by working together on other activities or projects, and through previous experience in social marketing or similar campaigns, evident by a number of existing initiatives receiving further or ongoing funding. Conferences and showcasing opportunities, such as the Live Longer! conferences (organised by the DoHA) and website, were also valued for the networking and information sharing, but the extent to which this transpired to greater collaboration between service providers at a local level was unclear.

While this measure included a funding program to support the promotion of relevant MBS item, at a site level there was no evidence of links between these activities and other initiatives under the measure. This may be because of the implementation timing of the different measure components (funding for MBS promotion activities were completed by June 2011; other measure activities commenced in April 2011) and/or that linkages had not been intended by the measure design.

4.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 4.3). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

4.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic. The program logic for measure A3 has been reviewed and updated since the original program logic developed by Urbis. The program logic used here is the updated version.⁵¹

Table 4.3: Summary of key findings in relation to the program logic – local Aboriginal and Torres Strait Islander campaigns to promote better health measure

	Key findings from SSE
Outputs for year 1 and beyond	
Local Indigenous media organisations and/or community groups involved in local or regional campaigns.	Program data indicate that media organisations and community groups were grant funding recipients. Further details about these organisations' involvement in the local or regional campaigns could not be ascertained through the SSE.
Implemented community campaigns	The evidence from the Sentinel Sites suggests that at local level, the funding covered a diverse range of activities, messages and target audiences across the sites. Use of targeted funding varied between the sites, in some cases being used to support or expand existing initiatives, and in other cases, new one-off or occasional outreach events were implemented. The potential for population health effects to be achieved may be enhanced by increased emphasis on integrating ICDP initiatives with existing programs, and building existing initiatives and capacity in a way that is consistent with Australian and international evidence on best practice in health promotion. Identifying and sharing of good practice between communities may be a useful focus in the future.
Community Health Action Packs	Developed and distributed to Regional Tackling Smoking and Healthy Lifestyle workforce and targeted grant recipients. Some challenges with distribution were noted and in some cases the packs were not seen to be relevant to local context and needs. More practical hands-on training on how to use the resource both in developing new initiatives and in strengthening existing initiatives will be an important future consideration so it is not another 'sit on the shelf' resource.

⁵¹ DoHA correspondence, 7 March 2012.

	Key findings from SSE
Expected early results for years 2 – 4	
Participants have increased awareness of importance of accessing primary health care.	There were pre-existing levels of awareness of chronic disease risk factors and the importance of healthy lifestyles, but little evidence that would reflect an increasing awareness of the importance of accessing primary health care and its importance in the prevention and management of chronic disease. Existing levels of awareness is evidence that non-ICDP activity was having an impact at a community level prior to ICDP implementation.
Funds for grants and events are spent efficiently.	Some evidence of on-the-ground activity related to targeted grant program but not open grant program as announcements of successful grant recipients were made when site visits were underway or completed so no impact could be investigated. The grants program was popular, but there is a risk of allocating the funding to organisations with existing capacity (those with dedicated resources to apply) in preference to organisations most in need of developmental support. Developing health promotion capacity in organisations could be a future area of focus.
Action packs are beneficial to the design and implementation of community campaigns.	Our findings indicate that there were mixed views on the quality and adequacy of the available resources. There was little evidence of use and uptake of the CHAP or Live Longer! website across Sentinel Sites, including those with targeted grant funding. A comprehensive dissemination and support strategy for health promotion tools, resources and training, possibly with a more clearly articulated vision for how these tools, resources and training could build capacity of workforce and organisations and enable them to deliver effective community level health promotion, could be a future area of focus.

4.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Local Community Campaigns to Promote Better Health measure.

Program awareness, reach and uptake

While it was difficult to draw conclusions about uptake due to targeting of (first round) grant recipients, there was increasing awareness of grant funding availability (evident in the high number of round two grant submissions), and evidence of project level activities related to the targeted (first round) grant funding. There was no evidence of activity relating to the competitive (second) grant round, due to program delays which affected commencement of projects.

Over the evaluation period, 21 out of 24 Sentinel Sites had exposure to at least one Local Community Campaign activity through the first round of grants. Access to grant funding was seen to be partially dependent on organisational capacity to apply for funding and local stakeholders perceptions of capacity to effectively utilise funding.

Implementation and perceptions of Healthy Community Day events

Healthy Community Day events are in early stages of implementation, with events held in ten out of 24 Sentinel Sites. Perceptions of Healthy Community Days were generally positive, although some challenges were highlighted regarding identifying and reaching particular target population groups.

Awareness and perceptions of program support strategies

There was evidence from the Sentinel Sites that awareness of the national support strategies had generally improved, although it was patchy within and across sites.

Where there was awareness of the support strategies, the SSE identified little evidence of the use and effectiveness of these resources in supporting on-the-ground activity. Some challenges with distribution of resources were noted and in some cases the packs were not seen to be relevant to local contexts and needs.

Community awareness and understanding of chronic disease

There were existing, high levels of awareness amongst community members of the risk factors for chronic disease throughout the evaluation period, but less awareness of the link between healthy lifestyle and the importance of regular health check ups in developing or managing chronic diseases.

The existing level of community awareness is evidence that non-ICDP activity was having an impact at a community level prior to ICDP implementation.

The SSE was not able to gauge the impact of the measure activities at a population level within the sites. Population level effects are unlikely to have been achieved at this early stage of ICDP implementation, because health behaviour change requires long-term and strategic programs, and because of the short time frame for most of these newly funded projects and their limited reach.

4.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Strengthen organisational environments to support evidence based, locally generated initiatives, including skilling staff and community participants to work together to adapt evidence based materials for local use in health promotion projects. Consider the development and roll out of specific training and mentoring to support uptake and use of the evidence-based resources, including the CHAP and Live Longer! website. Ensure training content includes skill development to adapt national resources to enhance appropriateness for use in local contexts, and strengthens a broader understanding of good health promotion practice. Provide support to evaluate local projects and improve systems to strengthen and sustain good health promotion practice.
- b) Support linkages between community and local service providers, including clarification of the complementary role of, and relationship with, organisations with a mandate to support health promotion and other ICDP activities. Consider requesting evidence of stakeholder collaboration and involvement of priority population groups in planning, implementing and evaluating local initiatives as a condition of funding and for ongoing reporting and monitoring.

- c) Consider increased investment in projects that address environmental, structural and individual barriers to healthy choices and lifestyles, for example addressing issues related to food supply and security, improving access to health services, and supporting smoke free spaces and events, as population level effects will not be realised on the basis of knowledge and understanding alone.

5. SUBSIDISING PBS MEDICINE CO-PAYMENT (*MEASURE B1*)

5.1. Description of measure

The Pharmaceutical Benefit Scheme (PBS) provides public subsidies for prescribed medicines in Australia. The aim of the \$88.7 million 'Subsidising PBS Medicine Co-payments' measure, which commenced in July 2010 was to improve access to PBS medicines for eligible Aboriginal and Torres Strait Islander people with or at risk of a chronic disease, through removing or reducing the PBS Co-payment for those eligible. The overall purpose of the measure was to improve medication access and adherence, and ultimately effective management of chronic conditions.

The measure is intended to benefit Aboriginal and Torres Strait Islander people of any age who present with an existing chronic disease or are at risk of chronic disease and who, in the opinion of the doctor, would experience setbacks in the prevention or ongoing management of chronic disease if the person did not take the prescribed medicine and who are unlikely to adhere to their medicines regimen without assistance under this measure. It is intended that nationally 70 000 Aboriginal and Torres Strait Islander people will benefit by 2012–2013.⁵²

Generally, in order for a Health Service to be eligible to participate in the PBS Co-payment measure they must be registered for the PIP Indigenous Health Incentive. A small number of AHSs that are not eligible for the PIP Indigenous Health Incentive are also able to access the PBS measure.⁵³

The patient is required to consent to register at a Health Service to participate in the PBS Co-payment measure. The patient can either register with a Health Service registered with the PIP Indigenous Health Incentive or with an AHS that has applied for and been approved for special arrangements to participate in the PBS Co-payment program directly (not through the PIP).⁵⁴ These Health Services then register eligible patients for the PBS Co-payment measure using the same patient consent and patient registration process as for the PIP Indigenous Health Incentive. Once a patient has been registered for the PBS Co-payment measure they do not need to be re-registered. GPs at Health Services participating in the PBS Co-payment measure must then appropriately annotate each prescription for these patients to enable them to access the co-payment relief.⁵⁵ The annotation can be done using upgraded software on clinical information systems or by hand. The prescriptions written and dispensed under the PBS Co-payment measure are commonly referred to as Closing the Gap (CtG) prescriptions.

When obtaining PBS medicines at their local pharmacy, eligible patients who would normally pay the full PBS Co-payment (\$35.40 per item in 2012) are able to pay the concessional rate (\$5.80 per item in

⁵² DoHA, Subsidising PBS Medicines Co-payment <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/subsidising-pbs-medicine-co-payments>> (accessed 10 December 2012).

⁵³ DoHA, Special Arrangements for Indigenous Health Services not currently Participating in PIP, <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/non-pip-participants/\\$file/Special%20arrangements%20Indigenous%20Health%20Services%20not%20participating%20in%20Practice%20Incentives%20Program%20\(PIP\).pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/non-pip-participants/$file/Special%20arrangements%20Indigenous%20Health%20Services%20not%20participating%20in%20Practice%20Incentives%20Program%20(PIP).pdf)> (accessed 4 December 2012).

⁵⁴ DoHA Closing the Gap [website] <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/non-pip-participants>> (accessed 23 October 2012).

⁵⁵ DoHA, PIP Indigenous Health Incentive Guidelines November 2011 <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/2864-0411-pip-ihl-guidelines.pdf>> (accessed 15 October 2012).

2012).⁵⁶ Those who would normally pay the concessional rate receive their PBS medicines without being required to pay a PBS Co-payment. However, premiums for a small number of medicines still need to be paid by the patient.

Community pharmacists are reimbursed both for the standard PBS medicine and for the proportion of the normal PBS Co-payment that has not been paid by the patient. The payments made by Medicare Australia to pharmacies are as per the normal payment process/schedule.

Pharmacy software updates were planned to accompany this roll out. The dispensing software allows the patient to be flagged under the measure and calculates the correct payment to be charged to the patient plus the correct safety net amount to count towards the family's safety net records. Pharmacists are obliged to dispense the prescriptions if correctly annotated. They have no role in assessing patient eligibility for the scheme.⁵⁷

This measure was built on an existing program — Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX), a program that commenced in 2008 available to AHSs in non-remote areas. The focus of the QUMAX Program was to improve quality use of medicines (QUM) through a range of support services provided by participating Aboriginal Community Controlled Health Services and community pharmacies in rural and urban Australia. Although the QUMAX program no longer includes the co-payment relief element (now funded under the PBS Co-payment measure), it has been extended until 2015 under the Fifth Community Pharmacy Agreement to continue to augment QUM within ACCHSs. PBS listings have also improved, with more medicines now available for conditions that predominate in the Aboriginal and Torres Strait Islander population. QUM support services funded under QUMAX include: Dose Administration Aids (DAAs), QUM Pharmacy Support; Home Medicines Review (HMR); QUM Devices; QUM Education; Cultural Awareness; and Transport.⁵⁸

There are separate arrangements in place for remote areas, patients of around 170 remote area AHSs have access to free medicines through the Section 100 (S100) supply arrangement of the National Health Act 1953. This provision, introduced in 1999, provides PBS medicines to patients of eligible remote area AHSs without a requirement for the normal PBS prescription form and without charge.⁵⁹

5.2. State of implementation – national context

Patient registrations commenced in March 2010, with the PBS Co-payment measure benefits available from 1 July 2010. DoHA indicated that the approval to allow specialists to annotate prescriptions for the PBS Co-payment measure registered patients came in July 2010. Specialists can prescribe under the PBS Co-payment when they are providing services at a registered urban or regional AHS, or when treating a registered patient who has been referred to them by a service in an urban or regional location.

⁵⁶ PBS patient contributions are adjusted annually in line with changes in the Consumer Price Index. From 1 January 2012, the amounts were: General patient co-payment \$35.40; concessional co-payment \$5.80. Medicare Australia, 2012 PBS Patient Contributions [website] <<http://www.medicareaustralia.gov.au/provider/pbs/pharmacists/safety-net.jsp>> (accessed 15 October 2012).

⁵⁷ DoHA, Closing the Gap PBS Co-payment Measure Pharmacy Staff Resource Booklet <<http://www.health.gov.au/internet/ctg/publishing.nsf/content/subsidising-pbs-medicine-co-payments>> (accessed 17 October 2012).

⁵⁸ DoHA, QUMAX Program Specific Guidelines, June 2011 <http://www.5cpa.com.au/iwovresources/documents/5CPA/Initiatives/ATSI_Programs/QUMAX%20Program%20Specific%20Guidelines%20v3.pdf> (accessed 10 December 2012).

⁵⁹ DoHA, Alternative Arrangements for Medicines, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous>> (accessed 10 December 2012).

The DoHA produced and distributed a range of PBS Co-payment resources to pharmacies, GPs, and specialists at varying points over the evaluation period through direct mail out and dissemination through peak bodies such as SBOs, DGPs and Medicare Locals, engagement with the Pharmacy Guild and Pharmaceutical Society of Australia and some medical specialist colleges. The PBS Co-payment guidelines were included with the PIP Indigenous Health Incentive guidelines. Materials included pharmacy resource booklets and posters that were distributed to pharmacies in June 2010, and GP resource kits that were distributed to all Health Services in December 2010. The earlier pharmacy information did not include specialist annotation as the legislation had not then been amended. However the GP resource did have this mentioned. There were also regular articles in key stakeholders' newsletters about the PBS Co-payment measure. In March 2011 DoHA reported that all communications materials for this measure were being reviewed and communication materials for medical specialists were being developed.

A range of materials were made available electronically, with a strong focus on dissemination of booklets and posters, supplemented by training and information sessions with key stakeholders including Medicare Australia, NACCHO, NACCHO affiliates, AGPN and SBOs, the Pharmacy Guild and a number of state/territory health departments.^{60,61}

The DoHA has continued to promote and disseminate information about the PBS Co-payment measure since the commencement of the program through a number of conference attendances such as QUMAX/S100 supply arrangements forum, RACGP conference and SBO conferences.

At the time of the final evaluation cycle, information provided by DoHA demonstrated high levels of engagement across the country over the period of 1 July 2010 to 30 June 2012 (Table 5.1).

Table 5.1: Cumulative trends in uptake of PBS Co-payment measure by Health Service, patient and numbers of pharmacies participating (1 July 2010 - 30 June 2012)

	End February 2011	End June 2011	End March 2012	End June 2012
Total no. of Health Services participating	Over 1600	Over 1900	Over 2600	Approximately 2900
Total no. of patients who have received at least one PBS Co-payment measure prescription	52 500	79 076	127 379	150 005
Total no. of pharmacies dispensing PBS Co-payment measure prescriptions	Over 2900	3694	4731	5127

Source: DoHA, Subsidising PBS Medicine Co-payment, measure updates: 28 February 2011, 30 June 2011, 31 March 2012, and 30 June 2012.

⁶⁰ DoHA, Practice Incentive Program (PIP) Forms and Guidelines [website]

<<http://www.medicareaustralia.gov.au/provider/incentives/pip/forms-guides.jsp>> (accessed 17 October 2012).

⁶¹ DoHA, Closing the Gap Tackling Chronic Diseases [website]

<<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/Improving-Chronic-Disease-Management-and-Follow-up>> (accessed 17 October 2012).

Data received from DoHA over the period of the evaluation show that:

- Around 2900 Health Services had registered to participate in the PBS Co-payment measure by June 2012. Of those, almost 150 were AHSs and more than 2750 were General Practices. An additional 17 AHSs had registered through the measure's special 'non-PIP' arrangements.
- There was a consistent trend of increase in the reported number of people who had registered for the PBS Co-payment. The national target of around 70 000 people expected to receive benefit by the end of 2012-2013 was reported to have been exceeded by June 2011, with over 150 000 people having received benefit by 30th June 2012.⁶²
- The total number of pharmacies dispensing PBS Co-payment measure prescriptions showed a steady increase over time.

Other data provided by DoHA were:

- The PBS Co-payment measure hotline statistics June 2010 - June 2012 showed a total of 8 535 calls over 482 working days, averaging around 17 calls per day. The hotline was staffed directly by DoHA personnel.
- There were 2431 email requests for information or assistance between June 2010 and March 2012, averaging nearly five emails per day (ranging from one to eight per day since inception).
- A total of 2 729 929 PBS Co-payment measure prescriptions were dispensed nationally (1 July 2010 - 30 June 2012) with uptake being highest in NSW (41.30%), followed by Qld (26.60%), WA (10.77%), Vic (8.94%), SA (8.22%), Tas (2.04%), NT (1.26%), and ACT (0.86%).
- Nationally, the top ten medicines most frequently dispensed were for cardiovascular diseases, mental disorders, diabetes, chronic respiratory conditions, pain relief, and bacterial infections. In descending order of frequency of prescription, these were: atorvastatin, metformin hydrochloride, salbutamol sulphate, perindopril, codeine phosphate, amoxicillin, paracetamol, cephalixin, amoxicillin with clavulanic acid and ramipril.

⁶² DoHA, Closing the Gap website < <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/subsidising-pbs-medicine-co-payments> > (accessed 18 October 2012).

5.3. Findings from Sentinel Sites

The findings from the SSE should be interpreted with an understanding of the evaluation methods and associated limitations which are described briefly in the Introduction (Chapter 2) and in more detail in Appendix C.

5.3.1. AWARENESS OF PBS CO-PAYMENT AND SOURCES OF INFORMATION

KEY POINTS

- High levels of awareness of the PBS Co-payment measure were evident in urban and regional sites, with lower but increasing awareness in remote sites.
- Opportunities for face-to-face communication about the measure, and about the whole of the ICDP, were particularly valued in conveying practical information about implementation and trouble-shooting access issues.
- Information about the measure flowed between different groups, including:
 - ICDP workforce working with GPs and pharmacists to improve their awareness and understanding of the measure, and find ways for it to work in practice; Medicare Liaison Officers and DGPs, taking an active role in assisting Health Services to find workable solutions to implementation.
 - IHPOs and OWs informing community members, who in turn informed their GPs and pharmacists, requesting annotated scripts;
- Although understanding of the measure increased over the evaluation period, at the end of the period specialists, pharmacists, hospital staff, and service providers in remote locations still generally lacked adequate understanding about the measure and its relevance to them.

Overall awareness

A first step to changing prescribing practices of practitioners to use the PBS Co-payment measure scripts is that practitioners are aware of the opportunity for their patients to receive this co-payment relief. From the commencement of the evaluation, almost all interviewees in urban and regional sites indicated that they were aware of the PBS Co-payment measure (Table 5.2).

Levels of awareness in remote sites started out fairly low, but increased over the evaluation period, to nearly 100%. Within community focus groups in urban and regional sites, awareness of the PBS Co-payment measure was also generally high in urban and regional sites, and lagged behind in remote sites. The generally lower awareness in remote sites is likely to be related to a perception that the measure has less relevance to remote areas because of the S100 supply arrangement, which has been available in remote locations for over ten years. Although some of the increase in awareness of the measure in remote sites may have come about due to engagement with the SSE team, the general increase in utilisation of the measure across remote Australia (shown later) suggests a broader increase in levels of awareness about the measure in remote locations.

Over the evaluation period, there was increasing recognition by service providers in remote sites of the potential of the PBS Co-payment measure to provide additional benefits for their patients, for example

removal of cost barriers to medications when patients are visiting regional towns. Issues and information needs specific to access of the PBS Co-payment measure in remote areas is discussed further in Section 7.3.3.

Across urban, regional and remote sites, despite reasonably high levels of awareness, community focus group members consistently identified examples of individuals who are still paying large amounts of money for medications, and who are not aware of the PBS Co-payment measure.

Table 5.2: Awareness of the PBS Co-payment measure for medicines available for Aboriginal and Torres Strait Islander people (% who responded 'yes'), overall and by rurality

	Evaluation Cycle					
		One	Two	Three	Four	Five
Are you aware of the PBS Co-payment measure available for Aboriginal and Torres Strait Islander people? MS, CS, PM ^a	Overall	86% (n=36)	91% (n=81)	95% (n=86)	99% (n=72)	96% (n=70)
	Remote	43% (n=7)	69% (n=16)	81% (n= 21)	92% (n=12)	92% (n=13)
	Regional	100% (n=15)	95% (n=40)	100% (n= 33)	100% (n=27)	100% (n=23)
	Urban	100% (n=13)	100% (n=25)	100% (n= 32)	100% (n=33)	94% (n=34)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded.

Sources of information for different groups

In general, communities, Health Services and other stakeholders in urban and regional areas seemed to be well informed about the PBS Co-payment measure, with sufficient information to participate in implementation. There were some remaining gaps in understanding evident in remote sites.

Community members received information about accessing the measure from IHPOs and OWs, and through other community members. It was apparent during the evaluation cycles that the PBS Co-payment measure was highly valued by community members, and community focus groups indicated that there was a great deal of discussion and information sharing about the measure within communities.

The quote below illustrates how one OW outlined her role in providing communities with information about the measure, and in explaining that not all medications would necessarily be covered.

'If patients have a problem with their medication, we say to the patients to go back and ask your doctor to prescribe something that is the same and will do the same, but under the PBS. We also say to patients, the only time that medication changes that you need and the doctor can't do that, we also say patient when they sign up, your health cards you get it for free, but sometimes some medications might have a gap and you got to pay – always make them aware, but people hear that word 'free' and they go away thinking it is always free. So we explain, if you work, you get the minimal \$5.60/80, but we say sometimes there is medication that is not covered and you got to pay that one. For example, a family rang me to ask about a heart tablet [that] was not covered under PBS and had to pay, encouraged the family to go back to the doctor and to find a medication that is covered under PBS, but you need to ask why that medication was given, maybe it is the one your mum has to have that medication for her heart condition.' (DGP, OW)

Pharmacists found out about the measure in various ways. In some cases, community members who brought prescriptions to pharmacists for supply of medications informed pharmacists about the measure. In other cases, patients requested information from pharmacists – often about why certain medications were covered and not others, or why the same medications provided by different health care providers were not equally covered by the measure – stimulating pharmacists to seek out information about the measure.

General Practices received information about the measure from the IHPOs and OWs in DGPs, and sometimes from pharmacists, and from patients requesting access.

'There is a big push and education from the Division to get the message out there.' (General Practice, GP)

'I found out about the PBS Co-payment through a pharmacist. A patient knew about CtG went to pharmacist, pharmacist rang GP and told GP.' (General Practice, GP)

GPs were also informed about the measure directly from community members seeking access. This role was particularly evident in the latter two evaluation cycles, with both GPs and community focus group members reporting significant information flows from patients to GPs.

'Patients make sure doctors prescribe under PBS measure.' (General Practice, GP)

This role was evident in relation to registration with the PBS Co-payment measure, and in relation to making sure individual scripts were CtG annotated.

'If CtG is not put onto the script, I remind the doctor.' (Community focus group)

GPs in AHSs reported receiving information from Medicare Liaison officers.

Pharmacists received information directly from some patients (as identified above) and also through the Pharmacy Guild and through Medicare Liaison Officers. There was also considerable work done by the IHPOs and OWs with pharmacists, including hosting education evenings, and raising awareness of issues of cultural safety. Some interviewees noted that work with pharmacists had been unanticipated, but was viewed as a key priority by the DGP.

'The department never anticipated the extent of the work DGPs have had to undertake with pharmacies. They intended the focus of the IHPO and OW to be on orientating General Practices, the orientation of pharmacies has been a hidden area really. Divisions have taken on this mission as it is integral to the pie.' (DGP, Interviewee)

As indicated by the quotation below, some interviewees were concerned that the Pharmacy Guild may not be adequately informed of the range of existing and new services that may have an important role in implementation of the ICDP.

'We are not seen as part of the community controlled health sector. Lots of the information came through from Pharmacy Guild on PBS Co-payment or the QUMAX has actually gone to the Health Services and we were missing out because we weren't seen to be an Aboriginal medical service so were not on their mailing list ... We did not have relationship with the Pharmacy Guild until recently. The PBS Co-payment has not been flagged to me as a major issue with the four Health Services.' (AHS, CEO)

Other interviewees noted the role of the measure manager for this area, and felt that this person had been very responsive to requests for clarifications by email and telephone.

'[Name of measure manager] the Measure Manager he was really good, a driving force, very determined, very reliable, would ring pharmacy personally if significant issue, came and spoke at two workshops ... a great passionate worker in a quiet and unassuming way ... he was determined there would be no barriers.' (DGP, IHPO)

The SBOs have been managing state-based email lists for ICDP workers based in the DGPs and these were noted as a good method for dissemination of information.

A number of interviewees indicated the value of having someone to discuss the ICDP package as a whole. The SSE team was frequently identified by key stakeholder organisations as playing an important role in this regard. The IHPOs appear to be the only ICDP funded workers who might have a reasonable understanding of the whole of the ICDP despite often being focused in their role on a particular aspect of the ICDP and having a large number of services to cover.

'... Need information about what is available ... also don't have time to search for information ourselves ... Mode of communication that would be most useful to our staff would be visiting facilitators, we could pull half of staff off at a time to hear and ask questions.' (AHS, practice manager)

'Information received was from the Site Evaluation Facilitators from Menzies and the IHPO based at the Division.' (General Practice, GP)

Several sites noted the value of having a dedicated practice manager position that was able to either process information sent or source information.

Appendix I presents an analysis of the relationship between different service use variables (for example PBS Co-payment measure, PIP Indigenous Health Incentive, health assessments and follow-up items) and contextual variables (for example pre-existing uptake of related MBS items and the number of ICDP workers in the site).

Perceptions of adequacy of information

Interviewees were asked about whether they felt Health Services had been provided with adequate and timely information about the measure and whether they felt stakeholder organisations had been clearly informed. Levels of agreement to these statements were generally fairly high across all evaluation cycles (Table 5.3). There were some differences evident by geographic location, as outlined below).

In the final evaluation cycle 81% (26/32) of interviewees from urban sites, and 91% (21/23) of interviewees from regional sites agreed with the statement that *'Health Services had been provided with adequate and timely information about the PBS Co-payment measure'*. Six out of ten interviewees from remote sites agreed with this statement. Patterns of response to the statement *'stakeholder organisations were clearly informed of the new PBS Co-payment measure'* showed similar patterns by type of geographic location, suggesting lower but increasing awareness of the measure in remote areas.

Table 5.3: Trends in perceptions and awareness of the PBS Co-payment measure (% who responded 'strongly agree' or 'partly agree'), overall

	Evaluation cycle				
	One	Two	Three	Four	Five
The Health Service was provided with adequate and timely information about the PBS Co-payment measure. MS, CS, PM ^a	71% (n=31)	68% (n=74)	75% (n=80)	80% (n=70)	82% (n=66)
Stakeholder organisations were clearly informed of the new PBS Co-payment measure. MS ^a	71% (n=14)	53% (n=34)	67% (n=36)	79% (n=29)	87% (n=23)
All doctors in this Health Service prescribe under the PBS Co-payment measure for Aboriginal and Torres Strait Islander patients. PM, CS ^a	65% (n=17)	73% (n=40)	84% (n=44)	85% (n=41)	95% (n=43)
The PBS Co-payment measure has added a large administrative workload. PS, MS, CS, PM ^a	52% (n=31)	43% (n=87)	44% (n=36)	35% (n=81)	24% (n=78)
Organising access for Aboriginal and Torres Strait Islander people to the PBS Co-payment measure has been easy. PS, MS, CS, OW, PM ^a	44% (n=32)	64% (n=90)	68% (n=100)	78% (n=93)	84% (n=87)
Eligibility criteria for Aboriginal and Torres Strait Islander people to access the PBS Co-payment measure are workable in practice. PS, MS, CS, PM ^a	71% (n=31)	69% (n=87)	72% (n=92)	81% (n=81)	85% (n=78)
Pharmacists have effectively introduced new systems to support implementation of the PBS Co-payment measure. MS, CS, PM ^a	48% (n=31)	46% (n=74)	55% (n=80)	69% (n=70)	53% (n=66)
Medications are more accessible for Aboriginal and Torres Strait Islander people than they have been previously. MS, PM CS ^a	77% (n=26)	72% (n=64)	84% (n=62)	89% (n=56)	89% (n=47)
Medication adherence has improved because of the PBS Co-payment measure. CS ^a	n/a	n/a	63% (n=27)	67% (n=27)	88% (n=24)

^a See Appendix C for listing of interview and respondent types.

Note: n = number of people who responded. Included in the denominator are the respondents who indicated 'don't know/can't say'.

Communication gaps

Although Aboriginal and Torres Strait Islander communities were in general well informed about the PBS Co-payment measure, there were some gaps identified in the Sentinel Sites.

Some of the community focus group members highlighted that there were some community members who apparently continued to pay for medications, although they would have been eligible for the PBS Co-payment measure. As indicated in the quotation below, this may have particularly applied to community members who were more vulnerable, or generally less connected to information sources.

'Some other people don't see what is going on, got a girl around with us pays for her mother's tablet, so my daughter explains, you don't pay for your mother you get medication for free for her, they don't see anything on TV or on trains or in the community notices, they don't read it so they don't know what it is about, that is what she has been doing all the time.' (Community focus group)

Examples of areas of where there was evidence of more widespread lack of knowledge about the measure, included whether or not specialists could prescribe under the PBS Co-payment, and whether medications that had been prescribed on discharge from hospital could be covered. There was also some uncertainty about whether or not it was possible to obtain PBS Co-payment relief when visiting another location.

The following quote from a GP in an AHS illustrates the confusion evident in some Sentinel Sites between S100 supply arrangements, the PBS Co-payment measure and the PIP Indigenous Health Incentive.

'I enquired about the PBS Co-payment and was informed that patients on the S100 would not be eligible for the PBS Co-payment. Apparently the PIP payment would be impacted. However, on further investigation, if a GP in [name of town] wrote a CtG script for a patient and it was presented to the local pharmacy they would receive the medication, however the PIP-IHI would not be affected.' (AHS, GP)

In some sites, particularly urban sites, pharmacists and their staff appeared not to be well informed about the measure, or considered that it did not apply to them (particularly in the earlier evaluation cycles). Conversely, in some regional areas in particular, there was good participation and support of the measure by pharmacists, particularly in pharmacies that had participated in the QUMAX program.

The SSE did not specifically interview specialists about the measure. Specialists were not included in the initial communications and measure design, but were included later, with promotional material available for specialists from around March 2011. Across the evaluation period, other stakeholders including GPs, practice managers and community focus groups in general believed that specialists were not participating in the measure and that limited awareness of the measure and their role was at least one factor contributing to lack of participation.

'Some specialists are still not aware of the measure and of the annotated scripts. More education and information needs to be targeted towards specialists, they seem to be out of the loop.' (General Practice, GP)

In addition to lack of awareness among specialists, there was a lack of awareness among GPs that in writing referral letters to specialists they should indicate that a patient is registered for the PBS Co-payment measure. This issue, and the response of Health Services and patients to specialists' limited awareness and participation in the measure, is discussed further in Section 7.3.6 ('situations identified').

5.3.2. OVERALL UTILISATION OF THE PBS CO-PAYMENT MEASURE AND ADMINISTRATIVE PROCESSES

KEY POINTS

- Around 1 in 4 Aboriginal and Torres Strait Islander adults in Sentinel Sites and 1 in 5 in the rest of Australia had received one or more medications under the PBS Co-payment measure during the March - May 2012 quarter.
- Rates of utilisation were higher in regional than in urban locations, and relatively low in remote locations.
- Rates of utilisation were generally higher in the Sentinel Sites than in the rest of Australia for urban and regional locations, but not for remote locations. This is probably due to relatively greater access to AHSs in the Sentinel Sites than in the rest of Australia, and greater use of \$100 supply arrangements by AHSs in remote sites.
- Registration appeared to be to some extent driven by community demand, and opportunistically by some GPs and Health Services. While there were significant organised efforts in some sites, often for defined periods and with dedicated resources, there was no evidence of systematic processes being applied to ensure that the most vulnerable were registered and consistently received access to annotated prescriptions.
- Overall the administrative requirements associated with the PBS Co-payment measure were considered manageable by Health Services.

Number of Aboriginal and Torres Strait Islander people receiving PBS Co-payment medications

There has generally been very strong uptake of the PBS Co-payment measure, with higher than expected numbers of patients being registered nationally.

Around 1 in 4 Aboriginal and Torres Strait Islander adults in Sentinel Sites and 1 in 5 in the rest of Australia had received one or more medications under the PBS Co-payment measure during the March to May 2012 quarter (Figure 5.1). This was an increase from around 1 in 7 who had received one or more PBS Co-payment medications during the corresponding quarter in 2011.

Numbers of people who accessed medicines through the PBS Co-payment measure in relation to population numbers, per quarter and by geographic location are shown in Figures 5.3–5.5 below, and in Appendix F, Tables F1 and F2.

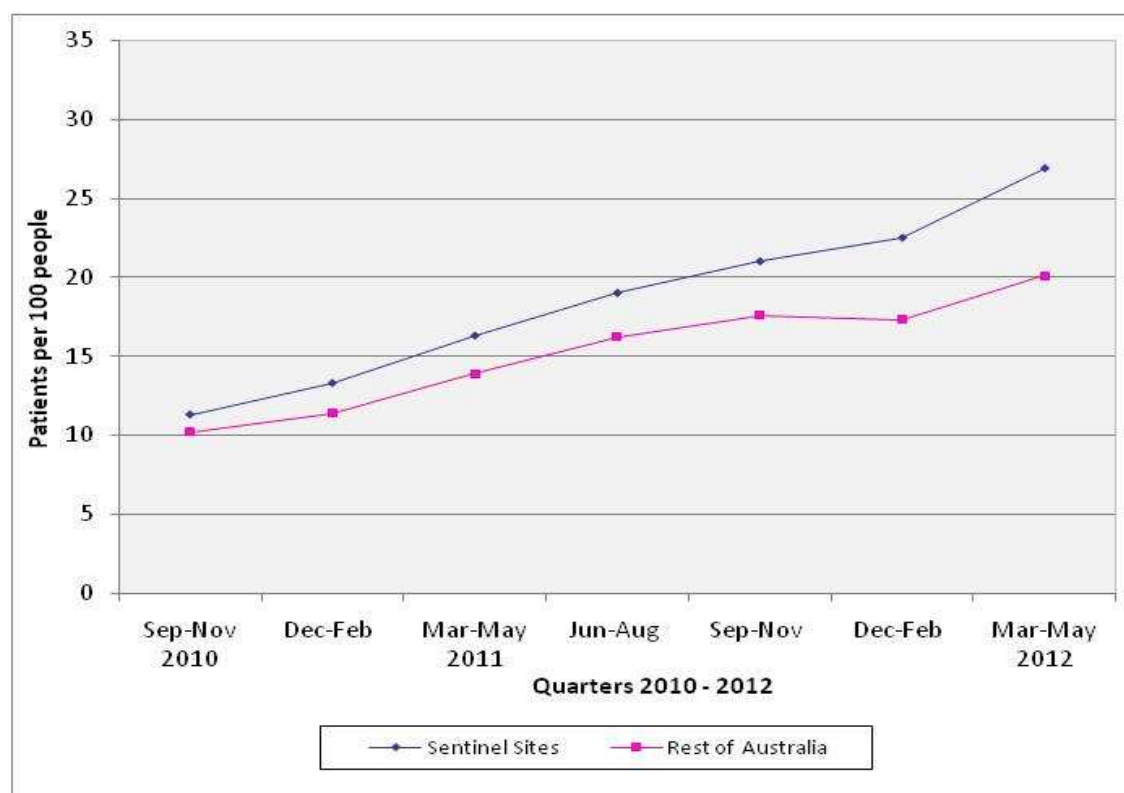


Figure 5.1: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia by quarter, September 2010 - May 2012

Possible inefficiencies in administration and processes

Consistent with these data on generally high uptake of this measure, it was evident in the Sentinel Sites that once community members were aware of the measure they wanted access to it, and were often prepared to 'shop around' or change their regular provider if necessary, to obtain the co-payment relief. This indicated the extent to which removal of cost barriers was a priority for patients. There were a few situations where barriers persisted and these are described further in Section 7.3.6.

Nonetheless it was apparent from the SSE that at the local level there were some inefficiencies in the process of getting those eligible registered and accessing PBS Co-payment medications. There was evidence of duplication of effort in some sites, as health care providers did not always know if patients were registered, and completed registrations 'just in case'.

There were also situations in which patients who had been provided with non-annotated prescriptions would then attend another health care provider, typically an AHS, for the purpose of replacing the prescription with one that was annotated. The AHSs who reported this felt it placed an additional administrative responsibility on them for managing prescriptions of patients, some of whom attended for care elsewhere and that it was not an ideal situation from a quality use of medicines perspective. Health care providers would complete routine checks, such as blood pressures, for these patients, being uninformed about whether or not these had been completed by the regular provider.

There was no clear evidence in the Sentinel Sites of systematic processes being applied to ascertain who was eligible for the PBS Co-payment measure, and to ensure that they systematically received access to the measure, regardless of whether they received prescriptions from General Practices, AHSs,

specialists or hospitals. Underlying these difficulties was a general lack of efficient clinical information systems in Health Services (Appendix E), and possibly weaknesses in information flows between Health Services.

Interviewees were asked whether they agreed with various statements about the ease of organising access to the measure. Perceptions tended to become more positive over time. By the final evaluation period, over three-quarters [84% (73/87)] of interviewees overall agreed with the statement *'organising access for Aboriginal and Torres Strait Islander people to the PBS Co-payment measure has been easy'* (Table 5.3). This represents a substantial increase since the first evaluation cycle. By the final evaluation cycle, less than 1 in 4 practice managers and clinicians who were interviewed agreed with the statement *'the PBS Co-payment measure has caused a large administrative workload'* with a clear decreasing trend over time (Figure 5.2).

In early evaluation cycles, interviewees from the AHS sector were more likely to perceive that the PBS Co-payment measure caused a large administrative burden, probably owing to their larger numbers of potentially eligible patients, but this declined over time suggesting that initial registration may have contributed substantially to the demands on administration capacity.

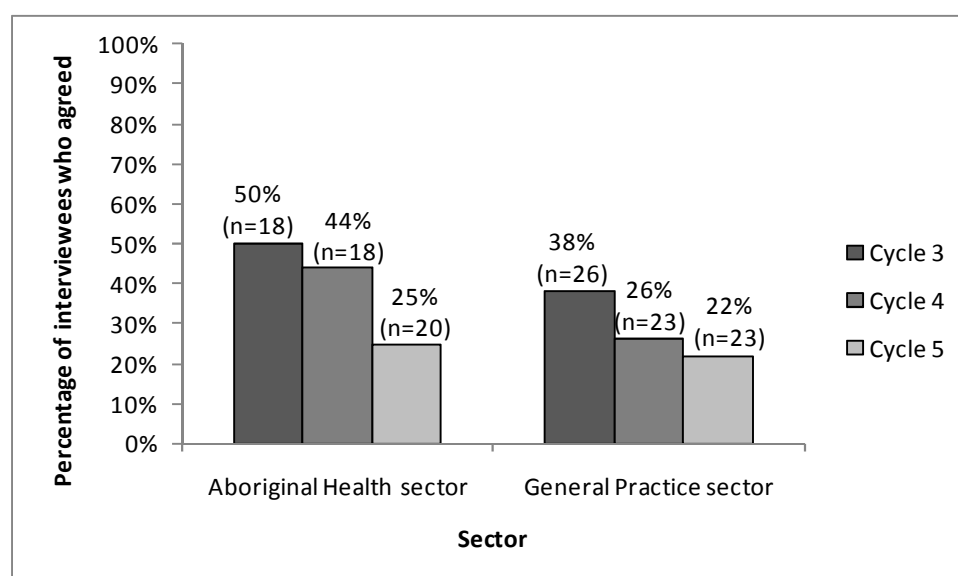


Figure 5.2: Clinicians' and practice managers' responses to the statement 'The PBS Co-payment measure has caused a large administration burden' (% who strongly or partly agreed)

Although the data presented above suggest that overall the administrative requirements associated with the PBS Co-payment measure were manageable for Health Services, there were some inefficiencies in processes, as identified above. We also noted that there was some flexibility in interpretation of the eligibility criteria for the measure, which could have resulted in lower administrative requirements. In some instances, health providers made efforts to verify eligibility for the measure, and this could be time consuming. In other instances, Health Services tended to provide access to the measure to whoever requested it and self-identified as Aboriginal or Torres Strait Islander.

The following section describes some of the differences in uptake of the measure by location, and by specific sites. These differences in uptake and associated qualitative data from the Sentinel Sites provide a basis for understanding how context has affected uptake of the PBS Co-payment measure.

5.3.3. VARIATION IN UTILISATION OF THE PBS CO-PAYMENT MEASURE BY GEOGRAPHIC LOCATION AND BETWEEN SENTINEL SITES

KEY POINTS

- Wide variation in the number of patients accessing the PBS Co-payment medications per 100 Aboriginal and Torres Strait Islander people was evident between specific Sentinel Sites and across urban, regional and remote locations.
- Utilisation of the measure was highest in regional locations, followed by urban locations, with utilisation in Sentinel Sites higher than that in the rest of Australia in both regional and urban locations.
- Numbers of people who accessed the PBS Co-payment medications during the March - May 2012 quarter was 34 and 26 people per 100 people in regional Sentinel Sites and the rest of regional Australia respectively. Corresponding utilisation in urban locations was 27 and 20 per 100 people for urban Sentinel Sites and the rest of urban Australia.
- Utilisation in remote locations was approximately 9.5 per 100 people for the rest of remote Australia, and 3 per 100 for remote Sentinel Sites, possibly reflecting different use of the \$100 supply arrangements in remote Sentinel Sites compared to the rest of remote Australia.
- There was wide variation in utilisation at site level in urban and regional sites, and less variation in remote sites. In the urban site with highest uptake, 93 patients per 100 Aboriginal and Torres Strait Islander people accessed PBS Co-payment medications during the March-May 2012 quarter, compared to 12 patients per 100 accessed PBS Co-payment medications in the urban site with lowest uptake.
- The variation in utilisation of the measure is due to a complex mix of local, regional and national influences, some of which vary over time.

Similarities and differences in utilisation of PBS Co-payment in urban, regional and remote locations and different Sentinel Sites

Numbers of people accessing PBS Co-payment medications per 100 Aboriginal and Torres Strait Islander people per quarter were highest in regional locations, and lowest in remote locations (Figures 5.3–5.8 and Appendix F, Tables F1 and F2). These patterns were broadly similar to those described for patient registration with the PIP Indigenous Health Incentive.

The generally lower numbers of people proportional to population who were accessing PBS Co-payment medications in remote locations was probably due to alternate access to medications through the \$100 supply arrangements applicable to these areas.

For both urban and regional locations, there were higher numbers of people proportional to population accessing PBS Co-payment medications in the Sentinel Sites compared to the rest of Australia. This may be due to the existence of an AHS in the Sentinel Sites, with AHSs likely to be providing PBS Co-payment measure prescriptions to larger numbers of people. Remote Sentinel Sites showed lower utilisation of the PBS Co-payment measure than the rest of remote Australia. This may have been because of relatively greater access to AHSs (and therefore the \$100 supply arrangements) in remote Sentinel Sites compared to the rest of remote Australia.

For all geographic locations, there were wide variations in numbers of people per population accessing PBS Co-payment medications evident in different Sentinel Sites. As for progress with implementation of most of the measures, it is clear from the evaluation that this variation in uptake cannot be simply attributed to geographic location or any other specific characteristic of specific sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. An analysis of these influences is presented later in this chapter.

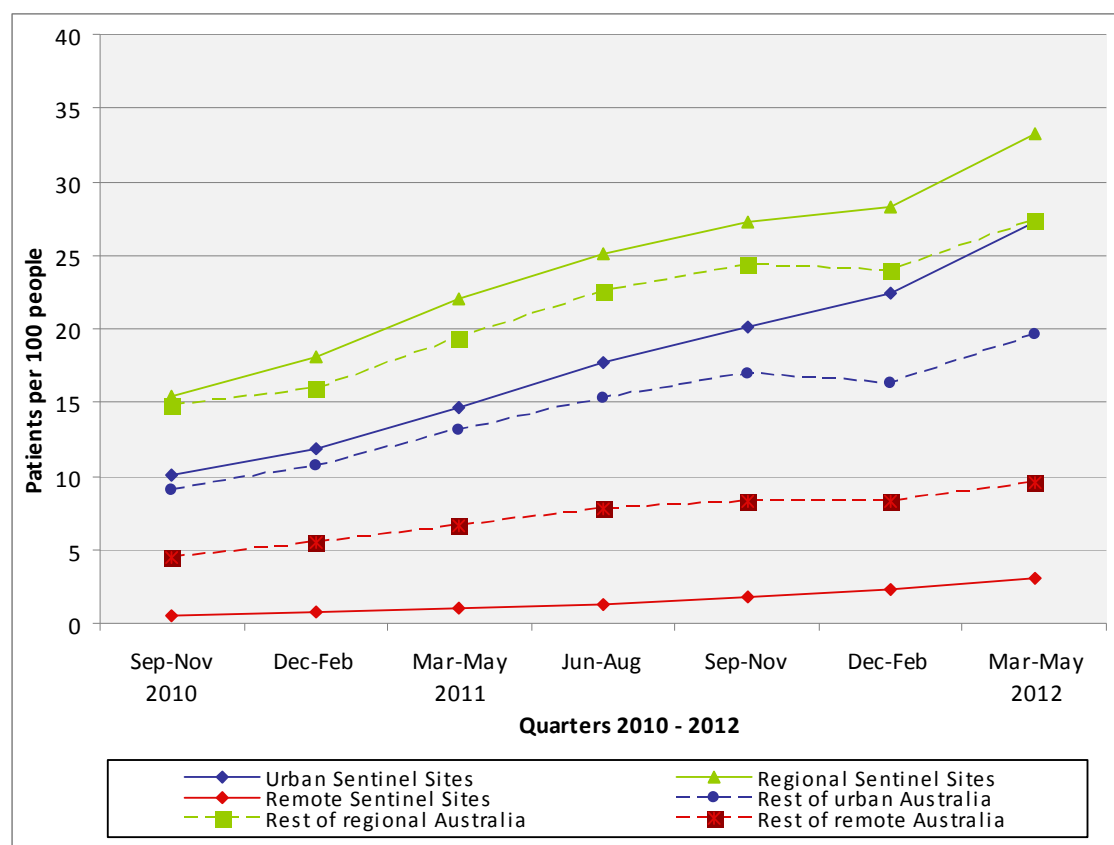


Figure 5.3: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia, by rurality, quarter, September 2010 - May 2012

Urban areas – illustrative patterns

Of the eight urban Sentinel Sites, numbers of people proportional to population accessing PBS Co-payment medications varied widely, ranging from about 13 to about 93 per 100 Aboriginal and Torres Strait Islander people in the March - May 2012 quarter (Figure 5.3).

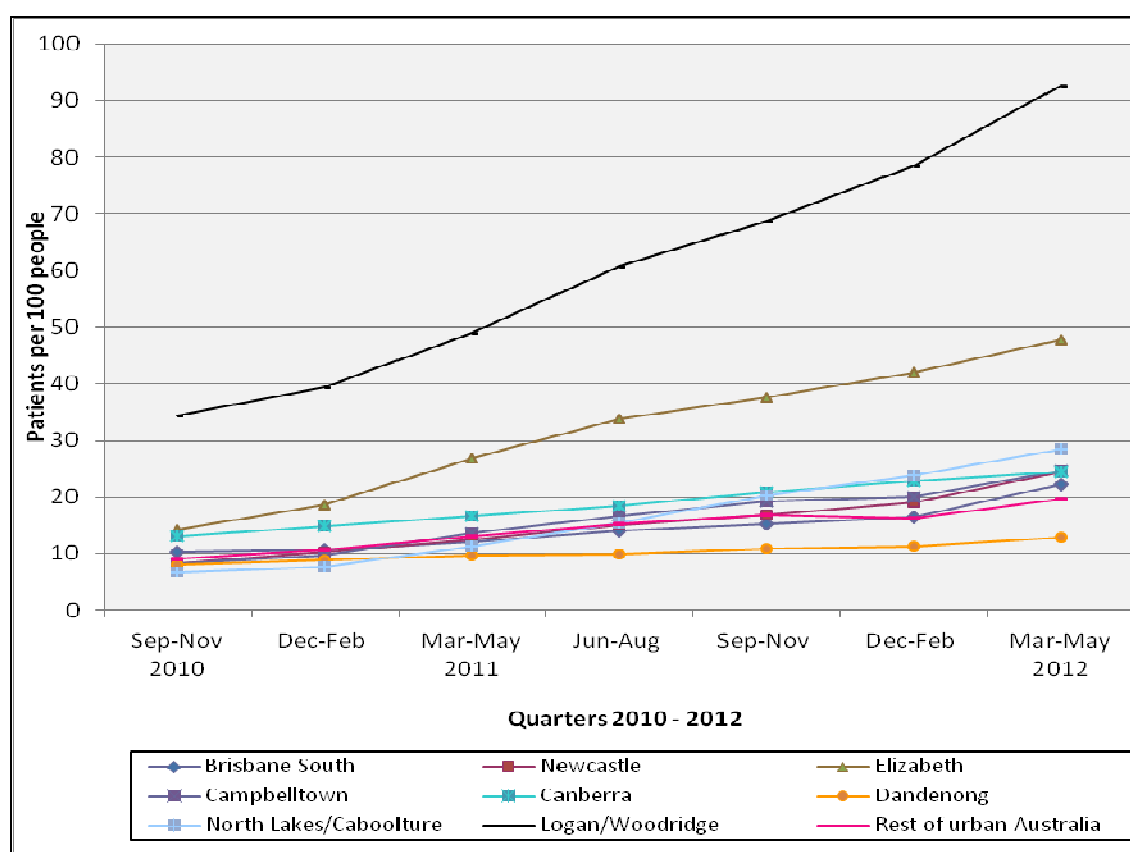


Figure 5.4: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, by site and quarter, September 2010 - May 2012

The site that stood out as having particularly high numbers of people accessing PBS Co-payment medications was Logan/Woodridge (Figure 5.4). This site had high levels of engagement with all components of the ICDP; it had the highest level of adult health assessments (see Chapter 6) at baseline and showed the most marked increase over the evaluation period. There were also large numbers of GPs claiming adult health assessments in this site compared to other sites and the highest number of PIP Indigenous Health Incentive patient registrations per 100 of the population (see Chapter 7). The relatively high use of PBS Co-payment medications is less likely to be explained by census undercounts of Aboriginal and Torres Strait Islander people than may be the case in other sites, see Introduction and Methods (Chapter 1) and the Evaluation Process and Methods (Appendix C). This high level of uptake relative to population numbers raises questions about variation between location and services in the application of eligibility criteria.

In general, utilisation rates were higher in all urban Sentinel Sites than the rest of urban Australia. Dandenong was the only urban site that showed lower utilisation of PBS Co-payment measure per population than the rest of urban Australia. Dandenong also had low numbers of adult health assessments per population, lower numbers of participating GPs and low Health Service and patient participation in the PIP Indigenous Health Incentive.

Regional areas – illustrative patterns

There was wide variation in trends in the different regional Sentinel Sites. Owing to the large number of regional sites, these figures are presented separately by site type (Figures 5.5-5.7). Of the 12 regional Sentinel Sites, numbers of people proportional to population accessing PBS Co-payment medications

varied widely, ranging from about 14 to about 66 per 100 Aboriginal and Torres Strait Islander people in the March - May 2012 quarter.

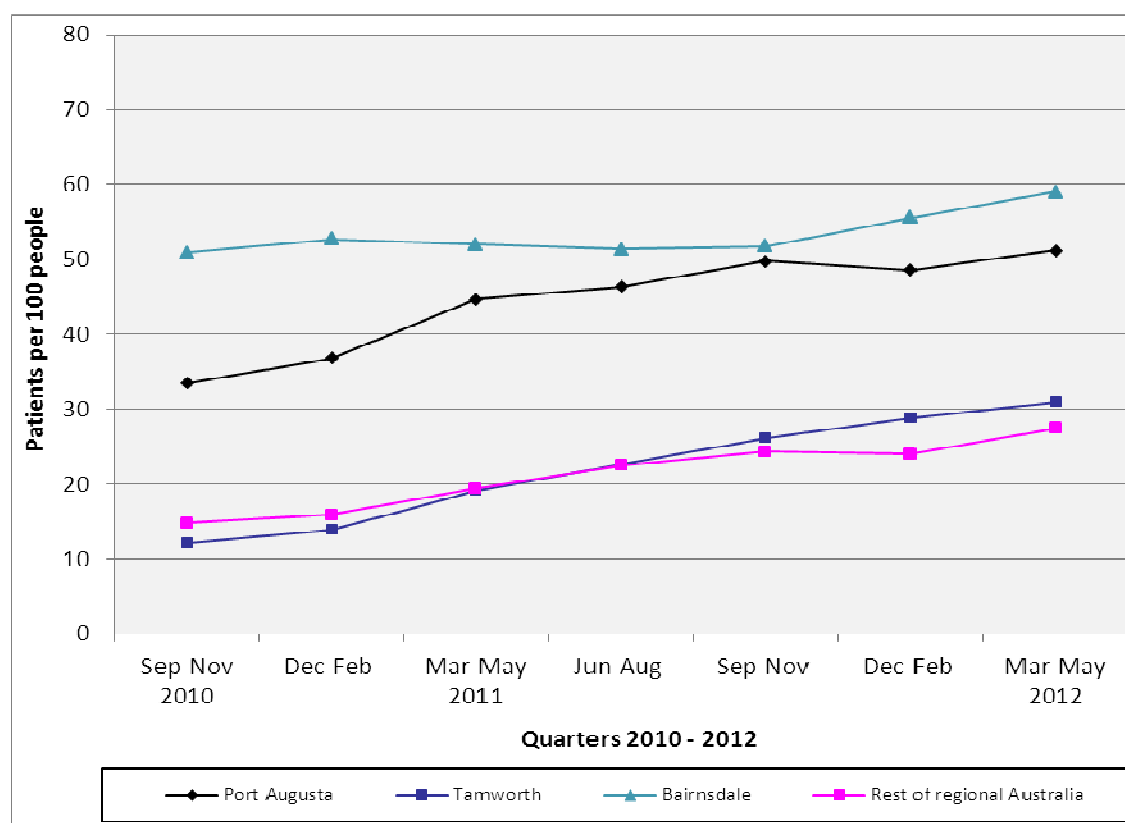


Figure 5.5: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for case study regional Sentinel Sites and the rest of regional Australia, by site and quarter, September 2010 - May 2012

Most regional Sentinel Sites had higher utilisation rates for the PBS Co-payment measure than the rest of regional Australia. Four of the sites generally had lower utilisation rates compared to the rest of regional Australia (Figure 5.5-5.7).

Five of the sites had markedly higher utilisation than the rest of regional Australia. In Dubbo, in the March – May 2012 quarter, numbers of people who accessed PBS Co-payment medications was around 60 per 100 of the population. In Bairnsdale, Geraldton, Grafton and Port Augusta, in the same quarter, between 50-60 per 100 Aboriginal and Torres Strait Islander people accessed medicines through the PBS Co-payment measure.

Some of the sites with high utilisation of the PBS Co-payment measure also showed high uptake of other ICDP measures. For example, Dubbo showed high uptake of adult health assessments and PIP Indigenous Health Incentive registrations. In contrast, Bairnsdale, which had consistently high numbers of people accessing the PBS Co-payment over the evaluation period, showed declines in both adult health assessments and PIP Indigenous Health Incentive registrations in the final evaluation cycles.

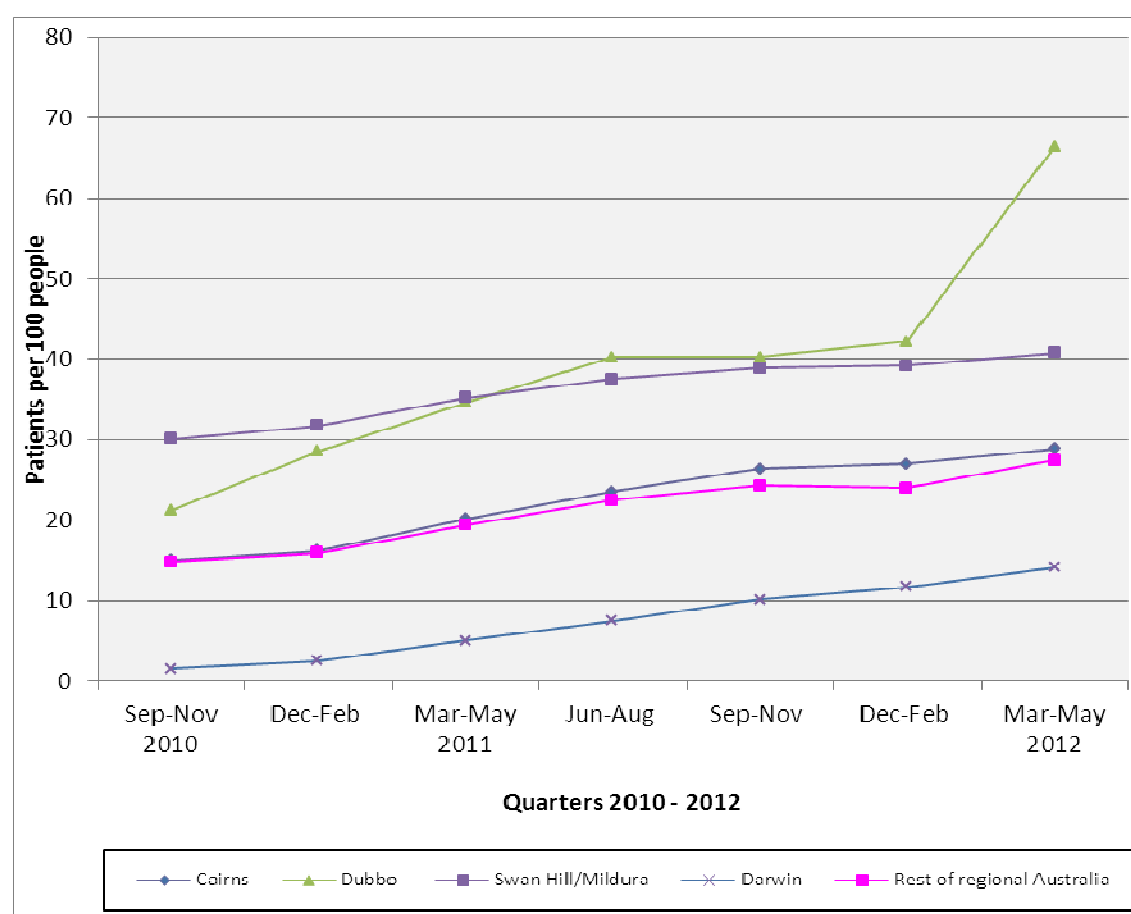


Figure 5.6: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for enhanced tracking regional Sentinel Sites and the rest of regional Australia, by site and quarter, September 2010 - May 2012

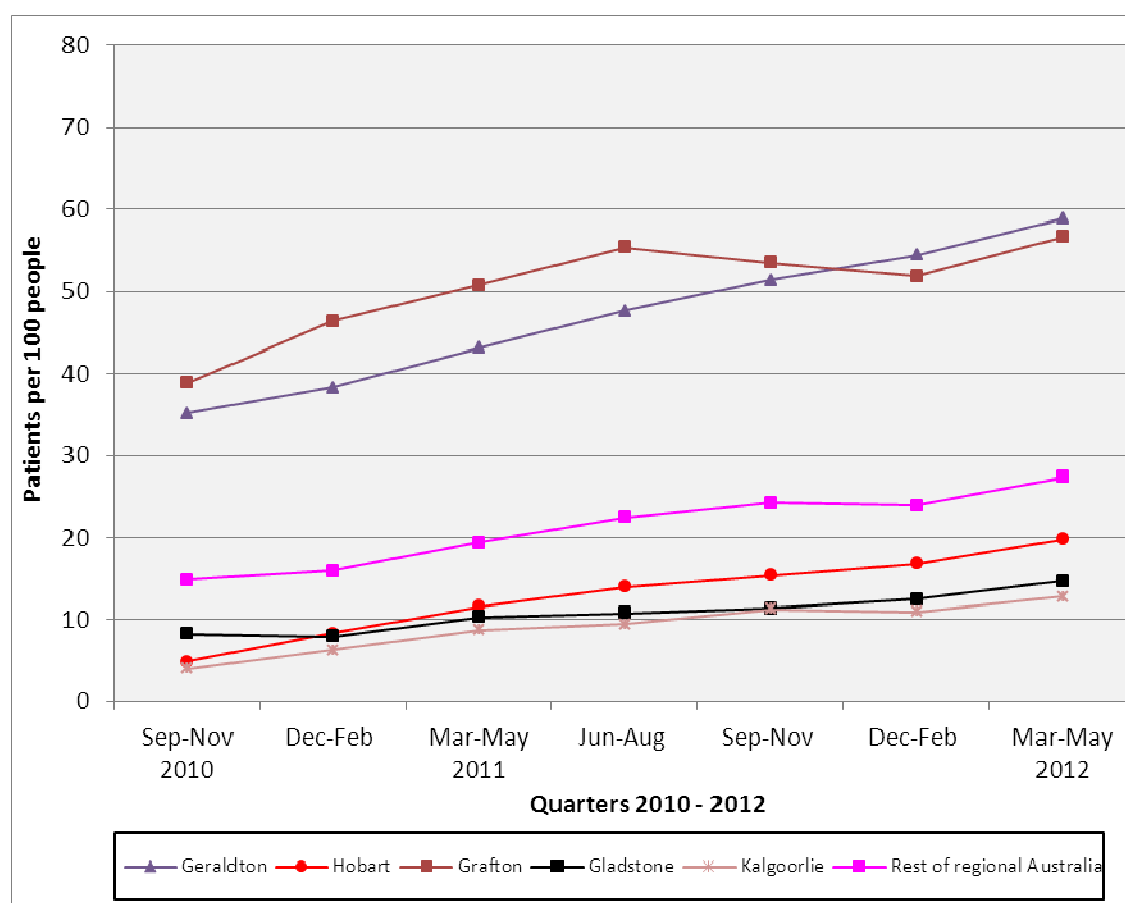


Figure 5.7: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for tracking Sentinel Sites and the rest of regional Australia, by site and quarter, September 2010 - May 2012

Remote areas – illustrative patterns

In the remote Sentinel Sites the number of people accessing S100 supply arrangements per 100 Aboriginal and Torres Strait Islander people appears to have been about 20% lower on average since implementation of the PBS Co-payment measure in early 2010 compared to the average for the 12 months preceding implementation (Figure 5.8). The difference appears to be greater than can be explained by uptake of PBS Co-payment medications. From information available to the SSE it is not clear what other factors may have contributed to the apparent decline in numbers of people accessing S100 supply arrangement medications over the evaluation period. However, the S100 supply arrangement and PBS Co-payment data are not directly comparable in that PBS Co-payment data includes the supply of medicines to individuals while S100 supply arrangement data concerns the supply of medicines to Health Services. S100 supply arrangement data included medicines for people of all ages. The S100 supply arrangements predate the introduction ICDP program. However, in the SSE we were primarily interested in the impact of the ICDP measures. The inclusion of S100 supply arrangement data for remote areas was to improve the robustness of the analysis in remote areas. The analysis therefore tracks trends in the use of medicines through S100 supply arrangement following commencement of the implementation of the PBS Co-payment measure.

Of the four remote Sentinel Sites, the number of people accessing medicines through the PBS Co-payment measure in the March - May 2012 quarter was under 2 per 100 people for all sites except East Pilbara, where 17 people per 100 Aboriginal and Torres Strait Islander people accessed PBS Co-payment

medications in the March – May 2012 quarter (Figure 5.9). In the rest of remote Australia 9.6 people per 100 Aboriginal and Torres Strait Islander people accessed medicines through the PBS Co-payment measure in the same period (Figure 5.3).

East Pilbara differed from some of the other remote Sentinel Sites in that it included a relatively large town that was not included under the S100 supply arrangements.

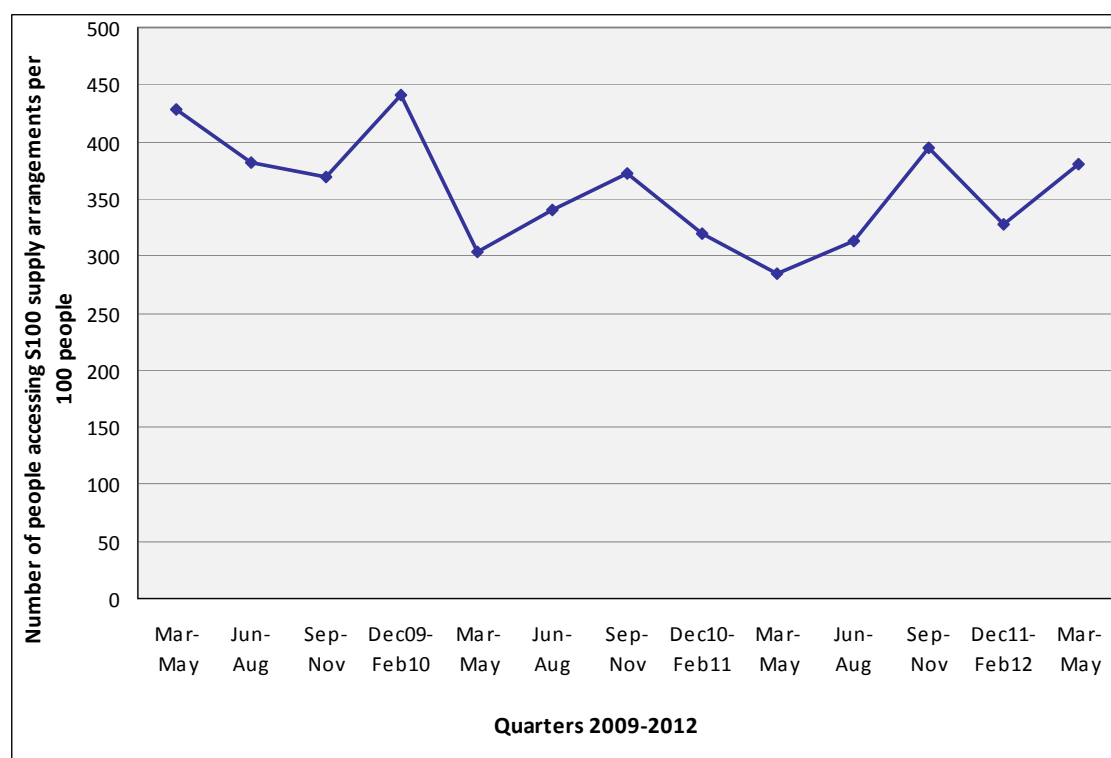


Figure 5.8: Number of Aboriginal and Torres Strait Islander people accessing the S100 supply arrangements per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for remote Sentinel Sites, by site and quarter, March 2009 - May 2012

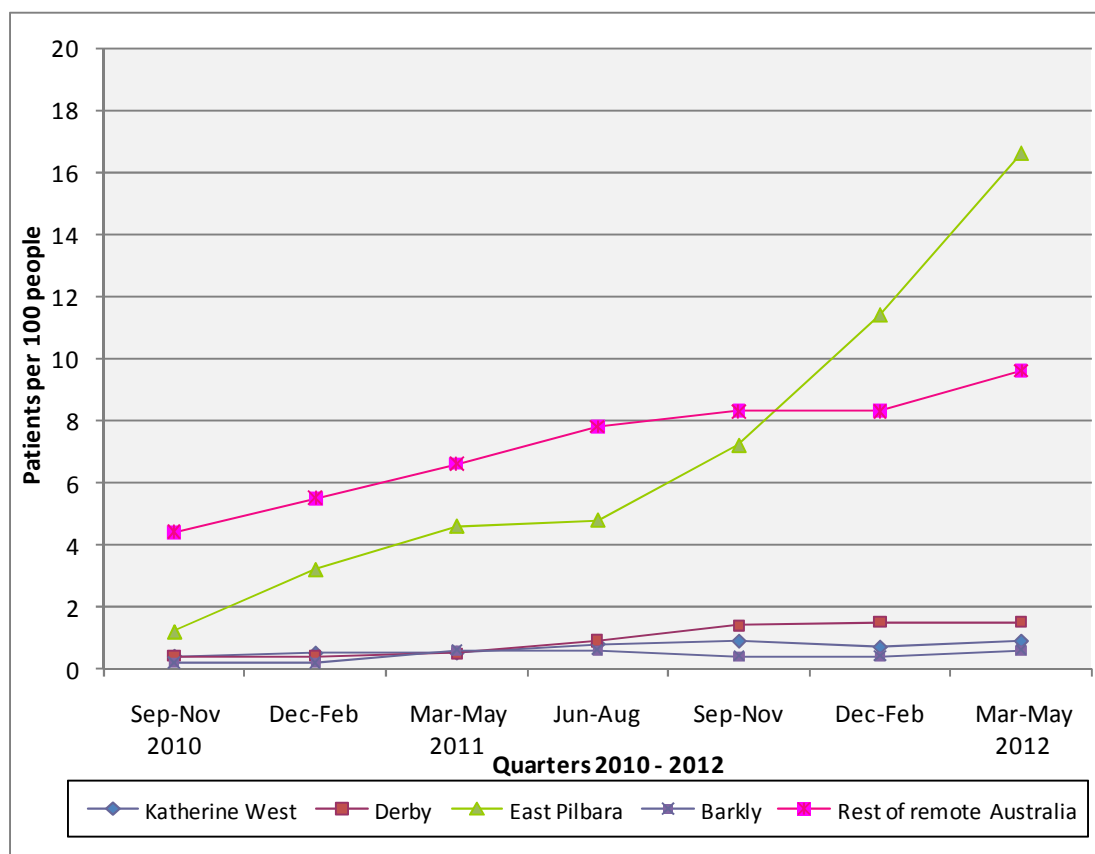


Figure 5.9: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for remote Sentinel Sites and the rest of remote Australia, by site and quarter, September 2010 - May 2012

5.3.4. USE OF MAJOR CATEGORIES OF MEDICATIONS AND COMMUNITY AND PRESCRIBER UNDERSTANDING OF AVAILABLE MEDICATIONS

KEY POINTS

- Differences in the list of medications available through the PBS Co-payment measure, the S100 supply arrangements, and QUMAX, caused confusion for patients and some providers, but this was generally able to be resolved through the work of IHPOs and OWs.
- There were reports of some patients having to pay for medications despite having a PBS Co-payment annotated prescription. This appeared to be because brands that were not fully covered by the PBS Co-payment measure were prescribed and dispensed, with misunderstanding by the patient (and at GPs) regarding requirements to pay a premium for non-generic brands.
- Some GPs may have been unaware of the range of medications covered by the measure.
- Use of all major categories of medications through the PBS Co-payment measure increased over the evaluation period.
- There were no differences in types of medications prescribed in the Sentinel Sites compared to the rest of Australia. There were more prescriptions of each type of medication in the Sentinel Sites compared to the rest of Australia, proportional to population.

Patients and Health Service understanding about the medications available

There were two aspects to the PBS listed medications that caused some confusion for patients, and to some extent for GPs, at site level.

First, there were some differences between the range of medicines eligible for the PBS Co-payment relief compared to those that had been available through the QUMAX program, and those that were available through S100 supply arrangements for remote areas. This caused some understandable confusion for patients. OWs and IHPOs played some roles in explaining differences to patients and helping them to understand that not all medicines would be covered to the same extent by the PBS Co-payment measure.

Although GPs were generally well informed about the measure, some GPs had formed the impression that the PBS Co-payment measure was only for medications used in the management of chronic conditions. This is illustrated by the quotation below, from an SBO.

‘Some GPs need to learn that access is for all medications not just those relating to the chronic disease ... if your patient has diabetes it is not just diabetes medication that they have access to.’ (SBO, program manager)

Second, there was the situation of different brands of the same medicine listed on the PBS and that some brands cost more because they have a brand premium added. Pharmacists interviewed noted that this was also difficult to explain to patients, who sometimes requested a particular brand, as prescribed, but did not understand that the same medicine could be provided under the PBS Co-payment measure without the brand premium.

OWs in some of the sites reported that they had encountered community members who had been prescribed medication types that were not covered by the PBS Co-payment (carried a brand premium). OWs, who did not always have the specific information to ascertain if this medication could be replaced by a generic equivalent that would be covered by the PBS Co-payment measure, encouraged these patients to return to the prescribing GP to clarify this issue. An alternate explanation is that these patients may have been prescribed medications that were not covered under the PBS Co-payment measure (and rather had a brand premium). These issues, and the challenges faced by OWs in explaining to patients why they were faced with unexpected gap payments, are illustrated by the quotation in the section above on sources of information for different groups.

In some sites, interviewees from Health Services reported that removal of cost barriers to access to some classes of drugs under the PBS Co-payment measure, such as benzodiazepines and codeine was leading to misuse and on-selling of medications. Although prescription of these drugs requires a clinical assessment by the prescriber, this does not prevent the on-selling of these drugs. The concern appeared to be related to a perception that removal of cost barriers to medications has the potential to increase misuse of some classes of drugs. There was no evidence from the Sentinel Sites that these situations had occurred, although it is possible. There was also no evidence that this concern had stopped health care providers from prescribing these drugs. As shown below, anti-psychotic drugs showed the highest proportional increase in prescription under the measure over the period of the evaluation. This may warrant further investigation.

Utilisation of the PBS Co-payment measure for medications of different types

Data on PBS Co-payment measure prescriptions dispensed per quarter were obtained for the Sentinel Sites, and for the rest of Australia, and extracted by Anatomical Therapeutic Chemical (ATC) classification and recoded into diabetes, cardiac conditions, obstructive airway diseases, antibacterial, anti-psychotic and 'other'. These classifications formed the basis for data presented (Appendix F, Table F3). The number and type of medications covered by the PBS Co-payment measure in relation to the population and the total number of people accessing prescriptions are shown in Appendix F, Tables F4 - F6.

Similar types of medications were dispensed in the Sentinel Sites compared to the rest of Australia, but numbers of prescriptions for all medicines were higher in Sentinel Sites than the rest of Australia.

Of all people receiving PBS Co-payment medications in the final quarter for which data were available, over 50 out of 100 people were dispensed cardiac medications and just over 20 in 100 were dispensed anti-psychotic medications. These were the two most commonly dispensed medications under the measure in both the Sentinel Sites and in the rest of Australia (Figure 5.10).

Overall, there was about a three-fold increase in the number of prescriptions under the PBS Co-payment measure between the September - November 2010 quarter and the March - May 2012 quarter (Figure 5.11).

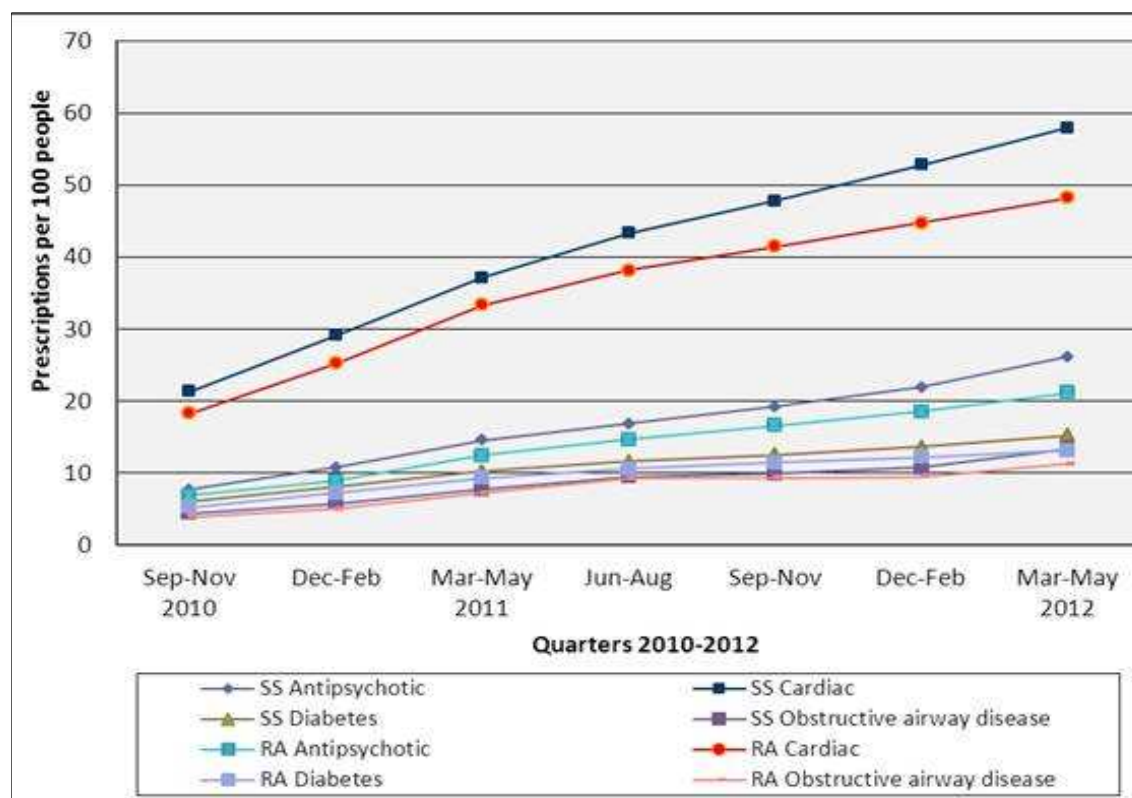


Figure 5.10: PBS Co-payment measure prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites (SS) and the rest of Australia (RA), by Anatomical Therapeutic Chemical category (anti-psychotic, cardiac, diabetes and obstructive airway disease) and quarter, September 2010 - May 2012

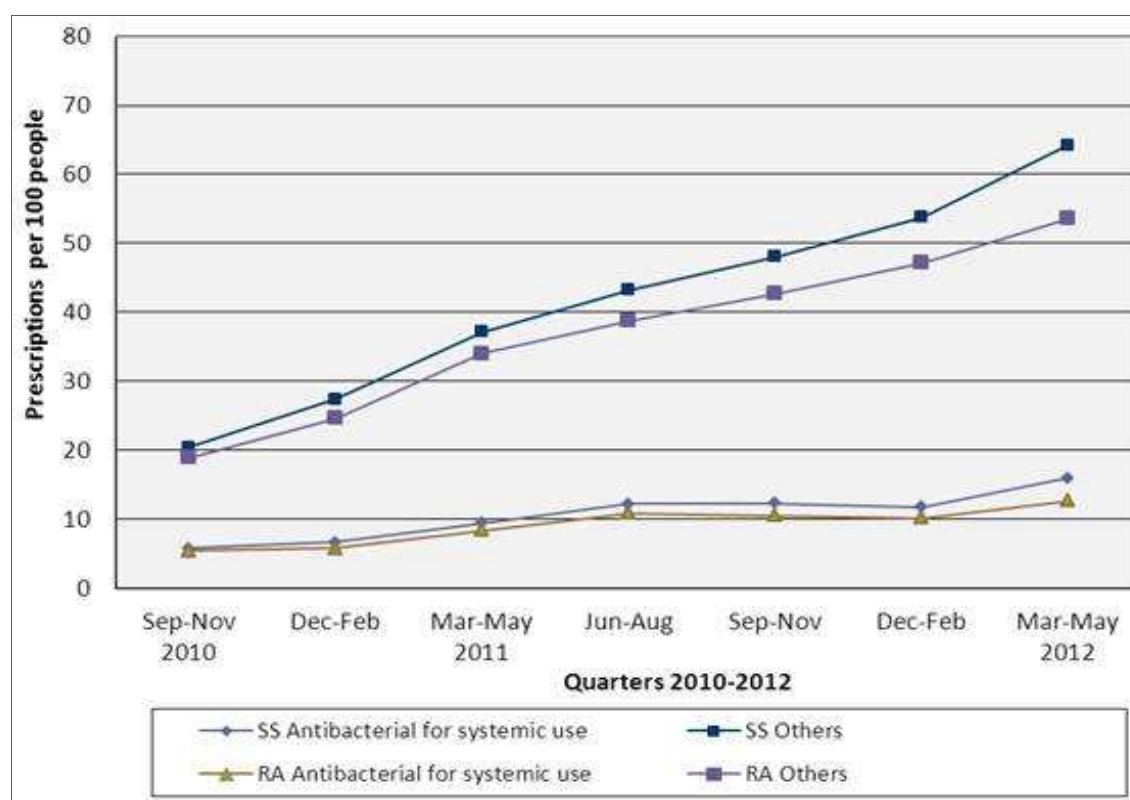


Figure 5.11: PBS Co-payment measure prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites (SS) and the rest of Australia (RA), by Anatomical Therapeutic Chemical category (anti-bacterial for systemic use and others) and quarter, September 2010 - May 2012

Use of different types of medications by different age groups

Overall, more prescriptions were provided to people aged ≥ 55 years than people aged 15-54 years. This is consistent with older people being more likely to have chronic illness than younger people, and more likely to use Health Services. The pattern of increase over time was similar for the two age groups. The patterns of use of different categories of medications in the two age groups are shown in Appendix F (Table F7 and Figures F1–F2), and summarised in the text below.

Cardiac medications were the most commonly prescribed category in both age groups. However, in relation to population numbers, cardiac medications were prescribed about ten times more commonly in the older age group than the younger group – consistent with the age distribution of the burden of cardiac disease.

Anti-psychotic medications were the second most commonly prescribed medication in the younger age group, at about 75% of the level of prescription of cardiac medications. While antipsychotic medications were prescribed to a similar proportion of people in the two age groups, relative to other medications antipsychotic medications were prescribed at lower levels in the older age group (less than 20% of the level of prescription of cardiac medications – indicating the greater use of cardiac medications in this group). Diabetes medications were the second most commonly prescribed medications in the older age group, at about 25% of the level of cardiac medications.

Anti-bacterials for systemic use were prescribed at slightly higher levels for the younger age group (between 25% and 30% of the level of other categories) compared to the older age group (less than 20% of the level of other categories).

Use of different types of medications in different geographic locations

Of all medications prescribed under the PBS Co-payment measure, over 60% of prescriptions were for the management of four chronic diseases: mental health, diabetes, cardiac conditions and obstructive airway diseases. A significant number of prescriptions were provided for the management of bacterial infections.

The distribution of types of medications prescribed under the measure over the evaluation period by urban, regional and remote Sentinel Sites, and by urban, regional and remote areas in the rest of Australia is shown in Figure 5.12.

The pattern of the increase in different categories of medicine in urban and regional Sentinel Sites was very similar to the overall trends. Increases were much higher in remote Sentinel Sites than in the rest of remote Australia and in urban and regional locations in general. However, this translated to relatively few prescriptions due to low take-up at baseline in remote sites (Appendix F, Table F5).

The distribution of medicines was similar in Sentinel Sites and the rest of Australia and across urban and regional areas. In remote areas there were fewer prescriptions for anti-psychotic medicines and more prescriptions for cardiac conditions and diabetes.

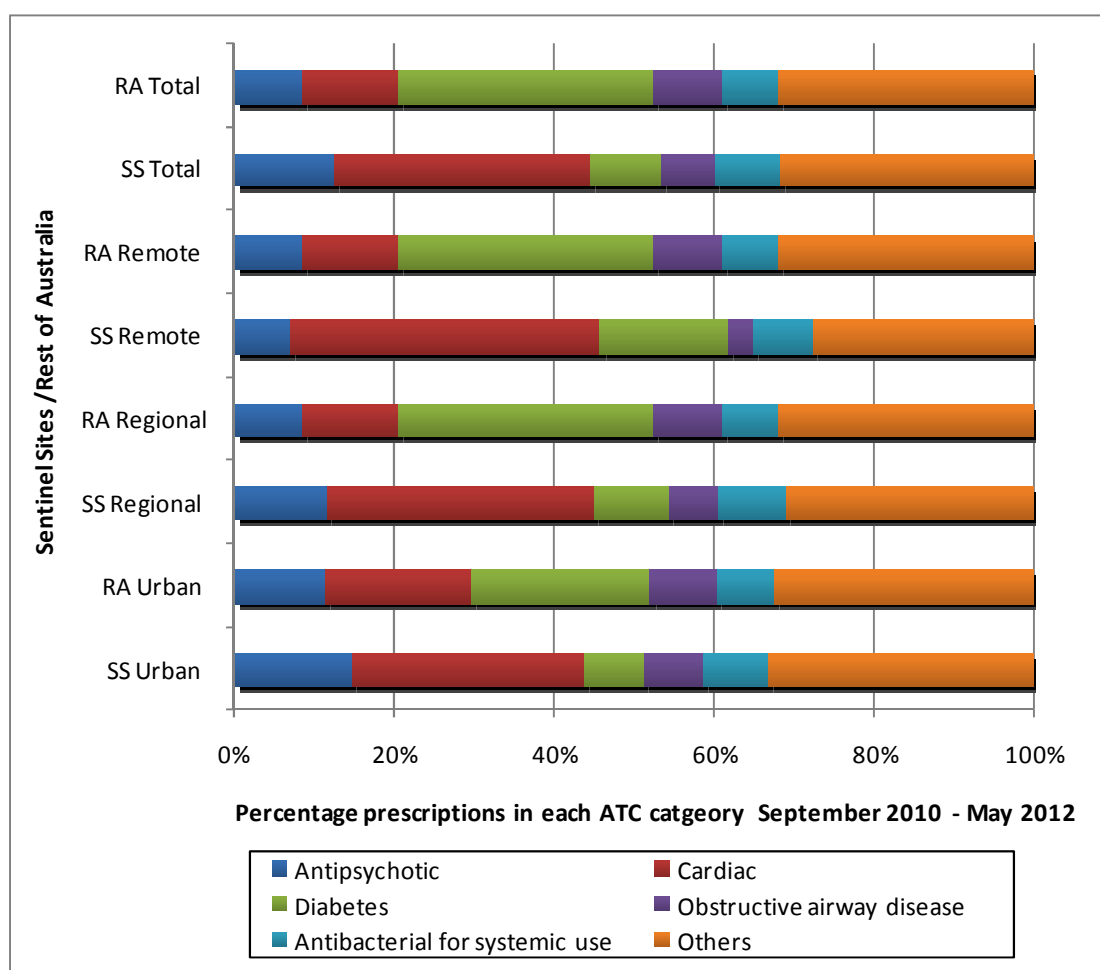


Figure 5.12: Percentage PBS Co-payment measure prescriptions dispensed for Aboriginal and Torres Strait Islander people aged ≥15 years by Anatomical Therapeutic Chemical category for Sentinel Sites (SS) and the rest of Australia (RA), September 2010 - May 2012

5.3.5. WORKABILITY OF ELIGIBILITY CRITERIA

KEY POINTS

- In early evaluation cycles, some AHSs trialled various means of verification of Aboriginal and Torres Strait Islander identity in order to ensure that access to the measure was restricted to Aboriginal and Torres Strait Islander people. This was not as evident in later evaluation cycles. General Practice appeared to accept self-reports of eligibility by patients.
- Aboriginal and Torres Strait Islander identity recorded or implicit in the PBS Co-payment measure prescription was questioned by some pharmacists.
- The precedent of subsidising medications for non-Aboriginal and Torres Strait Islander family members of Aboriginal and Torres Strait Islander patients that had been set by QUMAX, and the reluctance of some providers to see this benefit taken away from families on low incomes, may have resulted in some non-Aboriginal and Torres Strait Islander people accessing the measure.
- The eligibility criteria of being with or at risk of chronic disease and being unlikely, in the judgement of the health care provider, to adhere to medications without the measure's assistance, widely appeared to be interpreted as applying to all Aboriginal and Torres Strait Islander people.
- Data suggest that the PBS Co-payment measure is benefiting people most in need. People who were disadvantaged by worse health and/or poorer socioeconomic status were disproportionately accessing PBS Co-payment medications, as were those aged ≥ 55 years.

The higher than anticipated uptake of the PBS Co-payment measure, and the wide variation in utilisation in different sites, raises the question about how eligibility criteria are being applied at the local level. Some of the variation in uptake may be explained by patterns of Health Service use, and differing access to those Health Services eligible to prescribe under the PBS Co-payment measure, but some may be due to differing application of the criteria in different areas. This section presents the findings from the Sentinel Sites in relation to how each of the eligibility criteria was applied in practice and some of the enablers and constraints to applying these criteria.

The measure eligibility criteria specify that a judgment needs to be made by the GP regarding whether or not the person is eligible for the PBS Co-payment relief. The person needs to be (1) Aboriginal or Torres Strait Islander; (2) have or be at risk of a chronic disease; and (3) unlikely to adhere to prescribed medications without access to the PBS Co-payment measure.

Aboriginal and Torres Strait Islander identity

In the first place, in order to have access to the PBS Co-payment measure, a patient needs to be identified as Aboriginal or Torres Strait Islander. The health provider needs to know if the patient identifies as Aboriginal and Torres Strait Islander (1) in order to register the person appropriately for the PBS Co-payment measure and (2) have this information at hand, when writing an individual prescription for medication, so that the prescription can be appropriately annotated.

Typically, AHSs have had limited need to systematically record Aboriginal and Torres Strait Islander identity of their patients, since they primarily (although not exclusively) provide care to Aboriginal and Torres Strait Islander patients. The ICDP aims to encourage Aboriginal and Torres Strait Islander patients to identify as such at General Practice, through the work of IHPOs and OWs (see Chapter 14).

The exceptionally high levels of uptake of the PBS Co-payment measure in specific locations raises questions about possible inappropriate self-identification of Aboriginal and Torres Strait Islander people. There were suggestions in some of the sites that some patients who are not Aboriginal or Torres Strait Islander may be inappropriately accessing the PBS Co-payment measure through claiming to be Aboriginal or Torres Strait Islander, but this was difficult to verify. Generally it was recognised that attempts to police the incentive at local level may result in some eligible people being denied access, or being discouraged from attempting to seek access. This would be contrary to efforts to promote access for people in need, to efforts to encourage self-identification of Aboriginal or Torres Strait Islander status, and to the emphasis on self-identification in cultural awareness training.

In previous evaluation cycles some AHSs reported using processes to verify self-report of Aboriginal and Torres Strait Islander status – for example, through asking about community and kin, or asking for referral letters from Elders in the community. There were no reports of this nature in the last two evaluation cycles. The extent of these types of practices, or reasons for change in these practices is not clear.

There was some evidence from some sites in the early evaluation cycles of pharmacists playing an additional ‘gate keeping’ role, and questioning the Aboriginal and Torres Strait Islander identity of patients who presented with PBS Co-payment measure annotated prescriptions. This was less evident in the final evaluation cycle. Pharmacists generally believed that it was not up them to ‘police the measure’. In the final evaluation cycle there were a few instances of pharmacists processing a script as a PBS Co-payment measure annotated prescription even if it was not annotated, if the person had previously had a PBS Co-payment measure annotated script.

To the extent that there have been concerns about inappropriate self-identification expressed through the SSE these have generally been sporadic, and issues about self-identification have generally been more about Health Service and pharmacy staff inappropriately questioning patients about their self-reported Aboriginal and Torres Strait Islander identity.

Nevertheless, with steadily increasing uptake of the PBS Co-payment, and the substantial financial incentive for patients to identify, inappropriate self-identification as Aboriginal and Torres Strait Islander may become an increasingly important issue.

It is clear that the priority for most service providers is to ensure access to the PBS Co-payment measure for those who this measure is designed to benefit. There appear to be emerging concerns about ensuring that the funding allocated to this measure is used most effectively for the intended purpose.

Non-Aboriginal and Torres Strait Islander family members of Aboriginal and Torres Strait Islander people are not covered by the PBS Co-payment measure, and this was a cause of some concern in the sites. The precedent of covering non-Aboriginal and Torres Strait Islander family members was set by the QUMAX program, which meant that families who have non Aboriginal and Torres Strait Islander family members were losing a benefit through the change to the PBS Co-payment measure. Interviewees also noted that in most cases household budgets are shared, so the chronic illness of non-Aboriginal or Torres Strait Islander family members was impacting on the family as a whole. Practitioners reported that this loss of benefit created hardship, encouraged non-adherence to prescribed medication and impacted on the whole family, including Aboriginal and Torres Strait Islander family members. Some practitioners reported that they felt obliged not to strictly apply the eligibility criteria when they felt patients and their families may be worse off under the new PBS Co-payment measure.

'There it becomes a problem when there is a non-Aboriginal member in the family. It would be a good idea if it is a family unit other members of the family should be eligible for CtG. The program is going to be partially successful if this is just only for particular part of the family.'
(Pharmacist)

Some providers have questioned why the measure is specific to Aboriginal and Torres Strait Islander people, and have suggested the measure should be available for all patients or families who are in financial hardship.

Having or being at risk of a chronic disease

The criterion of at risk of or having a chronic disease was widely interpreted at the local level as applying to all Aboriginal and Torres Strait Islander people, although there were some differences in interpretation and application of the criterion. In some cases, particularly in early evaluation cycles, it appeared that some Aboriginal children with chronic illness were not accessing the measure. Interviewees explained that having the PBS Co-payment registration on the same form as the PIP Indigenous Health Incentive registration (which is for those 15 years and older) had led to a situation in which some health care providers were unaware that a child on chronic medications could be registered for the PBS Co-payment measure.

'What's happening on the consent form is that they are ticking ... question 8 is about PIP and question 9 is about PBS Co-payment measure but the service staff are ticking both and the person may be under 15 or over 15 and doesn't have a chronic disease. It's really confusing. This confusion is still an issue. The PIP & PBS Co-payments patient consent form needs to have separate sections for any PIP and PBS information required more clearly set out.' (NACCHO affiliate)

Being unlikely to adhere to medication without access to the measure

The additional criterion of being unlikely to adhere to medication without the PBS Co-payment measure was considered by interviewees in the Sentinel Sites as subjective, and in general was taken to apply to all Aboriginal and Torres Strait Islander people.

The liberal application of this, and the previous criterion, is likely to have contributed to greater uptake than expected. While there may have been some differences between sites in the application of the criteria, community mobilisation around the measure, engagement with the measure by Health Services, and patterns of health care utilisation are likely to have also contributed to variation in uptake of the measure between sites.

The lack of evidence of systematic processes to ensure that those who were less likely to adhere to medications without access to the measure were receiving the benefits of the PBS Co-payment measure is of concern from an equity perspective. In particular, we did not identify any systematic efforts to ensure that those patients receiving prescriptions from emergency departments, or hospitals, were receiving access. These patients may be more likely to have difficulty adhering to medications without financial assistance than other primary care patients – since it is often the more vulnerable who receive their primary care from emergency departments and hospital outpatient clinics.

Utilisation of PBS Co-payment by older people and those at greater socio-economic disadvantage

The measure intended to benefit Aboriginal and Torres Strait Islander patients who are at particular disadvantage, and would be unable to adhere to their medication regimen without co-payment relief. Although data to assess this are limited, as outlined below, to a large extent, those in need appear to be accessing the measure.

Utilisation by age group

In Sentinel Sites nearly 60 per cent of Aboriginal and Torres Strait Islander people aged ≥ 55 years had accessed medicines through the PBS Co-payment measure compared to about 23 per 100 Aboriginal and Torres Strait Islander people aged 15-54 years in March - May 2012. In the rest of Australia 43 per 100 Aboriginal and Torres Strait Islander people aged ≥ 55 years had accessed medicines through the PBS Co-payment measure compared to about 17 per 100 Aboriginal and Torres Strait Islanders aged 15-54 years in March - May 2012.

The number of people aged 15-54 years accessing the PBS Co-payment measures per 100 people more than doubled in the March - May 2012 quarter compared to the September - November 2010 quarter in both Sentinel Sites (2.4 times) and the rest of Australia (2.1 times). This rate of increase was slightly lower for people aged ≥ 55 years in Sentinel Sites in both Sentinel Sites (2 times) and the rest of Australia (1.8 times, Figure 5.13).

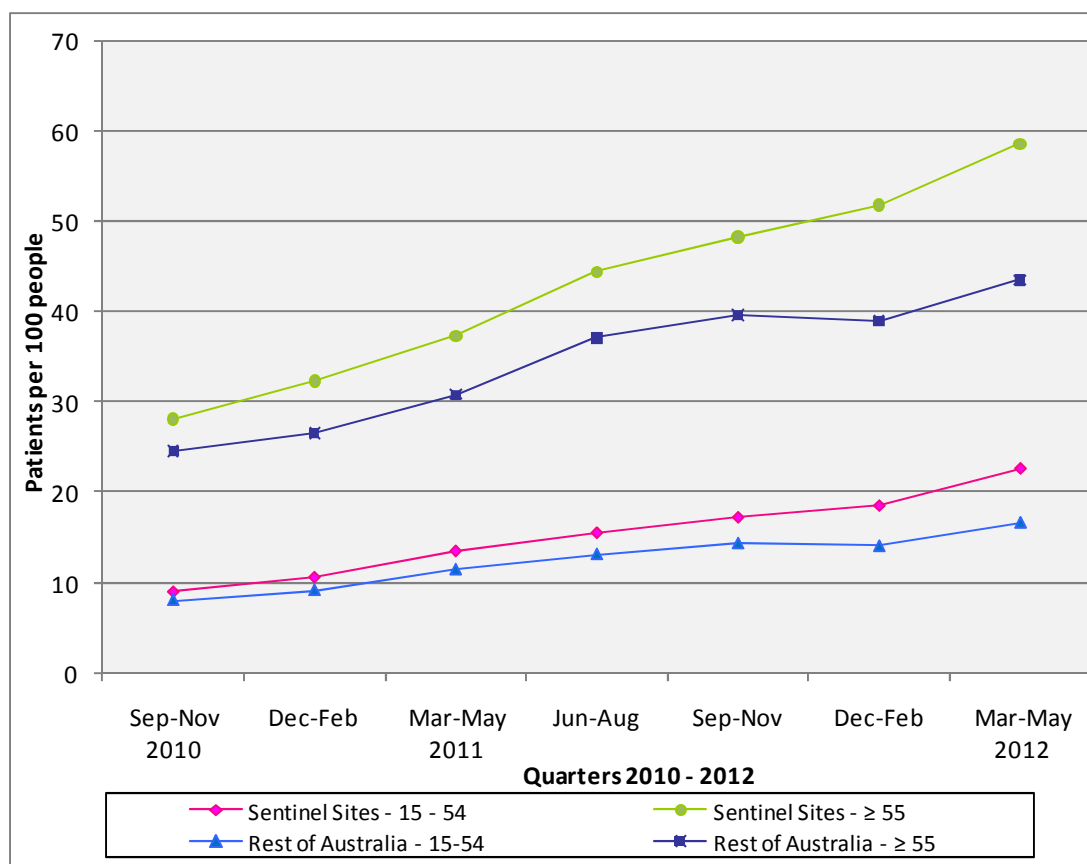


Figure 5.13: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia, by quarter and age, September 2010 - May 2012

Indices of disadvantage and use of PBS Co-payment measure

The PBS patient categories include two indices of disadvantage; concessional and people eligible for the safety net. People in the concessional category include low-income people who qualify for a health care card, pensioners and people who are eligible for a national senior's card. People who are eligible for the safety net have exceeded the threshold for expenditure on medicines and are therefore likely to be in worse health than other people.

People in all disadvantaged categories used the PBS Co-payment measure.

Over 70 per cent of people accessing medicines through the PBS Co-payment measure in Sentinel Sites and the rest of the Australia were in the concessional category (Appendix F, Table F7). Around three per cent of people accessing medicines through the measure in Sentinel Sites were in the safety net category, compared to about six percent of people in the rest of Australia.

The number in the safety net category is perhaps lower than might be expected based on the number of Aboriginal and Torres Strait Islander people reporting long-term health conditions.⁶³ However, this is difficult to assess in the absence of baseline data. The PBS Co-payment measure removes any financial incentive for people in the concessional category to apply for safety net eligibility so it may be that this group is included in the concessional ordinary category.

The percentage of people in each patient category was similar for Sentinel Sites and the rest of Australia (Figure 5.14). The percentage of people in each category varied little by urban, regional or remote sites or time. However, there were differences between age groups. As would be expected more people aged ≥55 years were in the concessional safety net category than people aged 15-54 years. More people aged 15-54 years were in the general ordinary category compared to people aged ≥55 years.

⁶³ For example, the 2004-2005 National and Aboriginal and Torres Strait Islander Survey reports the following percentages of Aboriginal and Torres Strait Islander peoples reporting three or more long-term illnesses; 15-24 years 21%; 25-34 years 34%; 35-44 years 46%; 45-54 years 65%; 55-64 years 79%), about 12.5% have heart disease and 6% with diabetes.

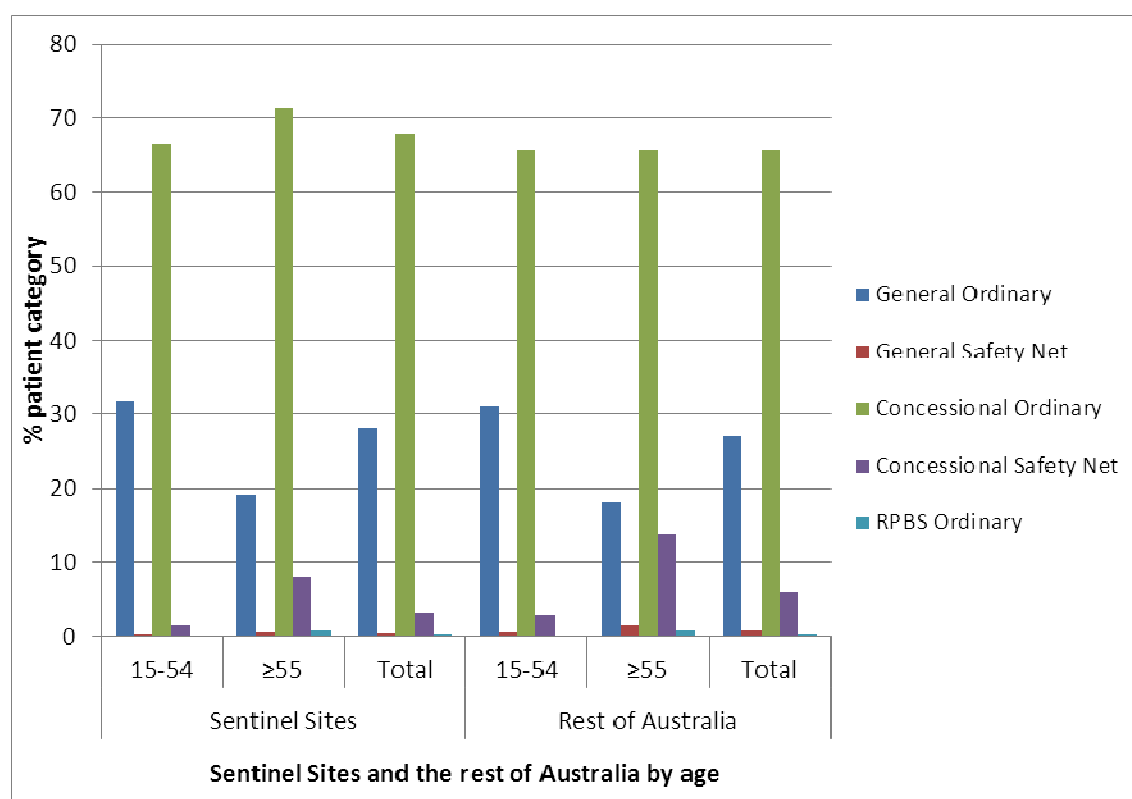


Figure 5.14: PBS Co-payment medicines dispensed by patient category for Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, September 2010 - May 2012⁶⁴

Assessment by interviewees of workability and ease of organising access

By the final evaluation cycle 85% (66/78) of interviewees agreed with the statement that ‘*patient eligibility criteria for the PBS Co-payment are workable in practice*’ (Table 5.3). The percentage of interviewees agreeing with this statement was lower in remote sites than in regional and urban sites; findings from the Sentinel Sites in relation to the barriers faced by people in remote sites; and reasons for these barriers are outlined below.

Perceptions about the workability of the eligibility criteria differed in different stakeholder groups. A higher proportion of practice managers agreed with the statement ‘*patient eligibility criteria for the PBS Co-payment are workable in practice*’ than clinicians (95% (18/19) and 79% (19/24) respectively).

About 1 in 5 clinicians responded that they ‘don’t know/can’t say’. This appeared to be because many clinicians were just signing off on forms that had been completed by administrative staff. This suggests that to some extent administrative staff may have been making the judgment about whether or not a patient met the eligibility criteria.

The percentage of clinicians and practice managers agreeing with this statement was similar in the AHS and GP sectors (Figure 5.15), with indication of increasing agreement in the GP sector.

⁶⁴ The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides a wide range of Pharmaceuticals and dressings at a concession rate for the treatment of eligible veterans, war widows/widowers, and their dependants. Department of Veterans Affairs [website] <http://www.dva.gov.au/service_providers/doctors/Pages/rpbs.aspx> (accessed 19 October 2012).

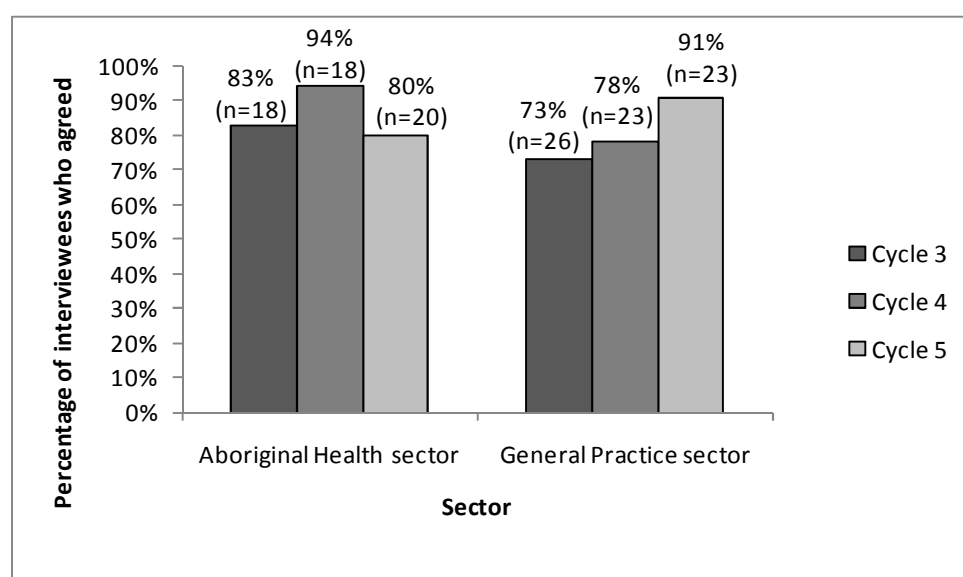


Figure 5.15: Clinicians' and practice managers' responses to the statement 'Eligibility criteria for Aboriginal and Torres Strait Islanders to access the PBS Co-payment measure are workable in practice' (% who strongly or partly agreed)

5.3.6. SITUATIONS IDENTIFIED IN WHICH ELIGIBLE PATIENTS HAD DIFFICULTY ACCESSING THE PBS CO-PAYMENT MEASURE

KEY POINTS

- Situations in which patients apparently had difficulty accessing the PBS Co-payment measure included:
 - where patients were seen by hospital doctors or specialists who were not eligible to prescribe under the PBS Co-payment measure;
 - where patients living in remote locations were visiting regional towns, and had difficulty accessing the measure;
 - where patients were travelling, and had difficulty identifying a practice that was registered for the PIP Indigenous Health Incentive and;
 - where patients encountered racist attitudes in pharmacies when they presented their PBS Co-payment measure prescriptions.

Whilst access to the PBS Co-payment measure was generally high, there were several situations identified where eligible patients faced particular challenges in obtaining access to the PBS Co-payment measure. These situations are outlined below, together with responses to these situations by patients, Health Services, pharmacists and the ICDP workforce. These situations provide indications of how the measure can be strengthened by systematically addressing challenges to equity of access.

Non-participation in PBS Co-payment by the regular health care provider

There were some situations identified in the Sentinel Sites in which patients' regular providers had few Aboriginal patients and chose not to be PIP registered and participate in the PBS Co-payment.

From the perspective of GPs, particularly with small numbers of patients, it was not worthwhile to invest in changing processes for the sake of a few, this has been described in relation to the PIP Indigenous Health Incentive in Chapter 7.

'The issue for the practice is that it does not have the volume of Aboriginal and Torres Strait Islander patients to be able to consolidate (be fully aware and have a working knowledge) of the information regarding the PBS Co-payment.' (General Practice, practice manager)

In these situations, patients could forego the opportunity to access the measure; could attend another Health Service for a 'prescription service' only; or they could transfer to a Health Service who was able to provide PBS Co-payment measure annotated prescriptions. All of these responses occurred to some extent – with different knock-on effects, as outlined below.

As illustrated by the quotation below, the non-participation in the PBS Co-payment measure and lack of ability to write the PBS Co-payment measure prescriptions by some providers raised an equity issue, particularly where a participating Health Service was not easily accessible.

'There is also an equity issue for patients in practices where Aboriginal patients are in small numbers. I have heard of GPs saying that they have only one or two Aboriginal patients so why register as a PIP practice. This means that their Aboriginal patients may be missing out on accessing the ICDP measures.' (NACCHO affiliate)

Several GPs, particularly from AHSs, indicated that patients came to them for the purpose of obtaining PBS Co-payment measure prescriptions, with no intention of obtaining their regular care from them. From the AHSs perspective, it was not responsible to simply write a prescription, without due diligence – as shown in the quotation below – which resulted in duplication and inefficiencies in care.

'My only problem is having patients who are only coming to me for medication ... to get the CtG scripts and are getting all the rest of their care somewhere else. I don't know if it's because their GP is not able to write CtG scripts or if they patient doesn't realise that all doctors at practices that are PIP registered can write CtG scripts. But it takes up my consultation time away from other patients when I am only seeing someone for their medication and nothing else. All GPs should be able to write CtG scripts for Aboriginal patients. It's important for the patient to receive their medication from their GP because it's double work because I won't write the scripts without taking their blood pressure and asking them a few questions.' (AHS, GP)

'I have had a few patients coming to [Health Service] now as their regular doctor won't get PIP accredited so they can dispense CtG scripts. This is because the patient base is perceived to be too low to bother or the doctor is not accredited and therefore ineligible. They are coming not because they want to sign up for PIP but because they want CtG scripts.' (AHS, GP)

A further issue for the AHS, was that when patients presented to a non-regular provider for the purposes of obtaining a prescription, the Health Service did not generally have information about whether or not the patient had been registered for the PBS Co-payment measure (or for the PIP Indigenous Health Incentive). It appeared to be common practice in this situation for providers to register the patient for the PBS Co-payment measure to ensure that the annotated prescription would

not be rejected. This sometimes resulted in duplicate registrations. Whilst the PIP Indigenous Health Incentive enquiry line was available for services to find out if a patient is already registered with another Health Service, interviewees noted that it was difficult to get the required information in the required timeframe (with the patient often needing a prescription immediately, and waiting to receive it whilst the call is being made). In other cases, Health Services were not aware of the enquiry line.

As indicated in some detail above, the requirement that prescriptions can only be annotated by PIP Indigenous Health Incentive registered services, together with non-participation of Health Services in the PBS Co-payment measure, may inadvertently have led to greater numbers of people fragmenting their care between different service providers, some duplication of care and duplication of registrations.

Prescription of medications by hospital doctors

PBS registered patients who were prescribed medications on discharge from hospital, or in hospital emergency rooms (or outpatient clinics) were faced with payments for medications that they were not expecting and in some cases were unable to meet.

In some cases, AHSs would pick up the bill for these medications – many AHSs have historically covered gap payments as part of their operating budgets. This was a common response, even after introduction of the PBS Co-payment measure, as illustrated by the quotation below.

‘There are two ways we deal with it, often this is the most common, the hospital will write out a great swag of medications and they pick it up from pharmacy and they have to pay for it, invariably, depending on the patient, a lot of them can’t afford it, we pay for it, alternatively some will come to us and get the doctor to write out the script.’ (AHS, practice manager)

Over the period of the evaluation, there were increasing reports of GPs at AHSs beginning to replace their patients’ hospital prescriptions with PBS Co-payment measure annotated prescriptions, with the result that the PBS Co-payment measure was used, instead of the AHS operating budget.

In some sites, AHSs reported that hospital doctors who were aware of the measure and concerned that their patients were able to access the PBS Co-payment measure, would recommend to patients that they go to the local AHS to get a PBS Co-payment measure annotated prescription. This was regardless of whether or not the AHS was the patient’s usual primary health care provider. As indicated by the quotation below, the AHS then felt responsible for these patients. There were also reports of GPs using script pads from their PIP Indigenous Health Incentive registered practices when they were doing sessional work in outpatient clinics. This was evident in regional centres where GPs were working in both private practice and as visiting medical officers at the local hospital.

‘With hospital scripts there is no CtG – doctors here will replace scripts – to get their script replaced with a CtG script patients have to come here and they are sick.’ (AHS, registered nurse)

This also delayed access, and commencement of recommended medications in some cases.

‘When a patient in the Emergency has received a prescription they often will not fill those scripts until they have come to the AMS clinic and changed the script to PBS Co-payment. Hospital cannot annotate CtG. The treatment gets delayed.’ (General Practice, GP)

In other sites, as indicated below, patients simply miss out on accessing annotated prescriptions.

'Challenge is patients can't access the PBS Co-payment if they go through the emergency hospital system. There are a lot of people accessing the hospital rather than going to the GPs or an AMS. It is a disadvantage if patients can't access the CtG scripts at the hospital.' (SBO, IHPO)

Prescription of medications by non-participating specialists

As indicated earlier in Section 5.3.1, not all specialists were aware that they could prescribe as part of the PBS Co-payment measure to patients, and prescriptions from specialists were often not annotated.

In the first place, the specialist needed to be aware of the PBS Co-payment measure and informed that the patient was registered with the PBS Co-payment measure. Some GPs specified this in their referral letters whilst others did not. Some DGPs had developed letter-writing templates that they disseminated to Health Services, with the intention that these would be embedded in the Health Service's clinical information system. This allowed automatic inclusion in referral letters to specialists of a statement that the patient was eligible for the PBS Co-payment measure and that scripts should be annotated. There was no evidence by the final evaluation cycle that this strategy had improved annotation by specialists. However, it would seem plausible that it would contribute to increasing awareness of the PBS Co-payment measure by specialists and in improvements in annotation of scripts over the longer term. This approach to improving communication about PBS Co-payment registration with specialists was dependent on systematic recording of PBS Co-payment registration information on the patient's record in the clinical information system. As shown in Appendix E, many Health Services would be unlikely to have clinical information systems developed to this level of functionality.

Some GPs, particularly in urban and regional sites, apparently told their patients that they needed to inform the specialist that they were registered with the PBS Co-payment measure. This may not have been something that all patients felt empowered to do – and as indicated by the quotation below, was not an optimal approach, since the patients should not have to be directing specialists on details of writing a prescription.

'I had to ask [specialist name] if he does the CtG, and he goes I don't know, anyway I will just write CtG on the script. I said no, you need a number and he goes no - I don't have a number.'
(Community focus group)

In some sites, Health Services reported that where patients had been unsuccessful in getting specialists to annotate the prescriptions, the patients would return to the Health Service, which would then replace the prescription with one that was correctly annotated.

'Doctors at [AHS name] educate patients to tell specialists to sign CtG scripts, and if they don't [AHS name] will replace the scripts.' (AHS, GP)

In other sites, where patients presented non-annotated prescriptions from specialists, pharmacists would just process them as PBS Co-payment measure prescriptions, as long as the patient was known to the pharmacist as registered with the PBS Co-payment measure. This obviated the need to re-issue the prescription, and although not strictly according to guidelines, was seen as a workable solution in some sites. This approach was identified only in the final evaluation cycle – suggesting that it was a solution that emerged in response to difficulties that had been faced over time – and did not reflect a misunderstanding or misinformation about the guidelines.

'... lots of specialists don't endorse scripts ... if a specialist script is non CtG when the patients regular GP writes CtG then we will prescribe as CtG ... it is definitely easier for us, we need help

with this ... or on the phone to specialists waiting for endorsements or fighting with customer over \$5.80.’ (Pharmacist)

Patients requiring medication whilst visiting towns from remote areas

Difficulties accessing the PBS Co-payment measure were reported in situations where patients living in remote locations were visiting regional towns. There were a number of aspects to this.

Some interviewees recognised the cost barriers faced by patients when they travel, but had not realised the potential of the PBS Co-payment to address this issue.

‘The big challenge in organising access is the remote people coming down to [name of town]. The patients used to getting their medications through S100 remote scheme. They come to town not realising they are not eligible for CtG.’ (Pharmacist)

‘The whole CtG script and S100 is messy and does not adequately address the transient nature of the population.’ (AHS, GP)

‘People who come down to [name of town] from the Lands have to pay for their medications; they would not know that as they get their medications for free.’ (Community focus group)

These concerns were evident across all interviewee types, including GPs and community members. For example, some AHSs indicated that they did not register their patients for the PBS Co-payment measure, as they did not recognise the value to patients since they were already covered by S100 supply arrangements. Other Health Service interviewees appeared to firmly believe that they were unable to write PBS Co-payment measure prescriptions, even for travelling patients, owing to the S100 supply arrangements. In other situations, Health Services registered their eligible patients for the PBS Co-payment measure, but were uncertain about how to follow through on this. For example in a remote site, the AHS-based GP was ordering medicines under the S100 supply arrangements for some things, and annotating prescriptions under the PBS Co-payment measure for others. The GP indicated that the pharmacist was encouraging ‘bush scripts’ (S100 supply arrangements) due to a perception of minimal paperwork for pharmacists using S100 supply arrangements.

Service providers in the regional centres noted difficulties in determining whether or not visiting remote patients were registered for the PBS Co-payment measure, sometimes resulting in duplication of effort or unnecessary administration.

‘Concerned that in remote areas patients may be signed up for PIP but as they are covered by S100 they are not signing patient for PBS Co-payment. They then arrive in [name of town] and not covered by S100 and need to be signed up for PBS Co-payment. Unsure how to know if patient is signed up for PBS Co-payment. Just sign them up in case.’ (Feedback from enhanced tracking site)

In some cases, these regional providers continued to pay for the gap out of their operating budgets, as had historically been the practice.

Hospital doctors were not able to prescribe under the PBS Co-payment measure, and the person was away from their regular provider and usual arrangements.

‘Getting medicines at the health centre is good ... is a problem when people go to town for hospital in [name of town] ..., when hospital staff ring [AHS] about their medication people have

to wait for a long time, and sometimes they have to pay for their medication, they suggested maybe Doctor should write a letter before they go to town'. (Community focus group, remote site)

Patients travelling and unable to identify a participating Health Service

Community focus group participants indicated that they sometimes had difficulty in locating a PIP Indigenous Health Incentive registered practice from which they could receive PBS Co-payment measure prescriptions at times of travel. There was no evidence from the Sentinel Sites of patients being aware of any efforts being made by local or regional health organisations to increase availability of information about the location of participating Health Services, although there was evidence of some of this type of activity – as reflected in the quote below.

Information on the location of participating Health Services should be available to some extent through the voluntary PIP Indigenous Health Incentive register, developed by DoHA since December 2011.⁶⁵ Community focus group members and Health Service interviewees in the Sentinel Sites were unaware of this register.

'With opt in register how do patients hear about this as the register is not supposed to be available to the public (said the Department). Divisions provide lists of General Practices with permission that dispense CtG scripts, distribution depends on local plan, e.g. IHPO and OW take lists to community events.' (SBO, IHPO)

Patients encountering racist attitudes in pharmacies

In many sites, there was evidence of pharmacies being supportive of the measure, and assisting patients with access, but in others, there appeared to be a lack of cultural safety, which restricted access to the measure for some patients.

As noted in the quotation below, lack of cultural safety was particularly an issue in urban areas. This may reflect a general lower awareness of the needs of Aboriginal and Torres Strait Islander communities in urban areas, who are often less visible than in regional and remote areas.

'... Patients are still reporting that some pharmacy staff are still questioning Aboriginal status. ... it appears to be an issue in urban areas more possibly due to the large volume of pharmacies and staff in each of these.' (SBO, program manager)

In some cases, the questioning of people's Aboriginal and Torres Strait Islander identity was possibly driven by a concern by pharmacists or their staff that the PBS Co-payment measure was being inappropriately accessed by people who were not Aboriginal and Torres Strait Islander and perhaps an underlying feeling that they had a duty to police this to some extent. This has been described more broadly in the Section 5.3.5 above in relation to workability of the eligibility criteria of the measure. In other cases, there may have been a lack of cultural awareness amongst pharmacists and their staff, in some cases along with more overt racist attitudes.

'Sometimes my staff have asked me whether a patient is eligible, usually based upon his/her appearance.' (Pharmacist)

⁶⁵ General Practice NSW, Closing -the-Gap e-communication, 6 December 2011.

'I mean how Aboriginal do they have to be! One-eighth? Some of them don't look Aboriginal.'
(Pharmacist)

Some of the program managers from SBOs, and IHPOs and OWs, reported that DGP-based IHPOs and OWs were working informally with pharmacists to improve awareness, and were including pharmacists in information sessions and events about the ICDP measures.

'... the IHPO and OWs have been spending time visiting pharmacists to let them know about the PBS Co-payment and try and address any issues, inviting them to ongoing GP education dinners [on topics that are relevant to closing the gap] where they can. ... [We also] encourage DGPs to continue to provide an education service to pharmacists...' (SBO, program manager)

A range of interviewees expressed concerns over lack of cultural safety in pharmacies, and a need for cultural awareness training for pharmacists and pharmacy staff. Whilst cultural awareness training for participating pharmacists was available through the QUMAX program, interviewees reported that there were challenges finding people to deliver the training and to get pharmacists to undertake the training, even though the training is a requirement of QUMAX participation.

As indicated in Section 5.3.1, DGP-based IHPOs and OWs reported considerable efforts in engaging pharmacists to increase their participation in the PBS Co-payment and to assist with overcoming barriers to medication access more broadly. This appeared to be unanticipated. In early evaluation cycles, some interviewees did not feel this was part of the IHPO role, and were unclear whether this type of support was permitted. One DGP indicated that there was *'some confusion about how to support pharmacists as we have been told we cannot work with them as we need to go through the guild. We think it's so important, we go through the backdoor. I ask when I pick up my scripts how things are going.'*

Vignette – educating pharmacists

In one urban site, implementation of the PBS Co-payment measure involves a number of pharmacies. As pharmacists have become more familiar with the processes required for processing CtG prescriptions, issues and challenges have been resolved.

Staff at the SBO commented that 'Pharmacists refusing to fill a script was an issue, [but is] now decreasing'.

Some pharmacists introduced the new systems very effectively. *'We have no problems with this at all – and the pharmacy is in the same complex [as our practice]'* (GP). Others have easily rectified initial 'teething' problems, including software problems.

However, it is evident that some pharmacists at the site are still not aware of the measure, or do not understand the processes. Opportunities to provide education are limited. *'[It is] a challenge having the capacity to get around to the pharmacies explaining what they need to do, and [having] only two people ... doing that, as face-to-face works best'* (DGP, manager and IHPO).

The DGP set up meetings with pharmacists and sent out letters about the PBS Co-payment measure. However, they are aware that in some pharmacies information does not reach staff at all levels.

5.3.7. CONTRIBUTION TO IMPROVING SAFE AND EFFECTIVE USE OF MEDICATION

KEY POINTS

- Removal of cost barriers to medication has alleviated the financial burden of adherence to medications recommended for people with chronic illness, and appears to have contributed to greater adherence to recommended care for some patients.
- The measure was regarded by stakeholders at local level as a success of the ICDP because of the direct and tangible benefit to patients.
- Some stakeholders felt it was timely to increase emphasis on providing education about medications such as home medication reviews. There was little evidence from the Sentinel Sites that these additional support interventions were designed with equity principles in mind - to reach all people registered with the PBS Co-payment measure, or a rationally defined sub-group of these people.
- The PBS Co-payment measure was well supported by the QUMAX program in those AHSs participating in QUMAX. AHSs that did not have access to additional complementary support to increase adherence, such as dose administration aids, home medication reviews, and cultural training for pharmacists, identified these areas as significant gaps in achieving meaningful medication adherence for vulnerable groups.

This section presents information available from the SSE on the extent to which the PBS Co-payment measure has contributed to the safe and effective use of medications amongst Aboriginal and Torres Strait Islander patients, and evidence for how this was achieved.

The key themes that emerged from the analysis were that:

- Cost barriers were a significant influence on medication adherence, and removal or reduction of cost appeared to increase adherence;
- Access to the measure resulted in greater willingness to attend for care, since patients realised that recommended care was not going to be a cost burden; and
- Supportive systems in Health Services, communities and pharmacies were critical to the measure achieving greater medication adherence at a population-level.

The sections below provide evidence from the Sentinel Sites in relation to each of these themes.

Removal of cost barriers

There was evidence across the evaluation periods that the cost of medications had been a significant barrier to adherence to prescribed medication prior to implementation of the PBS Co-payment measure. This was particularly the case where patients were taking multiple medications. Interviewees and community focus group members described situations in which patients had previously missed out on dosages of medications due to cost, and the PBS Co-payment measure had reduced the financial burden of following recommended care, and resulted in greater adherence.

'The PBS Co-payment has improved medication adherence simply because for example a typical diabetic patient would need four medications per month previously - with a health care card would cost them about \$20 and about \$80 without a health care card. The patients who were in

social and economic stress would simply miss their medications but with this PBS Co-payment it would help to improve access to medications as well as to health care.' (General Practice, GP)

This finding was confirmed by some community focus group members who cited instances of greater consistency in use of medications as a result of access to the PBS Co-payment measure.

'... stopped my mum compromising, like she has diabetes and heart problems, she used to alternate one week she'd go without one medication because she couldn't afford the other ... she's well now because she gets to take them both.' (Community focus group)

'I was having to pay \$80 now getting at pensioner rate ... cost used to stop me buying them, now I can take them.' (Community focus group)

Willingness to attend for care

In several of the Sentinel Sites, interviewees identified that the PBS Co-payment measure had changed the relationship between patients and the Health Service, with greater willingness on the part of patients to attend for care. As indicated in the quotations below, this was welcomed by GPs from both General Practices and AHSs, who felt that patients were attending services more regularly.

'There has been increased attendance at [name of AHS] as patients coming back for medications as they know they can afford them.' (AHS, GP)

'We had quite a few come to our surgery and joined the program and then they get CtG and then they keep coming back to see our doctors.' (General Practice, GP)

'There has been an increase over time because their friends are getting it and word of mouth spreads and I also think the number of patients who visit [AHS] has increased as a result also.' (Pharmacist)

Some interviewees also suggested that patients were more likely to attend the same Health Service consistently, if they knew that they would be able to get PBS Co-payment measure prescriptions from the service and this would be more likely to result in quality of care. The finding in relation to continuity of care was particularly evident in General Practice.

'PBS Co-payment has been helpful to retain and engage patients with the Health Service. The patients now tend to stick to the one practice as a main service provider, before they would go from doctor to doctor. They would most likely stick to one practice because the medicines are cheaper there.' (General Practice, GP)

As suggested by data presented earlier, this positive effect required that the patients' regular health care provider was participating in the measure. If the regular provider was not participating, patients changed to another provider, split their care between different providers, or were unable to access the measure.

Some GPs were aware of the financial burden that recommended care could place on patients, and this may have influenced prescribing patterns. We did not find direct evidence of GPs changing prescribing patterns because of patients' access to the measure, but it is plausible that this may have been an additional positive outcome. Indicated in the quotation below, some GPs were aware of the shame experienced by some patients in relation to inability to afford a medication.

'Removing the stigma of being able to access cheap medicines, CtG removes the stigma of 'I can't afford medicine. In the past you'd have to go to Vinnies or whatever.' (GP, AHS)

Where clinicians commented positively on the effect of the PBS Co-payment measure on adherence, this was in the context of patients attending a regular service provider, with a comprehensive approach to management of their chronic illness.

'I noticed that there is better adherence with medications particularly with my diabetic ones as they now know that they don't have to pay full price if working. The ones that are working, this is making a big difference for them.' (General Practice, GP)

Supportive systems

Systems at point of prescription

A small minority of GPs in PIP Indigenous Health Incentive registered practices appeared to lack motivation to prescribe under the PBS Co-payment measure. In explaining this, GPs referred to access to PIP Indigenous Health Incentive money, suggesting that this was a reason for some GPs to annotate CtG prescriptions systematically.

'Some of the doctors in the practice are part-time doctors and they do not get access to the PIP money therefore they are not interested to prescribe under the PBS Co-payment.' (General Practice, GP)

Under the PBS Co-payment measure, GPs and pharmacists have access to enhanced software that enables them to write and dispense prescriptions using an annotated PBS Co-payment measure prescription. There were many instances of successful use of this software, and other instances where providers were still unable to use it correctly.

The most important issue seemed to be the ability to link records of Aboriginal and Torres Strait Islander status in existing clinical information systems with the PBS Co-payment measure annotation system, so that scripts could be automatically electronically annotated. If patients were not identified as Aboriginal and Torres Strait Islander on the clinical information system, the script was not annotated automatically. Since Aboriginality identification was not well embedded in many clinical information systems (Appendix E), this was a stumbling block to most effective use of the prescribing software systems for the purpose of PBS Co-payment measure annotation.

Pharmacists indicated that they often received prescriptions handwritten with 'CtG' on them. In the earlier evaluation cycles, pharmacists indicated that they tended to receive hand-annotated scripts from General Practice, whereas AHSs were more likely to send electronically annotated scripts. However, there were increasing reports over the evaluation period of General Practices using the electronic annotation successfully. GPs interviewed in recent evaluation cycles indicated that they were using electronically annotated prescriptions regularly. This may be due to participation in the SSE of a select group of General Practices - practices that have a particular interest in Aboriginal and Torres Strait Islander health and therefore more likely to have made the time to understand and utilise the built-in functionality of their prescribing software.

It is well documented in the literature that patient adherence to medications is enhanced by a good understanding by patients of the medications, why they are important and how they need to be used. Failure of health care providers to satisfy patient needs for information may lead to non-adherence. Effective communication about medications can be particularly challenging in situations of general

lower health literacy and ‘cultural divide’ between patients and their health care providers. The prescribing health professional typically has first responsibility to explain the medication to patients at the time of prescription. In some of the sites, the IHPOs and other interviewees suggested that GPs and nursing staff did not always have sufficient time to discuss and review medications with their patients.

‘GPs and practice nurses are time poor so they don’t have time to explain to their Aboriginal patients.’ (DGP, IHPO)

In some sites, GPs reported that they used a practice nurse to provide education on medications. In these situations, GPs were able to use the Medicare system, noting that they were able to bill a Medicare item number for this role. Similarly, some practices reported that they used item numbers available through GP Management Plans to cover time for education about medications. Not all Health Services were oriented to using these systems correctly.

Systems at point of dispensing medications

In the final evaluation cycle there were increasing reports of pharmacists accepting and processing non-annotated prescriptions, as they were aware that the patient was registered for the PBS Co-payment measure because they had previously presented annotated prescriptions. There were also increasing reports of pharmacists being presented with prescriptions that were ‘self annotated’ by patient.

‘I had a conversation with one of the pharmacists with concerns in regards to scripts, I let them know what they had to have on it as some people might be writing CtG on the script who might not be eligible for CtG and I said that is not acceptable. I let the pharmacist know if they get anymore like that let me know and I can call the GP that issued that script to ensure that the patient is eligible. If some-how people’s Medicare care can be linked up and you can swipe it, nationally from the data point of view the pharmacist can see it that you are registered something like that may reduce these problems.’ (DGP, IHPO)

Pharmacists also played a role in explaining medications to patients. The systems to support their role in education about medications were less well defined – and involvement of pharmacists in this role varied.

In some sites, patients who were unable to access medications, had them delivered by OWs or health workers. As illustrated in the quotation below, whilst the benefits in relation to ease of access were recognised, it was also recognised that there was a lost opportunity for education about medications, since the OW did not always have the knowledge about the prescribed medication.

‘Even in terms of acute medicines, say if someone was being prescribed an antibiotic, it might actually be collected by a [name of AHS] worker or we might be asked to deliver it to [name of AHS] for the [name of AHS] worker to forward that on. From a quality use of medicines perspective its really not ideal, but in terms of access for the patient it does work pretty well, it’s better than them being given a prescription and not necessarily then getting it filled.’
(Pharmacist)

It was apparent that both knowledge about the medication, and skills to convey knowledge meaningfully, were both necessary when medications were dispensed. Patients needed to be informed about their recommended care, including medications, and provided with information in an accessible form that was suited to their circumstances.

Medication support in patients' homes and in community

There was wide support in the Sentinel Sites for Home Medication Reviews (HMRs).⁶⁶ Access to these interventions was uneven in the Sentinel Sites. Some GPs had no difficulty organising a pharmacist to undertake a HMR and the challenge was more about ensuring the patient was at home when the pharmacist visited to do the HMR. Others noted challenges in finding resources for HMRs, including qualified pharmacists.

One AHS in a regional site recognised the need for HMRs, but said that there was no accredited pharmacist in town to undertake these reviews. This service developed their own system in which someone else within the Health Service undertook the HMR and sent this on to an accredited pharmacist for verification, and organised for a pharmacist to fly from Sydney twice a year to ensure quality of processes.

'A gap in the program has been there [are] no home medication reviews being done as there is no accredited pharmacist in town. Patients now have a lot of medications but don't necessarily understand what they all are.' (AHS, nurse)

In one site the AHS used funding received from Medicare and PIP Indigenous Health Incentive to employ a medication review officer. The employee was a registered nurse who undertook additional training in Quality Use of Medicines being run by the NACCHO affiliate.

'She looks at all the people on Webster packs, about 52 on Webster packs, she gets them in and works with the pharmacist and they do home medication reviews in the clinic.' (AHS, Feedback from enhanced tracking site)

In other sites, it was reported that pharmacists were available and conducting HMRs, and that in some instances OWs were accompanying pharmacists to assist with access and issues of cultural safety.

In a small number of sites the DGP organised community education sessions on safe use of medicines.

'Some groups have been held with community about safe use of medicines, with a particular focus on why you don't share your medicines.' (Feedback from enhanced tracking site)

Where these had occurred, they were apparently well received. This indicates that there are alternative, and possibly more cost-effective strategies, for increasing patients' understanding of medications than HMRs.

⁶⁶ DoHA, Medicare [website], Home Medications Review. <<http://www.medicareaustralia.gov.au/provider/pbs/fourth-agreement/hmr.jsp>> (accessed 10 December 2012).

Vignette – Improved understanding of, and access to, medications

Community focus group participants in a regional site attribute the PBS Co-payment measure to their improved access to, and understanding of, prescription medications and a motivator for medication compliance. Cost is no longer a barrier - a recent further drop in the cost of prescription medicines has made a significant difference for some patients with chronic illnesses.

'There has been a price drop, \$3.70 each instead of \$5.70 which makes a difference when you have to take quite a few medications - makes you want to keep taking medicine'.

Most said their GPs explain what the medicines are for when prescribing, making the language simple to ensure a better understanding. Some pharmacies at the site are taking a similar approach when issuing prescriptions.

'I take about 16 tablets a day. The Pharmacist at [private pharmacy business] visited me at my home to explain what the medicine is about, wrote everything down as he was explaining. The majority of the medication is for my heart.'

Perceptions of contribution

Over the period of the evaluation there has been an increase in the proportion of interviewees agreeing that *'medications for Aboriginal and Torres Strait Islander people are more accessible than they have been previously'*, with 89% (42/47) agreeing with this statement in the final evaluation cycle (Table 5.3).

In remote sites there was less agreement that medications are more accessible (6/10) than in urban and regional sites (23/24 and 13/13 respectively).

Clinicians continued to have high levels of agreement that medications are more accessible as a result of the PBS Co-payment (Figure 5.16). This agreement was evident in both the General Practice and AHS sectors.

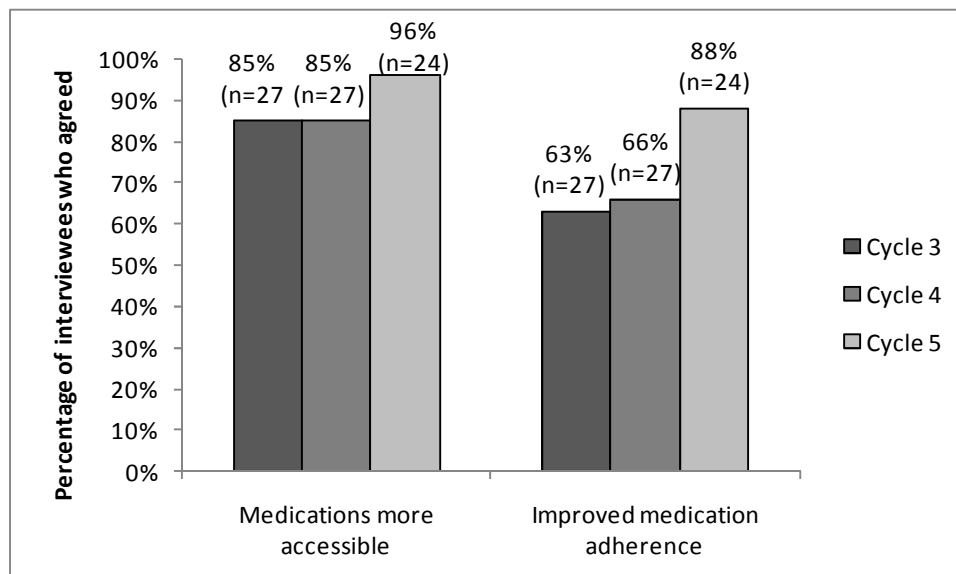


Figure 5.16: Clinicians' responses to the statements 'Medications are more accessible for Aboriginal and Torres Strait Islanders than they have been previously' and 'Medication adherence has improved because of the PBS Co-payment measure' (% who strongly or partly agreed)

Over the evaluation period clinicians increasingly reported that 'medication adherence has improved because of the PBS Co-payment measure' [63% (17/27) in the third cycle, increasing to 88% (21/24) in the final cycle] (Figure 5.16). Clinicians in AHSs provided positive responses to this statement from an early stage and were increasingly positive over time. Clinicians in General Practice were initially less positive, but by the final evaluation cycle they were as positive as clinicians in the AHS. This may be because of initial generally lower participation by General Practice in the PIP Indigenous Health Incentive and PBS Co-payment measure than AHSs.

Influence of the QUMAX program

As outlined in the 'Description of measure' section, the PBS Co-payment measure was built on the foundation of QUMAX, a program available to AHSs in non-remote areas. The majority of the regional and urban Sentinel Sites had AHSs participating in QUMAX. Experience with this program is likely to have significantly influenced patterns of utilisation of the PBS Co-payment measure in the urban and regional locations where this program was implemented.

While the QUMAX program no longer provides subsidies for medication co-payment relief (since this is now covered by the PBS Co-payment measure), other aspects of QUMAX continue. Support services funded under QUMAX include: Dose Administration Aids (DAAs), Quality Use of Medicines (QUM) pharmacy support; Home Medicines Review (HMR); QUM devices and education; cultural awareness; and transport.⁶⁷

Prior participation in QUMAX appeared to have given sites a 'head start' in utilisation of the PBS Co-payment measure. In the earlier evaluation cycles (1 -3), interviewees raised concerns about the imminent cessation of the QUMAX program, which had always been intended as a pilot. Interviewees understood that access to subsidised medications would still be available through the PBS Co-payment

⁶⁷ DoHA, QUMAX Program Specific Guidelines, June 2011

<http://www.5cpa.com.au/iwovresources/documents/5CPA/Initiatives/ATSI_Programs/QUMAX%20Program%20Specific%20Guidelines%20v3.pdf> (accessed 10 December 2012).

measure, but concern was expressed about the perceived loss of funding for DAAs (such as Webster packs), which were highly valued.

In the fourth and final evaluation cycles, stakeholder interviewees and community focus group participants did not express concern about access to DAAs under the PBS Co-payment measure, indicating that the decision to extend the QUMAX agreement with the associated support for DAAs had allayed concerns expressed in the earlier evaluation cycles (patients who are registered under the PBS Co-payment measure and who are patients of AHSs participating in the QUMAX Program are still able to access DAAs for free, or at a reduced rate). Access to the DAAs for patients who do not attend a QUMAX participating service was raised as a significant concern in the fifth evaluation cycle in community focus groups and in stakeholder interviews.

Interviewees in earlier evaluation cycles suggested that the Supplementary Services funding available through the CCSS program (Chapter 8) should be used to pay for DAAs. Shortly after the final evaluation visits the CCSS program guidelines were amended to allow Supplementary Services funding to be used for medical equipment, including DAAs.

The inclusion of funding for DAAs (and other medical equipment) raises questions about sustainability and equity, as the Supplementary Services funding is restricted to patients registered with a Care Coordinator. Care Coordinators generally have limited coverage across the population and are generally intended to provide a transitional service (i.e. the service to the patient is not intended to be permanent – although ‘step down’ care may be considered). There are many patients who have limited access to these aids because of financial barriers, and the potential for Supplementary Services funding to be used to overcome this barrier to access for the many people affected is limited by the current CCSS funding arrangements. Increasing population coverage through increasing numbers of Care Coordinators will go some way to addressing this issue, but there appears to be a need for more specific strategies to ensure equity of access and ongoing access to medical aids.

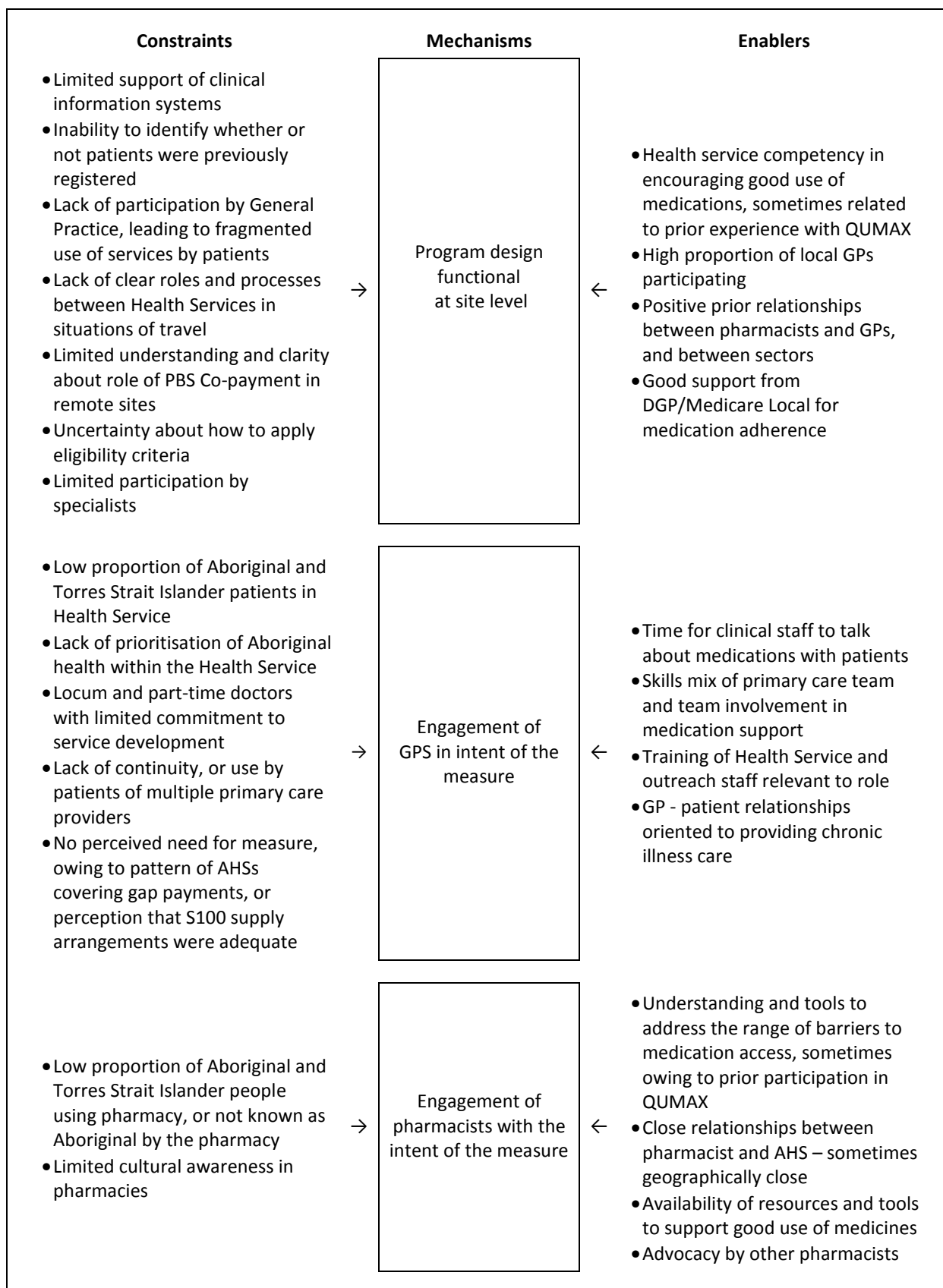
5.3.8. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the PBS Co-payment measure required that the program design was functional in a diverse range of local settings; that GPs were engaged in the intent of the measure; that pharmacists were engaged with the intent of the measure; and that there were complementary linkages with other ICDP funded activities.
- Some of the key enablers to effective implementation at the site level included prior experience with similar programs (such as QUMAX); positive relationships between GPs and pharmacists, and between the GP and AHS sector; and relationships between patients, GPs and the wider health care team being oriented to providing high quality chronic illness care.
- Some of the key barriers to effective implementation included limited capability of Health Service information systems to support the implementation of the measure, including poor recording of Aboriginal and Torres Strait Islander status, recording of PBS Co-payment registration status, uncertainty about application of eligibility criteria; and limited understanding of relevance of the PBS Co-payment measure in remote sites, and of the role of specialists and hospital doctors in prescribing through the PBS Co-payment measure.

Effective implementation of this measure would result in increased utilisation of the PBS Co-payment measure by Aboriginal and Torres Islander people, embedded in local primary health care systems, as part of regular coordinated chronic disease management.

Our analysis has identified four broad mechanisms of change identified for effective implementation (Figure 5.17). Constraints and enablers specific to each of the mechanisms are outlined below.



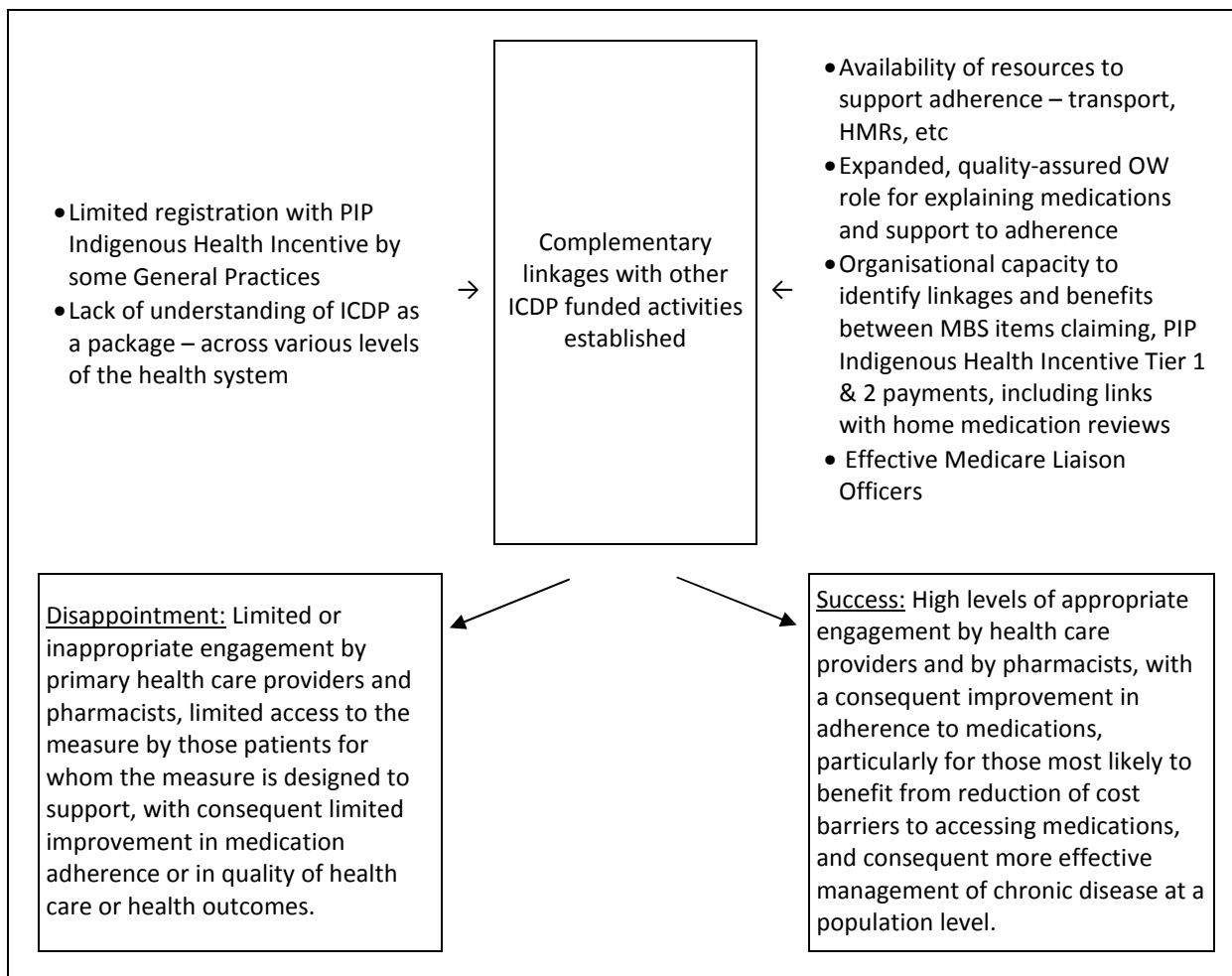


Figure 5.17: Enablers and constraints to effective implementation of the PBS Co-payment measure

PBS Co-payment measure functional at site level and aligns with improvements in care for Aboriginal and Torres Strait Islander people with or at risk of chronic conditions

This mechanism proposes that the PBS Co-payment measure was able to achieve some of its effects through implementation that was functional at site level and aligned with care for Aboriginal and Torres Strait Islander people. If this mechanism was activated, we would anticipate that the measure was aligned with the building blocks of chronic illness management - continuity of care; partnerships with patients, families and communities; support for patients in self-management; attention to preventive measures; decision making support for health care professionals and; availability of clinical information system.⁶⁸ Key factors that appeared to influence this mechanism are outlined below.

At the level of the Health Service, implementation of the measure was enabled by interventions to enhance competencies of health workers to address barriers to medication adherence – alongside the PBS Co-payment measure. For example, developing competencies for nurses and OWs in counselling, and educating patients about good use of medicines was evident in some sites, and appeared to enable functionality.

⁶⁸ Bodenheimer, T.; Wagner, E.; Grumbach, K.. Improving Primary Care for Patients With Chronic Illness: The Chronic Care Model. JAMA. 2002;288(15):1909-1914.

One of the most important factors constraining the development of a functional program design was the limited support provided by clinical information systems. This may have been a result of limited capacity of the information systems to deliver what was required for implementation. It also may have been a result of limited capacity of Health Service staff to use the available systems effectively. Supportive clinical information systems would have allowed Health Services to generate lists of their eligible Aboriginal and Torres Strait Islander patients, and to show whether they were registered for the PBS Co-payment measure. We did not identify any instances of this system capability in the Sentinel Sites. Effective set up and use of clinical information systems would also allow identification of Aboriginality and automatic electronic annotation of PBS Co-payment measure prescriptions. The lack of system capability – or staff able to use this capability – constrained the functional program design in many contexts. Some Health Services had been able to adapt at least part of their systems to make them support the PBS Co-payment measure more effectively. Strategies included embedding additional electronic templates into referral letter templates to pick up information on Aboriginal and Torres Strait Islander status and automatically include an instruction for a PBS Co-payment measure prescription in specialist referral letters. For other Health Services, lack of supportive systems – and lack of capacity or interest to refine the systems – seemed to be a key constraint.

Some Health Services felt that inability to identify whether patients were already registered with the PBS Co-payment had led to duplication of effort, and submission of multiple registrations – or in some cases – the Health Service not providing an annotated script. This constraining factor was related to another factor at site level. The extent to which General Practices that were involved in provision of care for Aboriginal and Torres Strait Islander patients were signed on to the PIP Indigenous Health Incentive was a constraint on functionality of the measure in some sites. If their regular GPs did not provide annotated prescriptions, patients ‘shopped around’ and split their care between providers, or changed to a different provider. Both of these outcomes adversely affected care continuity, at least in the short term.

Dispersion of General Practices, and communication between them and the DGP, AHSs and pharmacies, influenced the proportion of GPs participating. We noted in the Sentinel Sites that those sites with positive prior relationships between sectors tended to show high participation by General Practice in the various ICDP measures – including participation in the PIP Indigenous Health Incentive and PBS Co-payment measure. This may have been related to the level of communication and support that could be provided to these General Practices from DGPs, and the greater ease of communication between prescribing doctors and the dispensing pharmacists.

Lack of clear roles and processes between Health Services constrained functional models for some sites. In these sites, some patients moved between levels of care, were prescribed medications from a range of different providers in different places, and accessed medications from different sources. In regional and remote sites, this was sometimes associated with use of services in different towns or communities. Examples were identified in the Sentinel Sites where Health Services had come to some working arrangements to ensure that patients received access to medications without the cost barrier – but this was rather ad hoc, and sometimes included AHSs covering gap payments from operational budgets through separate arrangements with pharmacies. Uncertainty about, or differing approaches to, application of the eligibility criteria for the measure was also a constraint on the functional design of the measure at site level, with the potential to either make access to the measure wider or more restricted than intended, and to lead to patients moving between services to gain access to the measure. Similarly, the limited participation by specialists and by hospital doctors was also a constraint on the functional design at the site level, through constraining access to medications through the PBS Co-payment for eligible patients.

Engagement of GPs with the intent of the measure

Where GPs were engaged, not only with the practicalities of implementation, but to ensure that implementation worked for patients, this contributed to effective implementation at site level.

Several characteristics of the Health Service were an important influence on the extent to which GPs were engaged with the intent of the measure. These factors were inter-linked and included time allocation to talk to patients about medications; the skills mix of the team and how work and resources were organised within the Health Service and between team members.

The time available for discussion with patients about their medications appeared to be an important influence on GP engagement in some sites. Where GPs were in time-poor environments, and were not aware of or involved in additional strategies to promote medication adherence (apart from removal of the cost barrier through access to PBS Co-payment measure), their engagement with the intent of the measure was constrained. In some of the larger Health Services, it was noted that practice nurses had a role in educating patients about their PBS Co-payment measure medications, and this allowed increased allocation of time to talk to patients about medications. The Health Service in the urban site in which this model was described, recognised the importance of the additional skills needed for this role; the practice nurse was undertaking additional training in Quality Use of Medicines. In other sites, this support role, and wider skills of the team were evident through IHPO and OWs, some of whom had also received additional training in safe medication use.

The GP-patient relationship also appeared to be a key factor influencing GP engagement. We noted in the Sentinel Sites that where GPs believed that their patients' access to the measure had improved medication adherence, this was spoken about in the context of an established relationship oriented to chronic illness care. In some instances, patients moved between providers in order to access the PBS Co-payment measure. This resulted in discontinuity of providers, and it was clear from the Sentinel Sites that GP engagement was constrained in this context. Typically AHSs were known providers of access to the PBS Co-payment measure (hospitals sometimes sent patients to AHSs following discharge in order to access PBS Co-payment measure prescriptions).

Some AHSs historically had been paying costs associated with medications above and beyond what was available through QUMAX and S100 supply arrangements. Where AHSs had organisational capacity and leadership to do so, they changed this situation, and participated in the PBS Co-payment measure – which freed up this funding for use for other purposes. In other contexts, AHSs continued to subsidise the costs of medication from their own operating budgets, and in some cases this appeared to be related to a lack of organisational capacity and leadership to change these established ways of doing things. Some GPs in remote areas were not engaged in the measure, as they did not clearly identify the benefit to their patients, who were generally covered by the S100 supply arrangements. This illustrated a more general lack of understanding in remote sites about whether and how their patients could benefit from the PBS Co-payment measure. This constrained development of functional program design in remote sites.

Engagement of pharmacists with the intent of the measure

Engagement of pharmacists with the intent of the measure was demonstrated in situations where pharmacists were champions of the measure, where pharmacists actively promoted the measure within and beyond the pharmacy; where they identified and addressed barriers to cultural safety in the pharmacy; and where they worked in and with communities to promote safe and correct use of medicines.

Prior participation in the QUMAX program influenced engagement of pharmacists. This may have worked through provision of understanding and tools about the range of barriers to medication access and adherence and through the collaborative relationships that were established between AHSs and pharmacies through the program. These are outlined in more detail below.

The support services funded under QUMAX were highly valued at site level. Some stakeholders expressed concerns about inequity in this program, since these resources were not available to all.

Prior participation in the QUMAX program appeared to have strengthened collaborative relationships between AHSs and community pharmacies in the areas in which it operated – and this often had positive outcomes. In one regional site with high utilisation of the PBS Co-payment measure, the pharmacist based at the AHS had visited private pharmacies in the town to raise awareness of the PBS Co-payment measure. In another site, a pharmacist who owned a number of the local pharmacies worked with the IHPO and DGP-based OW to visit Health Services and explain the PIP Indigenous Health Incentive and the PBS Co-payment measure in an attempt to increase participation. These advocacy roles within the profession appeared to have been a further enabler to engagement with the intent of the measure.

Pharmacists who were located close to an AHS and had an existing relationship through QUMAX generally showed greater engagement with the PBS Co-payment measure. Lower numbers of Aboriginal and Torres Strait Islander patients using the pharmacy appeared to constrain engagement with the measure in some contexts. This was noted in urban sites, and where Aboriginal and Torres Strait Islander communities were possibly less visible, and relationships with AHSs not well established. In these contexts, there were also some situations in which pharmacies were felt to be culturally unsafe for Aboriginal and Torres Strait Islander patients.

Some interviewees identified challenges in working with, and engaging a large number and diverse range of private pharmacy providers in urban sites. One reported that some pharmacists believed that their participation in the PBS Co-payment measure was discretionary, commenting that ‘we are not part of that’, when handed a CtG script.

Complementary linkages with other ICDP funded activities established

There were several ways in which the measure could be complementary to other ICDP funded activities. Where this complementarity ‘worked’, patients were more likely to attend for care and more likely to participate in other recommended processes, such as adult health assessments, and follow-on interventions.

Health Services in general implemented the PBS Co-payment measure in close association with other elements of the ICDP, specifically including the registration of patients for the PIP Indigenous Health Incentive. The tangible benefit of the PBS Co-payment measure was widely regarded and used as an incentive to get patients to sign-on as PIP Indigenous Health Incentive patients with the practice, and in some instances to also undergo an adult health assessment. As the PBS Co-payment measure was highly valued as removing cost barriers to medications, getting access to this element of the package was a strong motivator for patients to agree to these requirements. This was not part of the original program design, but was an emergent behaviour in some of the sites. This coordinated approach to implementation of various ICDP related activities at the Health Service level was enabled by the presence of a champion or leader in the site with good knowledge of the scope of the ICDP. In SE Queensland, the work of the IUIH was an important contribution to implementation of a more coordinated approach at the Health Service level. In some cases the IHPO worked with General Practice,

providing this perspective about the scope of the package and how the various measures could work together.

While the literature shows that improving patients' self-management support is the chronic illness management building block that is most strongly related to adherence to medication regimens,⁶⁹ linkages between the ICDP measure that focused on self-management, and the PBS Co-payment measure, were not clearly apparent in the Sentinel Sites. As shown in Chapter 9, one of the criticisms by stakeholder of this measure was that it was not necessarily reaching those who were in positions in which they could apply any skills and competencies that may have been gained from the training. Health workers involved in HMRs and other initiatives that aim to enhance quality use of medicines may be in a good position to apply skills in modern self-management techniques, and are therefore a potentially important group for inclusion in self-management training programs. To be most effective these programs would need to be tailored to the needs and roles of particular groups of workers.

Through the program design, the PBS Co-payment measure was linked to the PIP Indigenous Health Incentive through the requirement that providers needed to be registered with the PIP Indigenous Health Incentive in order to prescribe PBS Co-payment medications. The attractiveness to patients of the PBS Co-payment measure through reduction of cost barriers to medications was therefore an important lever for encouraging Health Services to register for the PIP Indigenous Health Incentive. The reduction of cost barriers to medications through the PBS Co-payment also encouraged more regular attendance at Health Services, thereby facilitating the roles of the OWs and IHPOs, and creating more opportunities in Health Services for delivery of high quality chronic illness care, including those that are the focus of various ICDP measures.

OWs and IHPOs worked with communities to increase awareness of the PBS Co-payment measure, and with service providers to facilitate their participation, and also with pharmacists to ensure they were aware of the measure and able to participate. This complementarity was enabled in situations in which resources were available for transport and for home medication reviews. It was also enabled in situations of expansion of OW roles to include translation of information about medications, and correct use of medications during consultations. This was associated with additional training and supervision, to ensure that accurate information was conveyed. As indicated above, training of OWs in modern self-management techniques has the potential to enhance the skills of OWs in conducting this role.

⁶⁹ Busse, R, Blumel M, Scheller-Lreinsen, D, and Zentner, A, 2010. Tackling chronic disease in Europe: Strategies, interventions and challenges. Copenhagen, Denmark: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

5.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 5.4). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

5.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The National Framework program logic deals separately with the participation of AHSs and General Practices in the PBS Co-payment measure (see Appendix A for relevant program logic). We report here on both sectors together as similar issues were raised for both sectors in the SSE across the evaluation period.

Table 5.4: Summary of key findings in relation to program logic - PBS Co-payment measure

	Summary of key findings from SSE
Outputs for year 1 and beyond	
Health Services participate in the program.	The higher than expected uptake of the PBS Co-payment measure by patients reflects a generally high level of participation by Health Services. AHSs tended to register early for the PIP Indigenous Health Incentive (which allowed GPs to annotate prescriptions), and special arrangements have been made to enable participation by AHSs that are not accredited. General Practices have showed a slower but steadily increasing level of participation in the PIP Indigenous Health Incentive, with a consequent increase in the potential for participation in the PBS Co-payment measure. However, there are indications that some General Practices will not register for the PIP Indigenous Health Incentive, despite their patients wanting to have access to the PBS Co-payment measure. Pharmacies have generally shown a high level of participation, and this has been facilitated by software systems in many pharmacies. Awareness, understanding, and participation by doctors working in hospitals and by specialists remains limited.
Eligible Aboriginal and Torres Strait Islander people participate in the program.	Many people are participating in the program – more than double the number that was expected at this early stage of implementation. While there is strong agreement among stakeholders in the sites that the eligibility criteria are workable, the large numbers of people accessing the PBS Co-payment measure has raised questions regarding the application of the eligibility criteria for the measure. These questions relate to all three aspects of eligibility through: a) the potential for inappropriate self-identification of Aboriginal and Torres Strait Islander status, b) the assessment by practitioners that many (or all) Aboriginal or Torres Strait Islander people are at risk of chronic disease, and c) the assessment by practitioners that cost is a barrier for many (or all) Aboriginal or Torres Strait Islander patients to obtaining and therefore taking prescribed medication. The significant cost to patients in paying for medication has clearly been and will continue to be a strong driver for high uptake of this measure.

Summary of key findings from SSE	
Expected early results for years 2 – 4	
The financial barrier to using PBS medicines is removed/reduced	The financial barriers to accessing PBS Co-payments medicines have been substantially reduced, and this is reflected in comments from community focus group participants as well as from Health Service providers. There are a few situations that limit the effective operation of the PBS Co-payment measure, resulting in continued financial barriers to access to medication. These situations include: where patients are seen by hospital doctors or specialists who are unaware of the PBS Co-payment measure and do not annotate prescriptions; where patients living in remote locations are visiting regional towns, and have difficulty accessing medications (many people residing in remote locations are not registered for the PBS Co-payment because they usually have access to medications under S100 supply arrangements); where patients are travelling, and having difficulty identifying a practice that is registered for the PIP Indigenous Health Incentive or, they or the practice do not have information about whether the patient is registered or not; and where patients encounter racist attitudes in pharmacies when they present their PBS Co-payment measure prescriptions. Ongoing work is required to achieve more effective operation of the measure in these situations.
Expected medium term results for years 4+	
The utilisation of PBS medicines by Aboriginal and Torres Strait Islander people with or at risk of chronic disease is increased	There was an increasingly widely held perception in local Health Service organisations and among community members that the PBS Co-payment is resulting in improved adherence to prescribed medications. This was partly due to the removal of cost barriers, and is also likely to have been influenced by other factors, such as patients attending Health Services more regularly for repeat prescriptions, and additional support provided by complementary initiatives such as QUM, and the work of the ICDP OWs and IHPOs in some sites.

5.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the PBS Co-payment measure.

Awareness of the measure and sources of information

High levels of awareness of the PBS Co-payment measure were evident in urban and regional sites, with lower but increasing awareness in remote sites. Community networks were an important source of information in the later evaluation cycles. For service providers, opportunities for face-to-face communication about the measure, and about the whole of the ICDP, were particularly valued. Specialists, pharmacists, hospital staff, and service providers in remote locations, were still in need of developing understanding about the measure and its relevance to them and people in the local communities.

Overall utilisation and administrative processes

Utilisation of the PBS Co-payment measure increased both in Sentinel Sites and in the rest of Australia, with levels of use exceeding what had been anticipated. Rates of utilisation were higher in regional than in urban locations, and relatively low in remote locations.

Owing to the direct benefit for patients, Health Services and patients generally found ways to manage the administrative requirements for access to the measure. Inefficiencies in administration related to

the following two situations. Where patients sought care from different providers in order to find a provider who would prescribe through the PBS Co-payment measure, and where prescribers were unsure whether or not patients had been previously registered, and submitted registration 'just in case'.

Administrative barriers were not considered burdensome by Health Service interviewees. Registration appeared to be encouraged by community demand. There was no evidence of systematic processes being applied to ensure that those who were likely to benefit most from the measure (not just those who demanded it) were registered. There was also no evidence of systematic processes to ensure that people registered actually received PBS Co-payment medications consistently, regardless of whether or not they received prescriptions from General Practice, AHSs, specialists or hospitals.

Variation in utilisation by geographic location and between Sentinel Sites

Wide variation in the number of patients accessing the PBS Co-payment medications per 100 Aboriginal and Torres Strait Islander people was evident between specific Sentinel Sites and across urban, regional and remote locations. There was wide variation between sites, within and across geographic locations. The variation was due to a complex mix of local, regional and national influences, some of which varied over time. Use of the PBS Co-payment measure was generally lower in remote sites than in urban and regional sites, primarily due to availability of medications through the S100 scheme in remote locations.

Use of major categories of medications and community and prescriber understanding of available medications

Perceptions regarding differences in the medications available through the PBS Co-payment measure, the S100 supply arrangements, and QUMAX, caused confusion for patients and some providers, but this was generally able to be resolved through the work of IHPOs and OWs. Some patients were prescribed and dispensed brands that were not covered by the PBS Co-payment. This may have been due to the medication type not being covered or the incorrect brand being prescribed and dispensed. Some GPs appeared to be unaware of the range of medications covered by the measure.

Use of all major categories of medications through the PBS Co-payment measure increased over the evaluation period. Cardiac medications were the most commonly dispensed medications under the measure. Relative to levels during the first six months of the measure, dispensing of anti-psychotic medications increased more than any other category of medication. There were no differences in types of medications prescribed in the Sentinel Sites compared to in the rest of Australia. There were more prescriptions of each type of medication in the Sentinel Sites compared to the rest of Australia, proportional to population.

Workability of eligibility criteria

In early evaluation cycles, some AHSs reported use of various processes to verify Aboriginal and Torres Strait Islander status. There were fewer such reports in later evaluation cycles. The extent to which this reflects a real change or the reasons for any change in practice are unclear. General Practice appeared to generally accept self-report of Aboriginal and Torres Strait identity for the purpose of the PBS Co-payment measure. Aboriginal and Torres Strait identity recorded or implicit in the PBS Co-payment measure prescription was questioned by some pharmacists. The precedent of subsidising medications for non-Aboriginal and Torres Strait Islander family members of Aboriginal and Torres Strait Islander patients that had been set by QUMAX, and the reluctance of some providers to see this benefit taken away from those in need, may have resulted in some non-Aboriginal and Torres Strait Islander people

accessing the measure. However if this happened, it was unlikely to be on a large scale. The criteria of having or being at risk of chronic disease and being unlikely, in the judgment of the health care provider, to adhere to medications without the measure's assistance, were generally interpreted to apply to all Aboriginal and Torres Strait Islander patients. Data suggest that the measure benefited people most in need. People who were disadvantaged by worse health and/or poorer socioeconomic status were disproportionately accessing PBS Co-payment medications, as were those aged ≥ 55 years.

Situations in which eligible patients had difficulty accessing the PBS Co-payment measure

Although uptake of the measure was generally high, there were some situations in which patients apparently had difficulty accessing the PBS Co-payment measure. These included situations in which patients were seen by hospital doctors or specialists who were unaware of the PBS Co-payment measure and did not annotate prescriptions; where patients were travelling, and had difficulty identifying a practice that is registered for the PIP Indigenous Health Incentive and; where patients encountered racist attitudes in pharmacies when they presented their PBS Co-payment measure prescriptions.

5.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Consider reviewing the eligibility criteria, and the application of the eligibility criteria for this measure with a view to ensuring that implementation of the measure is consistent with the measure design, including specifically to ensure that those most likely in need of support through this measure do effectively benefit from the measure. Consider how community outreach and education strategies might be used to achieve this objective, including through raising awareness amongst community members likely to be in need of support, and raising awareness of the relevance of the measure to patients living in areas covered by S100 supply arrangements.
- b) Consider how specialists and hospital doctors can be more effectively engaged in the implementation of the measure in a way that enhances potential to achieve the aims of the measure.
- c) Consider how the measure might be refined in a way that enhances the appropriate and safe use of medications, including through synergies with other ICDP measures (such as self-management training) and other more general initiatives (such as the National Prescribing Service Quality Use of Medicines Program⁷⁰).
- d) Consider how the availability and accessibility of information on where patients can access medications through the PBS Co-payment scheme can be enhanced, including specifically for patients who are visiting regional towns or cities away from their regular primary health care provider. Consider the role that Medicare Locals can play in this.

⁷⁰ NPS [website] <http://www.nps.org.au/about_us/what_we_do/about_quality_use_of_medicines> (accessed 5 April 2012).

6. HIGHER UTILISATION COSTS FOR MBS AND PBS (*MEASURE B2*)

6.1. Description of measure

This measure provides funds to meet the expected increased costs to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) associated with parts of the ICDP.⁷¹

Whilst this measure relates to higher utilisation costs for both MBS and PBS, this chapter focuses on the utilisation of Medicare items numbers that are specific to Aboriginal and Torres Strait Islander people. These include additional health care benefits that are available for annual adult health assessments (MBS item 715); for follow-up by a practice nurse or AHW (MBS item number 10987); and for follow-up by an allied health care professional (MBS item number 81300-83160). As outlined below, these items have undergone a number of changes in recent years, with the purpose of streamlining for greater uptake. Findings from the Sentinel Sites in relation to the PBS Co-payment measure are presented in Chapter 5.

This measure differs from the other ICDP measures in that it makes funding available to cover the costs of expected increases in services billed to Medicare. Its establishment did not include new funding streams, or additional workforce capacity – nor a specific program logic within the National Framework. The chapter provides an overview of the uptake of the relevant Aboriginal and Torres Strait Islander specific MBS item numbers, both in the Sentinel Sites and in the rest of Australia at baseline and over the period of the evaluation. It identifies underlying reasons behind uptake of these items, including the potential contribution of other ICDP measures, and the fit with service delivery at a local level. The overall purpose of the chapter is to contribute to understanding how and in what circumstances these MBS item numbers are taken up and how uptake contributes (or fails to contribute) to the goal of early detection of chronic illness and effective coordinated care for people identified as having chronic illness.

6.1.1. ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH ASSESSMENTS (MBS ITEM 715)⁷²

Since their introduction, the uptake of adult health assessment items for Aboriginal and Torres Strait Islander people has been lower than uptake of comparable items for the general population. The Federal Government introduced changes to simplify claiming for Aboriginal and Torres Strait Islander adult health assessments, with effect from May 2010 and coinciding with implementation of the ICDP. The changes aimed to encourage preventative care and increase the uptake of adult health assessments amongst Aboriginal and Torres Strait Islander people from baseline levels (around 10%) to 45% of eligible adults over four years to 2012-2013.

⁷¹ DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet

<<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/meeting-the-costs/>> (accessed 7 December 2012).

⁷² DoHA, Practice Detail Card, - Aboriginal and Torres Strait Islander Health Assessments

<[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-4-aboriginal-and-torres-strait-islander-health-assessments/\\$file/DHA0002.9%20A4%20Practice%20Detail%20Card%204%20Aboriginal%20Health%20Assessments%20WEB.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-4-aboriginal-and-torres-strait-islander-health-assessments/$file/DHA0002.9%20A4%20Practice%20Detail%20Card%204%20Aboriginal%20Health%20Assessments%20WEB.pdf)> (accessed 4 October 2012).

Prior to 1 May 2010 there were three separate MBS Aboriginal health assessment items, comprising child, adult and older person health assessment items - these were merged into one health assessment item (715) in 2010. This new MBS item attracted a rebate of \$208.10 in 2012 and could be claimed annually. Previously, adult health assessments could only be claimed annually by a GP for children and older persons, but only every two years for adults aged 15-54 years. Health assessment components specified included an assessment of the patient's physical, psychological and social wellbeing, and needs for preventive health care, education and other assistance.⁷³ There were no time requirements specified, and assessments could be provided in or out of consulting rooms.

6.1.2. FOLLOW-UP SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER (MBS ITEM 10987)⁷⁴

Subsequent to a health assessment (MBS item 715) follow-up items can be claimed by GPs in respect of follow-up services delivered by a practice nurse or registered AHW on behalf of the GP (MBS item 10987). Introduced in 2008, this MBS item allowed five follow-up services per patient per calendar year. This was expanded in 2009 to allow ten follow-up services per patient per calendar year.⁷⁵ This item attracted a rebate of \$24.00 in 2012.⁷⁶ The services provided may include any further examinations or interventions as indicated by the health assessment; education regarding medication compliance; medication monitoring; lifestyle advice; taking a medical history; and prevention advice for chronic conditions.

Whilst claims could be made for follow-up services delivered by AHWs on behalf of GPs, until recently (July 2012) this only applied to AHWs professionally registered with the Aboriginal Health Worker Registration Board of the Northern Territory. This meant that services delivered by AHWs in other jurisdictions and not registered with this board, could not be claimed from Medicare.⁷⁷ Under national registration for Aboriginal and Torres Strait Islander Health Practitioners, which commenced on 1 July 2012, the qualifications of AHWs from all jurisdictions are recognised under the national registration and accreditation scheme.⁷⁸ If lack of recognition of qualifications had been a barrier to claiming for follow-up items delivered by AHWs, we would anticipate an increase in claims using this item number in the future, corresponding with an increase in the number of registered AHWs.

A recent initiative to support an expanded role for practice nurses in Health Services, the Practice Nurse Incentive Program (PNIP), also has some bearing on this MBS item, as it streamlines some nurse-billing against Medicare items, and therefore may simplify the billing of follow-up services delivered by nurses. PNIP funding also supports a \$5000 one off payment for Health Services to become accredited; an additional loading payment to AHSs to encourage use of practice nurses and AHWs; support for AHSs in urban areas of workforce shortage; and support for Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ allied health professionals such as physiotherapists,

⁷³ DoHA, MBS Online [website] <<http://www9.health.gov.au/mbs/search.cfm>> (accessed 7 December 2012).

⁷⁴ DoHA, Practice Detail Card - Follow – up services provided by a Practice Nurse or registered Aboriginal Health Worker <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-8-follow-up-services-provided-by-a-practice-nurse-or-registered-aboriginal-health-worker-mbs-item-10987/\\$file/DHA0002.9%20A4%20Practice%20Detail%20Card%208%20Practice%20Nurse%20AHW%20WEB.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-8-follow-up-services-provided-by-a-practice-nurse-or-registered-aboriginal-health-worker-mbs-item-10987/$file/DHA0002.9%20A4%20Practice%20Detail%20Card%208%20Practice%20Nurse%20AHW%20WEB.pdf)> (accessed 4 October 2012).

⁷⁵ DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, op cit.

⁷⁶ DoHA, MBS Online [website], op cit.

⁷⁷ DoHA, MBS Online [website], op cit.

⁷⁸ Aboriginal and Torres Strait Islander Health Practice Board [website] <<http://www.atsihealthpracticeboard.gov.au/Codes-Guidelines/FAQ>> (accessed 2 October 2012).

dietitians and occupational therapists instead of, or in addition to, a practice nurse and/or Aboriginal Health Worker.⁷⁹ This initiative may increase uptake of these follow-up items as a result of greater availability of relevant health professionals in services, and re-orientation of Medicare billing patterns to include billing for nurse and AHW services.

6.1.3. ALLIED HEALTH FOLLOW-UP SERVICES (MBS ITEMS 81300–81360)⁸⁰

Subsequent to an adult health assessment, if the GP identifies a need for follow-up by an allied health professional, up to five allied health services can be claimed under MBS items 81300 to 81360. Eligible categories of allied health professional services registered with Medicare Australia include Aboriginal Health Worker, diabetes education, audiology, exercise physiology, dietetics, mental health work, occupational therapy, physiotherapy, podiatry, chiropractic, osteopathy, psychology and speech pathology. Claims can be made using MBS 81305 (Diabetes Education), without a health assessment.

Reimbursement for allied health services is also available to Aboriginal and Torres Strait Islander people, as for the general population, using MBS items 10950 to 10970⁸¹. Claims for services against these items require that the patient has an established chronic disease and that referral to the allied health professional is through the referring GP developing a General Practice Management Plan (GPMP)/Team Care Arrangement (TCA).

6.1.4. ANTICIPATED INCREASE IN BILLING AS A RESULT OF THE ICDP

At a broad level, an increase in MBS and PBS expenditure was expected due to synergies between a number of measures within the ICDP, specifically including: the provision of incentives through the PIP Indigenous Health Incentive for GPs to register Aboriginal and Torres Strait Islander patients and provide target levels of care; encouraging Aboriginal and Torres Strait Islander people to access Health Services and increasing access to and affordability of private healthcare and; providing coordinated care and flexible funding for follow-up care through the new Care Coordination and Supplementary Services program (CCSS).⁸² In addition, it was anticipated that increased staffing capacity available through various ICDP measures would lead to increased claims for adult health assessments and for follow-up services, due to potential roles in facilitating demand for adult health assessments, and facilitating return visits for follow-up. An analysis of the data showing the influence of these factors on uptake of adult health assessments and follow-up items is presented in Section 6.3.8.

⁷⁹ Department of Human Services, Practice Nurse Incentive Program Guidelines
<<http://www.medicareaustralia.gov.au/provider/incentives/files/9689-1208en.pdf>> (accessed 5 November 2012).

⁸⁰ DoHA, Practice Details Card, allied health follow-up services
<[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-7-allied-health-follow-up-services-mbs-items-81300-81360/\\$file/DHA0002.9%20A4%20Practice%20Detail%20Card%207%20Allied%20Health%20WEB.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-detail-card-7-allied-health-follow-up-services-mbs-items-81300-81360/$file/DHA0002.9%20A4%20Practice%20Detail%20Card%207%20Allied%20Health%20WEB.pdf)> (accessed 4 October 2012).

⁸¹ DoHA, MBS primary care items [website] <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm> (accessed 4 October 2012).

⁸² DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, op cit.

6.2. Data sources and analysis

Data reported derive from routinely available data sourced from Medicare claims for specified items, supplemented with explanatory data obtained from in-depth interviews and discussions with key informants at case study sites, enhanced tracking sites, tracking sites and state-wide organisations. Discussions with key informants at site-level specifically sought to elicit informants' views on reasons for the trends that were observed in uptake of the adult health assessment and the relevant follow-up items as outlined below. Further details about the methods and notes on interpretation are available in Appendix C.

On the basis of information obtained from case study and enhanced tracking sites, we have constructed composite figures that show the uptake of various administrative items over the period of the evaluation – including adult health assessments and follow-up items – in relation to major service delivery developments and the employment of ICDP workforce in each site. These figures are provided in Appendix B and referred to at various points in this chapter – these data, together with qualitative data obtained through site visits, provided an important source of evidence in developing an understanding from the Sentinel Sites about the complex interplay of factors that influence uptake of the adult health assessment and follow-up items at a local level.

Appendix I presents an analysis of the relationship between different service use variables (for example PIP Indigenous Health Incentive, health assessments and follow-up items) and contextual variables (for example pre-existing uptake of related MBS items and the number of ICDP workers in the site).

Aboriginal and Torres Strait Islander adult health assessments (MBS item 715)

Data are provided showing the uptake of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 and thereafter 715) for Aboriginal and Torres Strait Islander people aged ≥ 15 years. The analysis excludes 0-14 years from the MBS 715 claims. The analysis includes exploration of the uptake and trends of adult health assessments per 100 Aboriginal and Torres Strait Islander people, overall, disaggregated by urban, regional and remote locations, and disaggregated at site level. We also similarly report the number of GPs who are billing for adult health assessments and the average number of adult health assessments per GP. This is because comparing sites in relation to these patterns provide some insight into underlying factors driving trends in various contexts.

Follow-up services provided by a Practice Nurse or registered Aboriginal Health Worker (MBS item 10987) and Allied Health follow-up services (MBS items 81300–81360)

We also report on the uptake of the relevant MBS follow-up items for adult health assessments: follow-up services by a practice nurse or registered AHW (MBS item number 10987) and follow-up by allied health professionals (MBS item numbers 81300-81360). These are presented as absolute numbers and also as a proportion of adult health assessments. As will be evident below, uptake of these items was low overall, restricting ability to present disaggregated data on these items.

6.3. Findings from the Sentinel Sites

6.3.1. OVERALL UPTAKE OF ADULT HEALTH ASSESSMENTS

KEY POINTS

- Uptake of adult health assessments in all Sentinel Sites taken together increased almost four-fold over the evaluation period, from approximately two per 100 to around seven per 100 Aboriginal and Torres Strait Islander people.
- Uptake of adult health assessments in the rest of Australia increased more than two-fold over the evaluation period. This lower rate of increase in the rest of Australia may reflect different patterns of service utilisation and/or different characteristics of service providers in the rest of Australia, compared to Sentinel Sites.
- The number of GPs who claimed one or more adult health assessments increased in the Sentinel Sites, and in the rest of Australia (from 0.3-0.4 GPs per 100 Aboriginal and Torres Strait Islander population billing against these items at baseline, to 0.8-0.9 per 100 in the May 2012 quarter in both Sentinel Sites and the rest of Australia).
- The number of adult health assessments conducted per GP remained relatively stable, at around 5-7 adult health assessments per quarter, or 20-30 per year per participating GP.
- Uptake of adult health assessments increased for both older and younger age groups with uptake amongst older age groups consistently higher than uptake amongst younger age groups. Uptake amongst younger people was slower but more sustained than uptake amongst older people.
- Uptake of adult health assessments increased for both males and females, although male health assessment rates lagged behind those for females. This lag probably reflects lower service utilisation in general for males.

Number of adult health assessments claimed annually

The most recently available data obtained from Medicare shows a total of 63 827 adult health assessment items claimed during the year June 2011 to May 2012; based on the estimated Aboriginal and Torres Strait Islander population, this indicates that about 11.5% of eligible Aboriginal and Torres Strait Islander people had adult health assessments billed during that 12 month period. There were 15 020 items claimed from the Sentinel Sites – equivalent to around 24% of the total claims in Australia during that year – and equivalent to a coverage of 12.7% in the Sentinel Sites. These data indicate that the expectation that 45% of the adult Aboriginal and Torres Strait Islander population should receive a health assessment over the four years to 2012-2013 is not being achieved.⁸³

The number of adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people has increased steadily over the evaluation period since the commencement of the ICDP (Figure 6.1, Table 6.1, Appendix G, Table G1 and G2). The general pattern has been that fewer adult health assessments are claimed during the summer months of each year (December - February quarters).

⁸³ DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, op cit.

Although adult health assessments increased in both Sentinel Sites and in the rest of Australia, the increases in Sentinel Sites were more marked. For example, there were nearly four times as many adult health assessments conducted in the March - May 2012 quarter in Sentinel Sites compared to baseline and around twice as many adult health assessments in March - May 2012 in the rest of Australia compared to baseline.

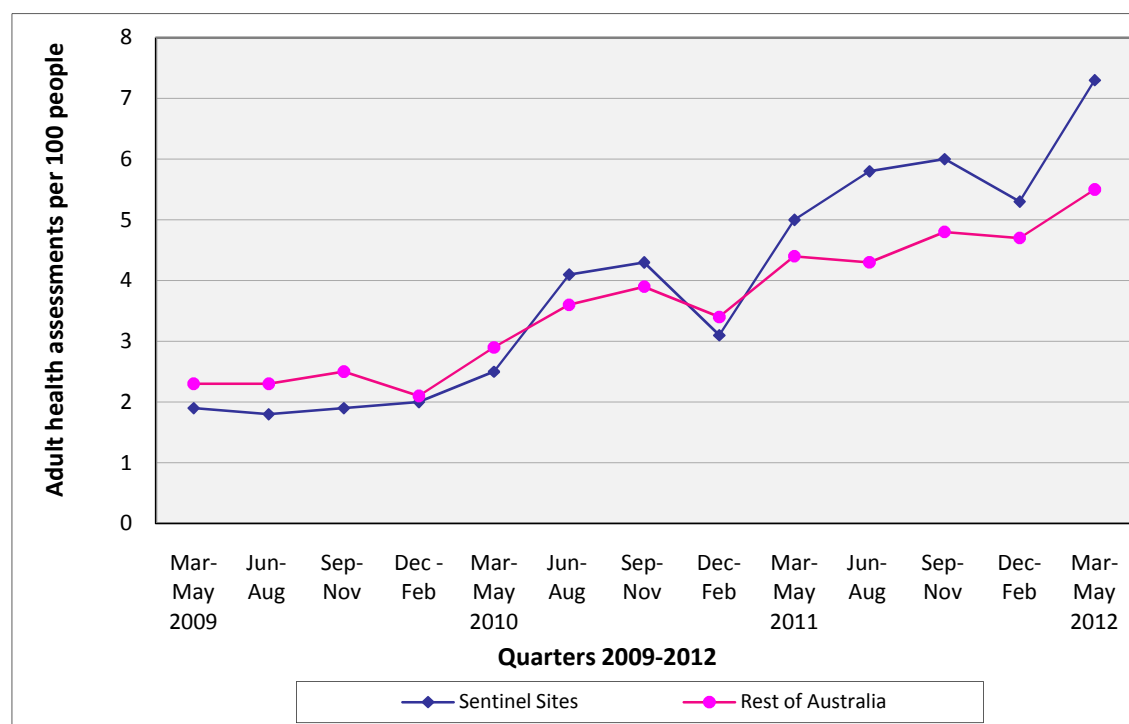


Figure 6.1: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Table 6.1: Number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia, March 2009 - May 2012

Sentinel Sites/ Rest of Australia	Adult health assessments claimed												
	2009				2010				2011				2012
	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May
Sentinel Sites	1144	1069	1113	1165	1496	2435	2566	1882	3080	3554	3686	3230	4550
Rest of Australia	5512	5484	5947	5118	7188	8919	9734	8385	11079	10833	12065	11717	14192

Claims for adult health assessments in both the Sentinel Sites and the rest of Australia have increased since commencement of the ICDP implementation (March - May 2010), coinciding with the following ICDP initiatives:

- introduction of the PIP Indigenous Health Incentive and PBS Co-payment measures as part of the ICDP
- changes to allow claims for payment for a health assessment once a year instead of once every two years – representing an increased allowance for people in the 15-54 year age group
- other ICDP-related efforts (including activities of the IHPOs and OWs) to increase uptake of health assessments, and which have varied in intensity between sites and over time
- ICDP funded Healthy Community Days which included activities to promote uptake of adult health assessments; at times health assessments were conducted during Healthy Community Day events.

We present an analysis of how these and other initiatives may have influenced or failed to influence effective implementation of the measure overall in Section 6.3.8.

GP engagement in adult health assessments

In order to understand the reasons underlying the increase in uptake of the adult health assessment, the analysis below examines the trends in numbers of GPs who claimed adult health assessments in the Sentinel Sites and in the rest of Australia, and the trends in the numbers of adult health assessments claimed per GP.

Overall, in both the Sentinel Sites and the rest of Australia, the number of GPs claiming for adult health assessments has steadily increased over the period of ICDP implementation, whilst the average number of health assessments completed per GP remained relatively stable. This suggests that to date, at an overall level, the increase in uptake of the adult health assessment items has in general been driven by increased numbers of GPs billing against this item, rather than greater numbers billed per GP.

The increase in the number of GPs claiming adult health assessments coincides with the introduction of the ICDP (March - May 2010). The sustained increase in the number of GPs over the period of ICDP implementation suggests that the capacity of the program to improve the uptake of MBS items is still growing (Figure 6.2).

The trends in the number of GPs claiming adult health assessment items were very similar in the Sentinel Sites and the rest of Australia. In the Sentinel Sites, the number of GPs claiming for adult health assessment items in the baseline period (March 2009 - February 2010) was around 0.3 per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years then increased to about 0.9 per 100 people by March - May 2012. For the rest of Australia, the number of GPs who claimed for adult health assessment items was around 0.4 per 100 people for the baseline period (March 2009 - February 2010) and increased to 0.8 per 100 people in the March - May 2012 quarter (Figure 6.2, Appendix G, Table G3).

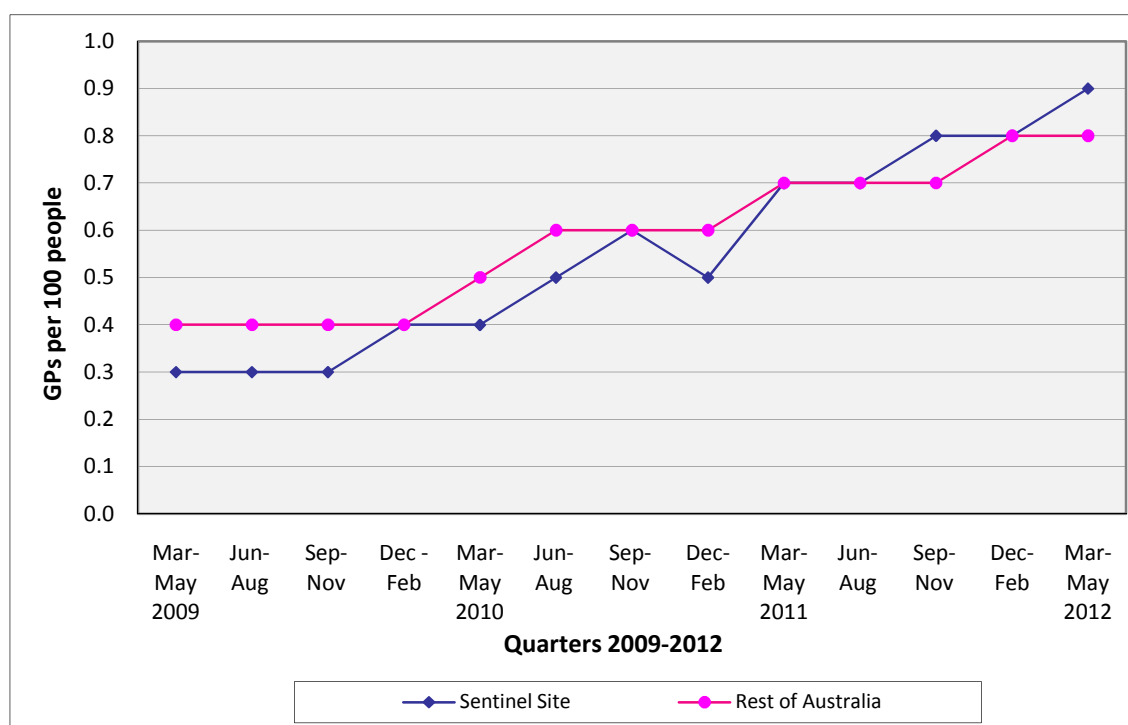


Figure 6.2: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Health Services in the Sentinel Sites put in place strategies that were seen to enable an increase in the number of GPs claiming adult health assessments (and to some extent enabled an increase in the number of adult health assessments per GP). Strategies put in place by Health Services, and by regional support organisations, to increase uptake of adult health assessments are outlined in Section 6.3.3.

Uptake by age and gender

The number of adult health assessments per 100 Aboriginal and Torres Strait Islander people aged 55 years and over was higher than for people aged 15-54 years over the evaluation period. The older population are often considered to be easier to reach as they generally attend Health Services more regularly.

There has been a levelling off of uptake during the past three quarters for both age groups in the rest of Australia. However, within the Sentinel Sites, different patterns of increase in uptake were observed for younger and older people over the evaluation period. There was a similar relative increase in the number of adult health assessments per 100 people for those aged ≥ 55 years and aged 15-54 years following the baseline period up until the March - May 2011 quarter (Figure 6.3). However, following this initial steady increase for older and younger adults, there was a continuing increase for people aged 15-54 years, and no further increases in the ≥ 55 year age group in the period of June - November 2011. All groups showed a seasonal dip at December 2011 - February 2012 and all groups showed renewed increases in the number of adult health assessments in March - May 2012.

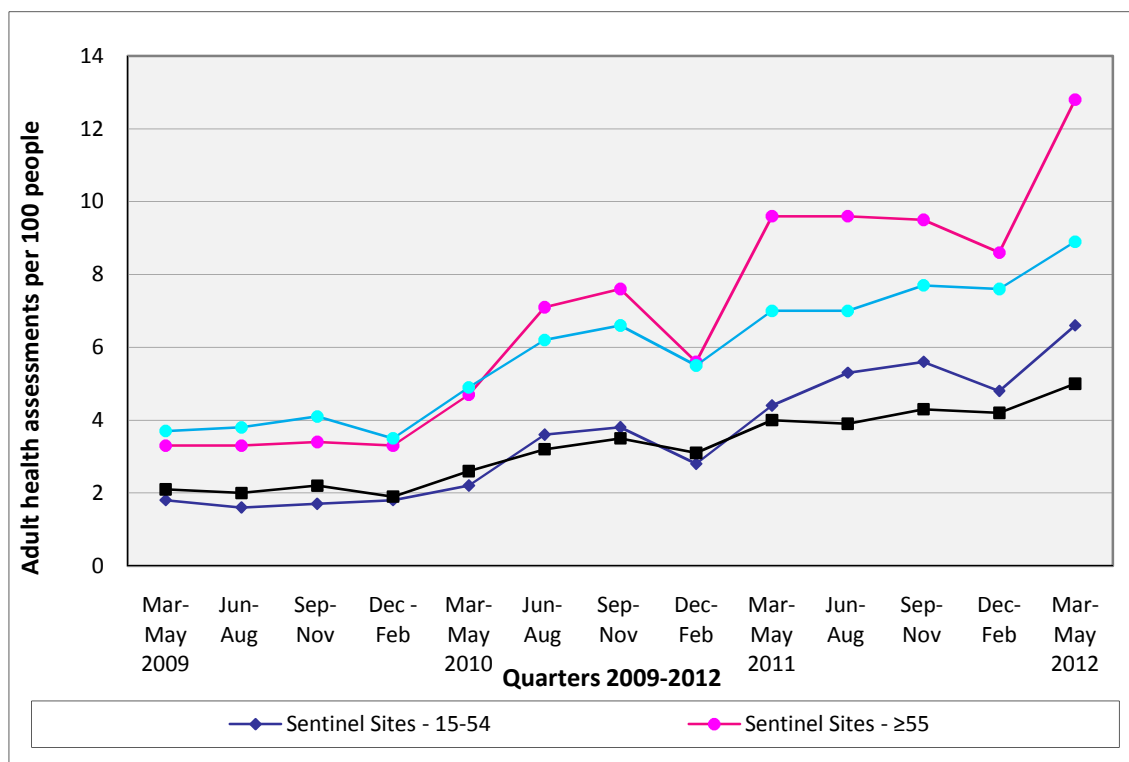


Figure 6.3: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - May 2012

The increase in adult health assessments per 100 Aboriginal and Torres Strait Islander people was slightly lower for men than for women (Figure 6.4), although rates increased in both groups. Men commonly access Health Services less readily than women, so it was not surprising that less adult health assessments were being carried out for males.

These and other factors that may explain different patterns in the different Sentinel Sites are described in Section 6.3.2 below in relation to specific sites.

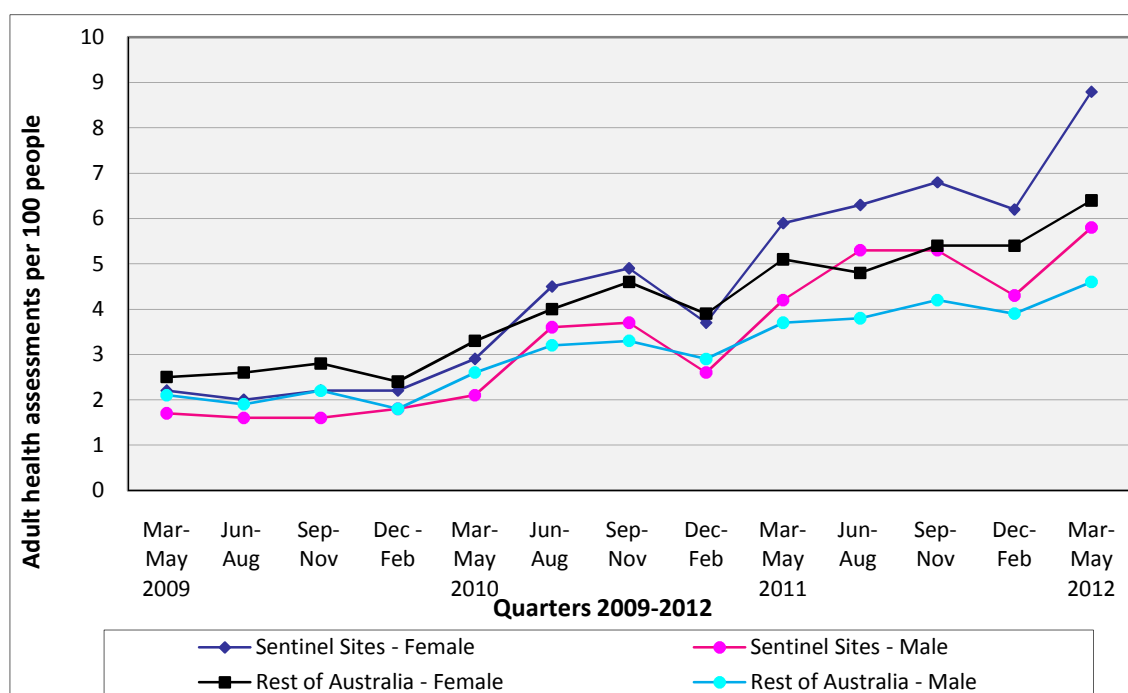


Figure 6.4: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by gender and quarter, March 2009 - May 2012

The sections below compare trends in uptake of adult health assessments in specific sites in urban, regional and remote locations. We also examine and integrate data by urban, regional and remote sites, showing trends in number of GPs claiming adult health assessments per site, and average number of assessments claimed per GP provider.

6.3.2. VARIATION IN ADULT HEALTH ASSESSMENTS AND GENERAL PRACTITIONER BILLING BY GEOGRAPHIC LOCATION AND BY SENTINEL SITES

KEY POINTS

- In the final quarter of the evaluation period the number of adult health assessments per 100 Aboriginal and Torres Strait Islander people was highest in regional Sentinel Sites and the rest of regional Australia, and lowest in the rest of urban Australia.
- Over the period of the evaluation, the number of GPs claiming adult health assessments per 100 people increased substantially in urban and regional locations but showed little change in remote locations.
- On average, in urban locations, amongst GPs who claimed for adult health assessments, 3.5 to 6 adult health assessments were claimed per quarter – or 12 to 24 per annum. The average number of adult health assessments per GP was slightly higher in urban Sentinel Sites than in the rest of urban Australia over the evaluation period.
- Health assessments in urban locations increased over the evaluation period, with some fluctuations evident; there were up to 5.6 adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people in March - May 2012.
- The urban Sentinel Sites that achieved high numbers of adult health assessments per population

were characterised by high numbers of GPs claiming adult health assessments and, to a lesser extent, high numbers of adult health assessments per GP.

- Uptake of adult health assessments in regional sites increased over the evaluation period; there were approximately 9 and 6 assessments per 100 people in the Sentinel Sites and in the rest of regional Australia respectively by the final evaluation period.
- Uptake of adult health assessments in regional locations increased fairly steadily over the period of evaluation, with small seasonal declines evident over the summer months of each year.
- In regional sites, both increased numbers of GPs claiming for adult health assessments and increased number of assessments per GP were key factors underlying the increased rates of adult health assessments achieved in some sites.
- The regional Sentinel Sites tended to show wider variation in the average number of adult health assessments per GP between quarters than the urban sites.
- There was a wide variability in uptake of adult health assessments in remote Sentinel Sites.
- There was no evidence in remote sites of an increased number of claiming GPs. Changes appeared to be driven by changes in the number of adult health assessments completed per GP.

Overall differences by geographic location

Number of adult health assessments claimed per 100 people during the baseline period (March 2009 - February 2010) varied by geographic location. Higher rates were found in regional and remote locations compared to urban locations.

All locations, with the exception of remote Sentinel Sites, showed relatively steady increases in adult health assessment rates from the quarters of March - May 2010 to March - May 2012 (Figure 6.5, Appendix G, Table G2). Uptake of adult health assessments in urban locations increased from the March - May 2010 quarter, plateaued in the September - November 2010 quarter, and declined in the December 2010 - February 2011 quarter. Uptake of adult health assessments was slightly higher in the urban Sentinel Sites compared to the rest of urban Australia, but followed a similar pattern initially. However, since the March - May 2011 quarter there has been a substantially greater increase in uptake of the adult health assessment in urban Sentinel Sites compared to the rest of urban Australia (Figure 6.5).

Over the period of the evaluation, the number of GPs claiming adult health assessments per 100 people increased substantially in urban and regional locations. However there was little change in GP participation in remote locations. For both urban and regional Sentinel Sites, the increase in number of GPs claiming adult health assessments was greater than that observed for the rest of urban and regional Australia respectively (Appendix G, Tables G4 - G6, Figures G1 - G3). The number of GPs in remote locations claiming for adult health assessments was generally stable in both remote Sentinel Sites and the rest of remote Australia with an indication of a slightly increasing trend (Figure 6.5).

Trends in the average number of adult health assessments conducted per GP also varied by geographic location. The average number of adult health assessments per GP was greatest in remote locations followed by regional and then urban locations. The average number of adult health assessments per GP in remote Sentinel Sites and the rest of remote Australia increased overall, with indications of increased numbers of assessments per GP from around 8 per GP per quarter over the baseline period to an average of 10 per GP per quarter since March - May 2010. Data for the most recent three quarters of

the period covered by this report indicate that the increased levels seen over June - August 2010 to June - August 2011 may not be fully sustained (Figure 6.5).

Higher rates of adult health assessments per GP in remote locations is probably at least partly a result of smaller numbers of GPs per 100 Aboriginal and Torres Strait Islander people, with these GPs being more heavily involved in providing care to Aboriginal and Torres Strait Islander people (Appendix G, Tables G7 - G10, Figures G4 – G6).

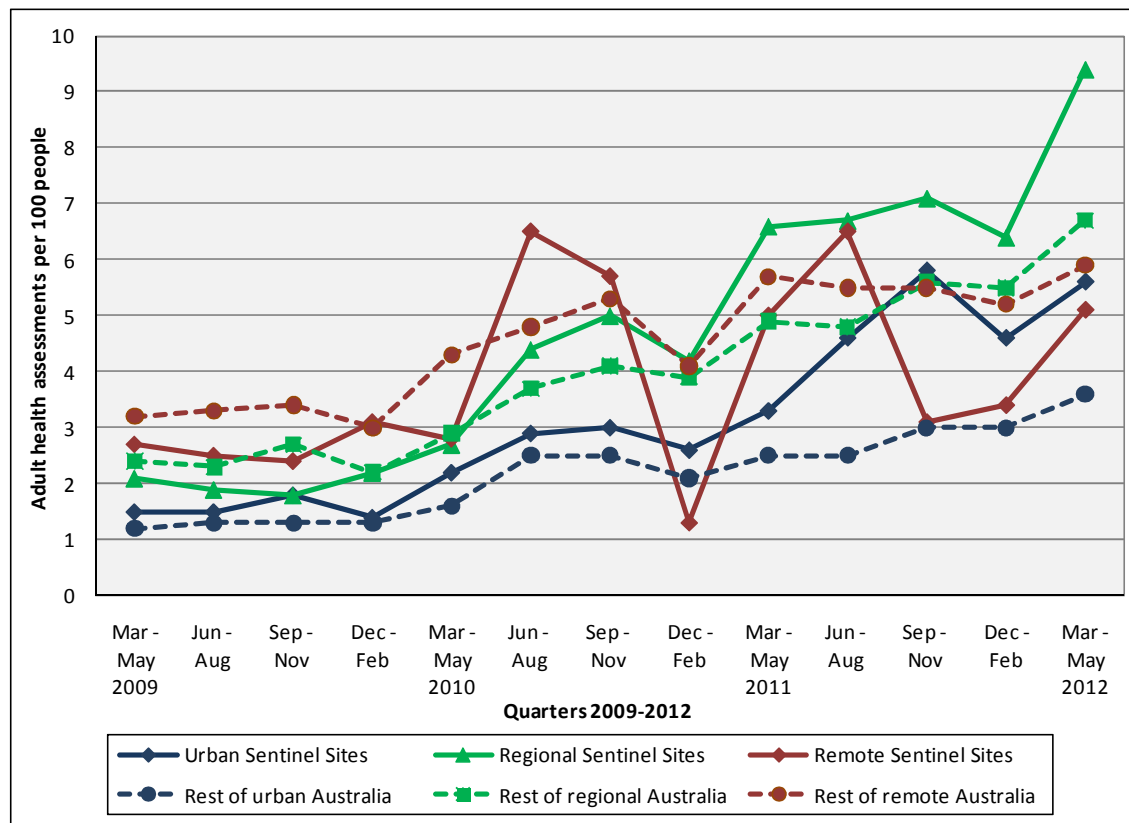


Figure 6.5 Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites and the rest of Australia, by quarter and rurality, March 2009 - May 2012

Patterns by urban, regional and remote locations are described in more detail below. Examining the variation in uptake of adult health assessments between the Sentinel Sites in more detail provides some insight into the enabling factors and barriers related to increasing adult health assessment uptake in different contexts.

Urban areas – illustrative patterns

The urban Sentinel Sites had fairly low uptake of health assessments and low GP participation at baseline, with between 0 and 4 adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people per quarter and 0 to 1.5 GPs claiming per 100 people per quarter (Figures 6.6 and 6.7 respectively).

By the end of the evaluation period, there was a wide variation in the number of adult health assessments claimed in different sites, with between 3 and 34 health assessments claimed per 100 and wide variation in the numbers of GPs claiming per 100 population, ranging from 0.5 to 4.6 per 100. The

average number of adult health assessments claimed per GP also varied widely in the different urban Sentinel Sites (Figure 6.8). None of the Sentinel Sites showed a clear trend of increase in the average number of adult health assessments per GP over the period of the evaluation. However in several sites, the average number of adult health assessments per GP was considerably higher than most other sites.

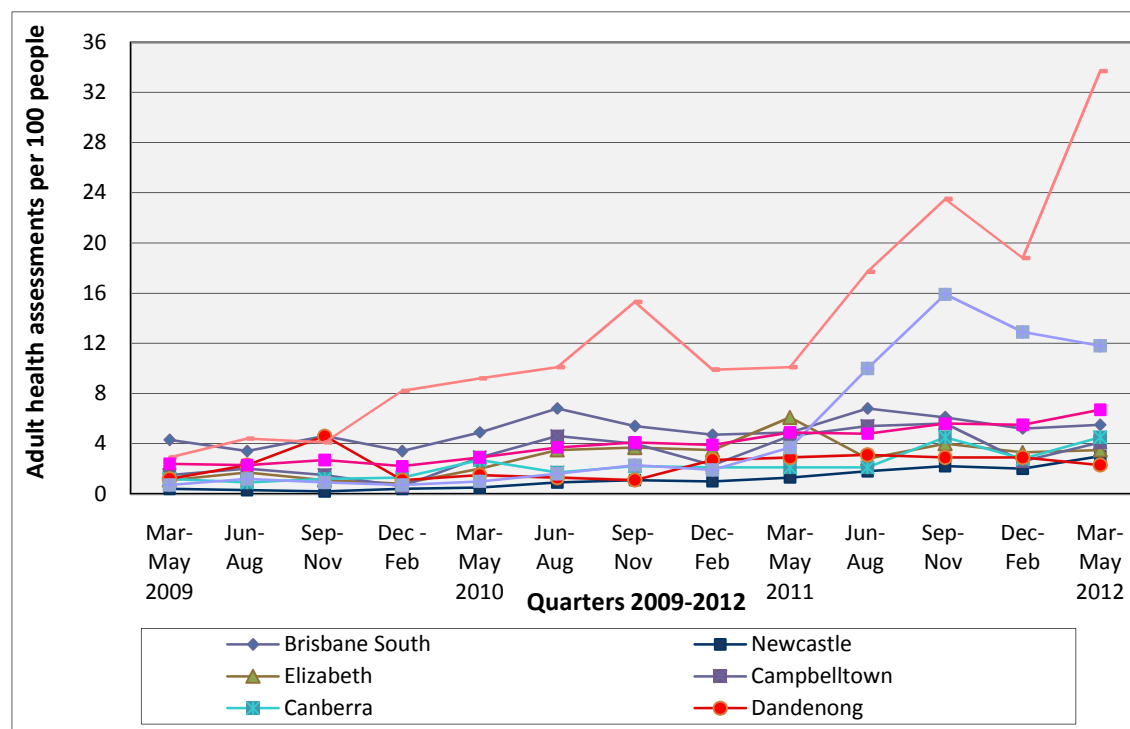


Figure 6.6: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in urban Sentinel Sites and the rest of urban Australia, by site and quarter, March 2009 - May 2012

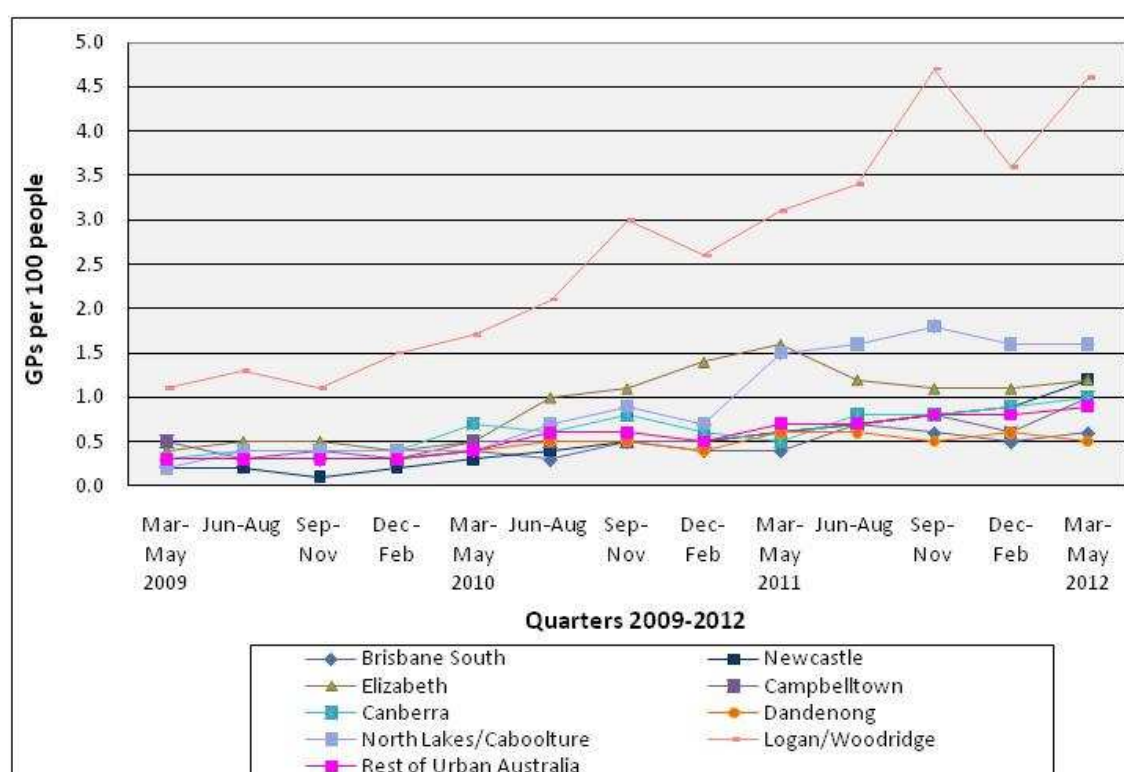


Figure 6.7: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for urban Sentinel Sites, by quarter, March 2009 - May 2012

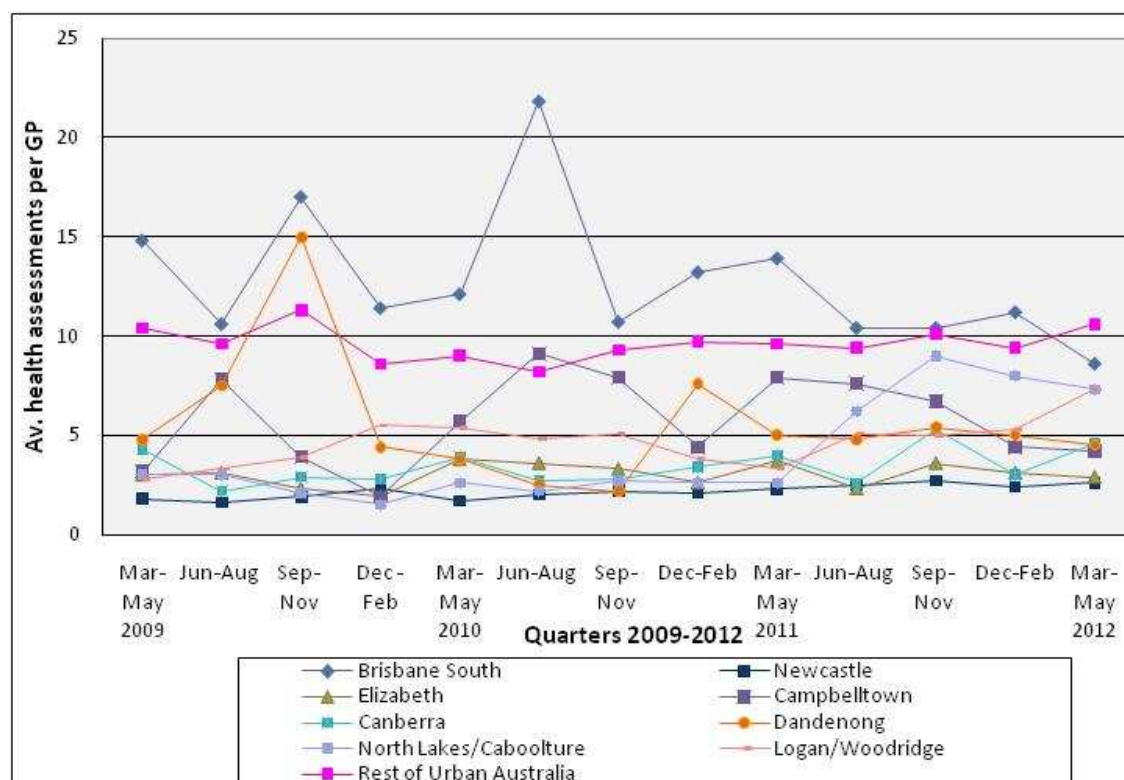


Figure 6.8: Average number of adult health assessments (MBS items 704, 706, 710 and to 1 May 2010 thereafter 715) claimed per GP in urban Sentinel Sites, by quarter, March 2009 - May 2012

There were two sites which stood out as having particularly high levels of adult health assessments and GP participation by the final evaluation cycle – Logan/Woodridge and North Lakes/Caboolture.

Logan/Woodridge showed the highest level of adult health assessments at baseline and showed the most marked increase over the evaluation period. Logan/Woodridge had a greater increase in the number of GPs claiming adult health assessments compared to other sites. Logan/Woodridge has achieved high uptake of adult health assessments through many GPs each doing a relatively small number of adult health assessments. In this site it was reported that in addition to there being an AHS, there were a number of larger General Practices (with established practice nurses) who were willing to engage in ICDP related activities, such as making the practice more culturally friendly and participation in the PIP Indigenous Health Incentive. This is reflected in the data showing Logan/Woodridge to have the highest number of PIP Indigenous Health Incentive patient registrations per 100 of the population (Chapter 7).

The increases in North Lakes/Caboolture have been driven by more GPs doing adult health assessments and an increase in the average number completed by individual GPs.

Note that the data for North Lakes/Caboolture (and to a lesser extent Logan/Woodridge) may have been disproportionately affected by undercounts in the census data, with potential for relatively large overestimates in uptake of MBS items.

Dandenong showed low numbers of adult health assessments per population and lower numbers of participating GPs (this site also showed low Health Service and patient participation in the PIP Indigenous Health Incentive per 100 population).

Brisbane South and Campbelltown had relatively low uptake of adult health assessments and low numbers of participating GPs relative to population. Brisbane South was the only Sentinel Site where the average number of adult health assessments conducted per GP exceeded levels for the rest of urban Australia. Campbelltown had the second highest number of adult health assessments per GP (after Brisbane South) over most of the ICDP implementation. A major constraint on increasing uptake in these sites therefore appears to be the relatively small number of GPs doing adult health assessments.

As illustrated above, factors identified as responsible for the ability of urban sites to demonstrate relatively higher uptake of the adult health assessment included: both AHS and General Practice involvement in providing adult health assessments and; increased numbers of GPs claiming for adult health assessments.

Regional areas – illustrative patterns

There was wide variation in trends in the different regional Sentinel Sites. Owing to the large number of regional sites, these figures are presented separately by site type (Figures 6.9 - 6.17).

In regional Sentinel Sites, the prevailing pattern was one of an increase in the number of GPs claiming adult health assessments per 100 people between the baseline period and the end of the period covered by this report, with some fluctuation and variation in timing of the increase in trends (Figures 6.12 - 6.14).

The regional Sentinel Sites in general showed low uptake of adult health assessments and low GP participation at baseline - the differences between sites were fairly similar to those observed in urban sites, with between 0 and 5 adult health assessments claimed per 100 Aboriginal and Torres Strait

Islander people per quarter and 0 to 0.5 GPs claiming per 100 people per quarter at baseline (Figures 6.9 - 6.11 and 6.12 - 6.14 respectively). By the end of the evaluation period, there was a wider variation in the number of adult health assessments claimed in different sites, with between 3.5 and 16 adult health assessments claimed per 100 per quarter and wide variation in the numbers of GPs claiming per 100 population per quarter, ranging from 0.7 to 1.6 per 100.

The average number of adult health assessments claimed per GP also varied widely in the different regional Sentinel Sites (Figures 6.15 – 6.17). None of the regional Sentinel Sites showed a clear trend of increase in the average number of adult health assessments per GP over the period of the evaluation.

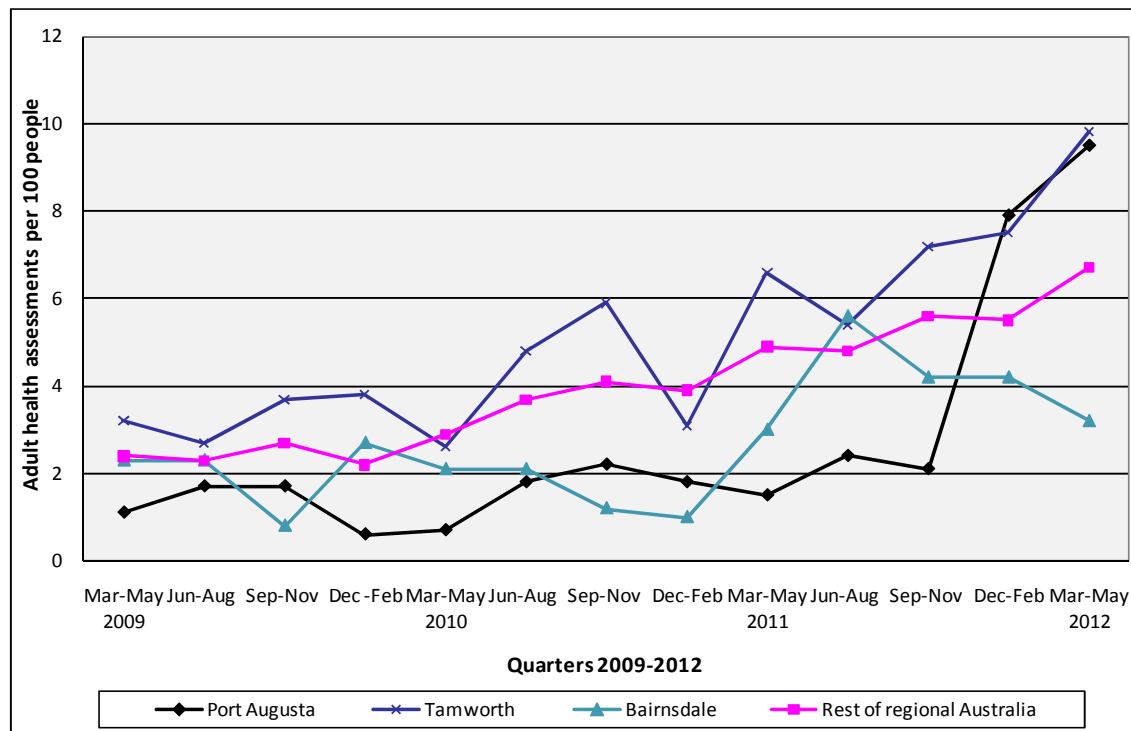


Figure 6.9: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in case study regional Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2012

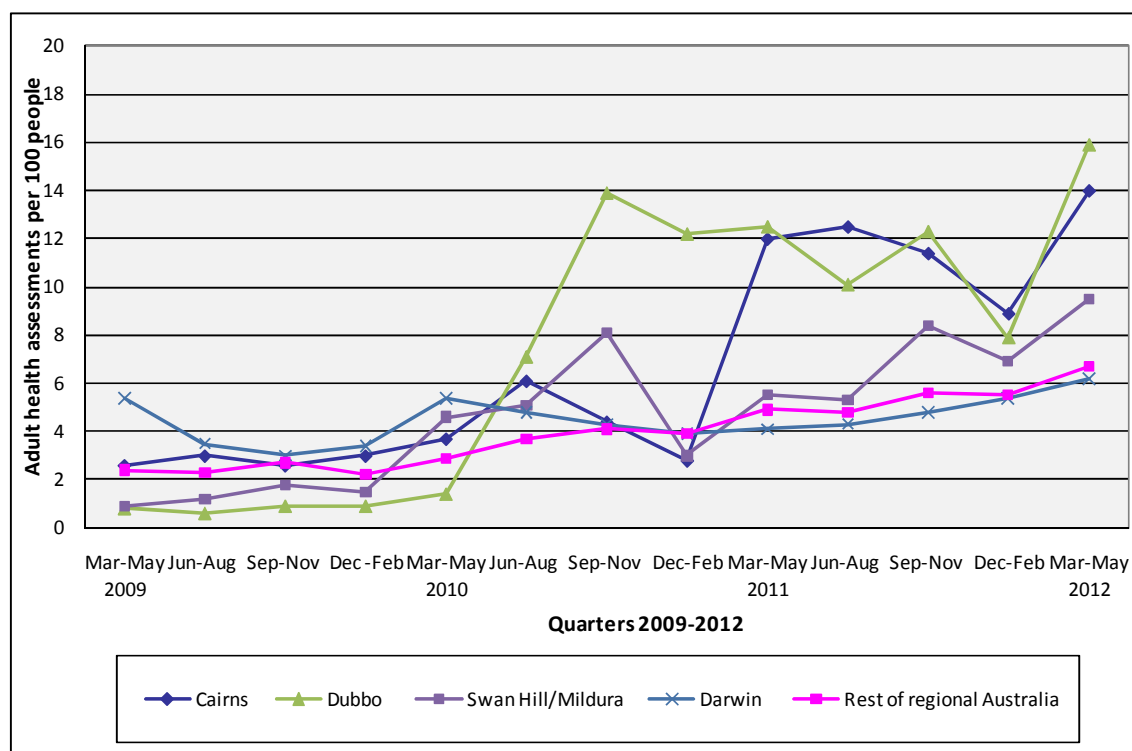


Figure 6.10: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in enhanced tracking regional Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2012

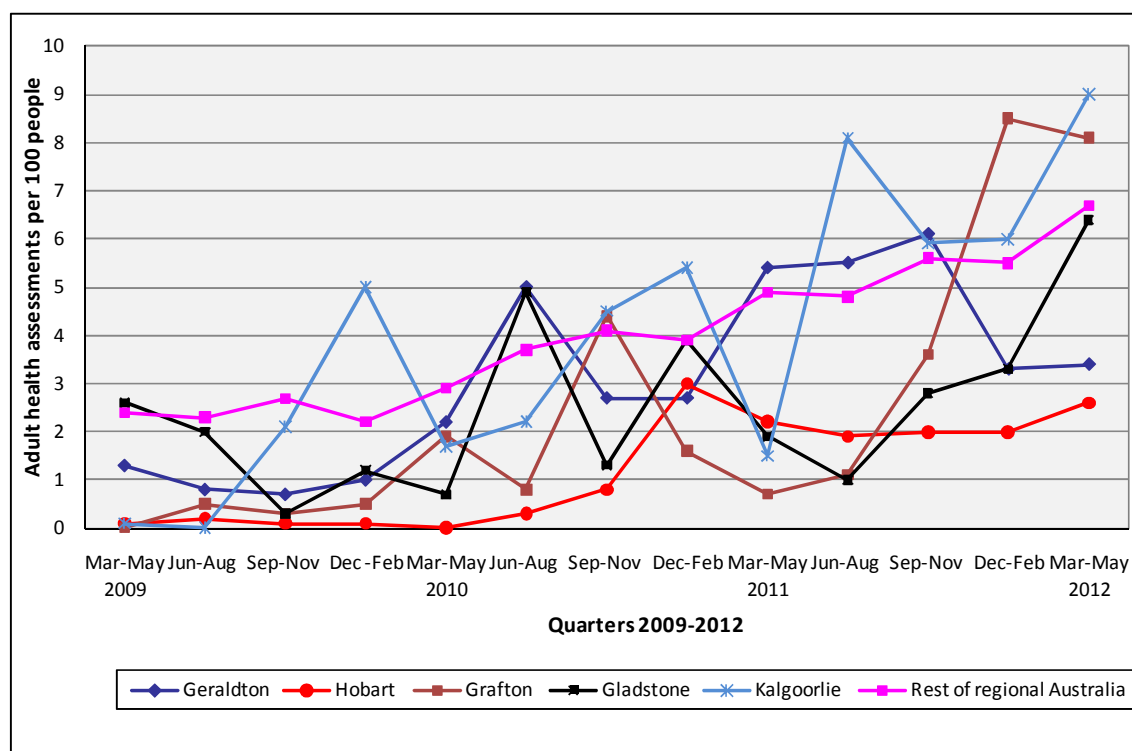


Figure 6.11: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in tracking regional Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2012

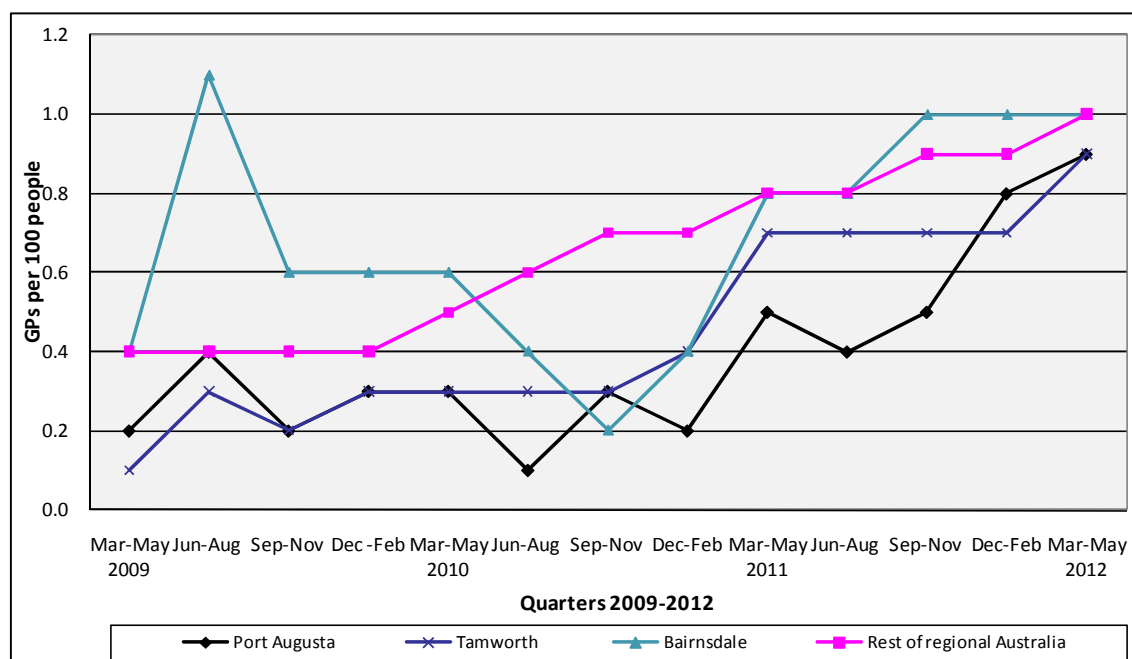


Figure 6.12: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for case study regional Sentinel Sites, by quarter, March 2009 - May 2012

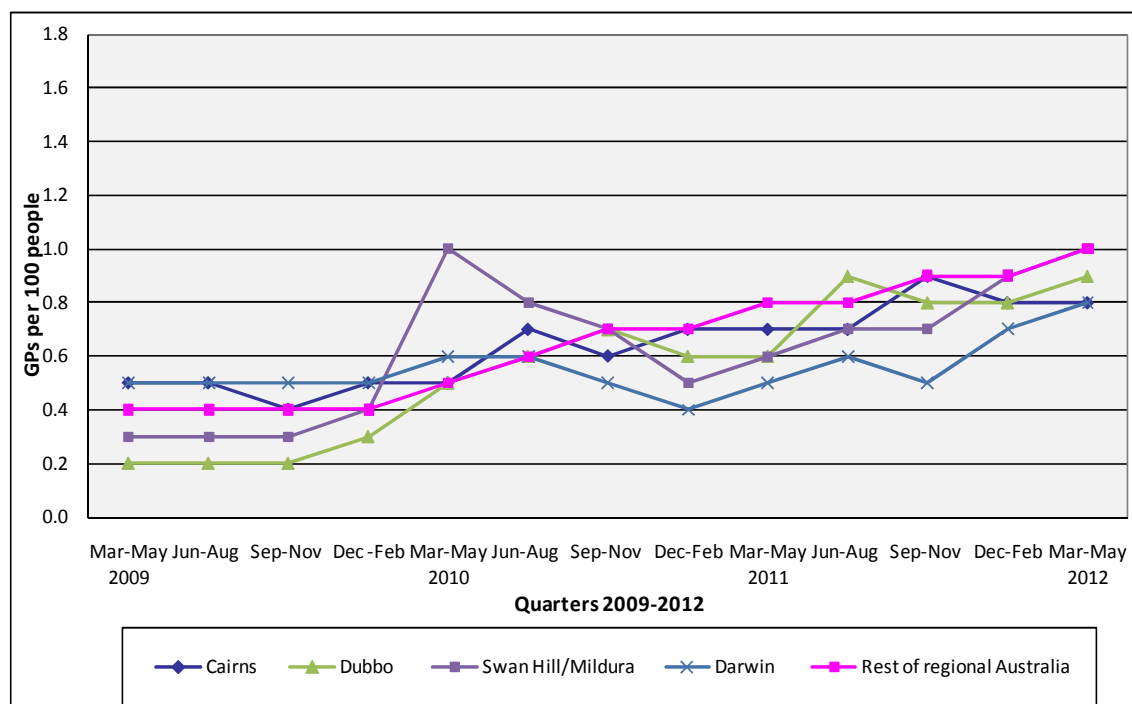


Figure 6.13: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for enhanced tracking regional Sentinel Sites, by quarter, March 2009 - May 2012

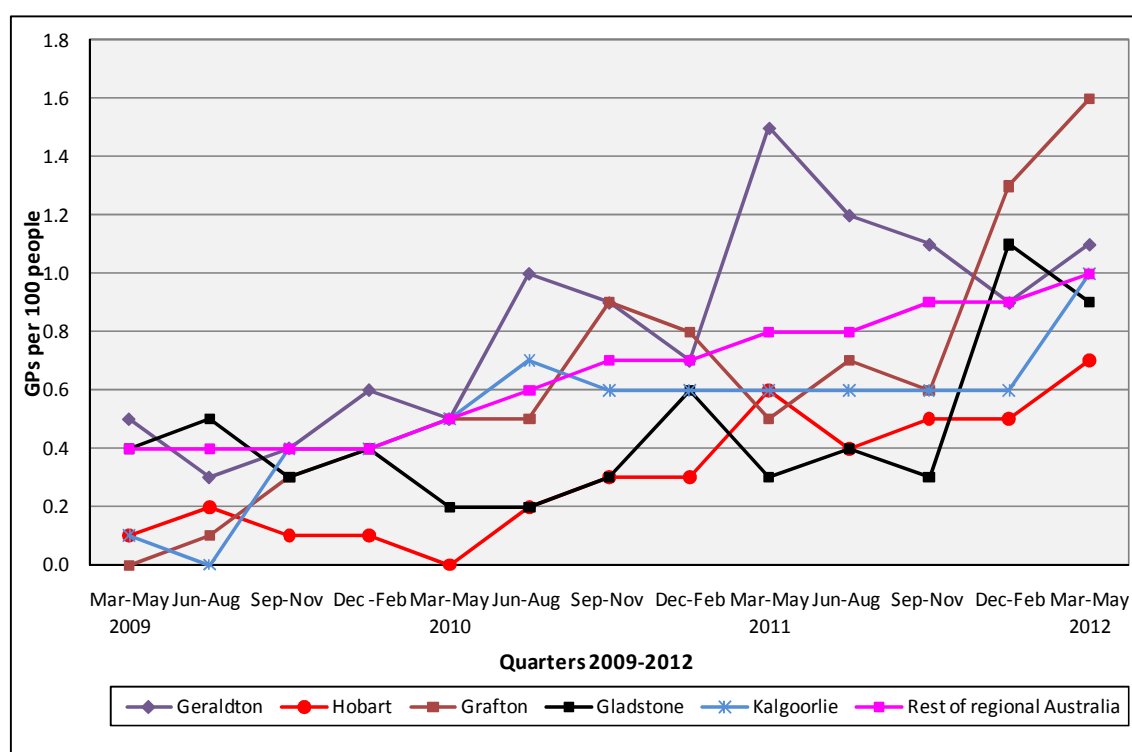


Figure 6.14: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for tracking regional Sentinel Sites, by quarter, March 2009 - May 2012

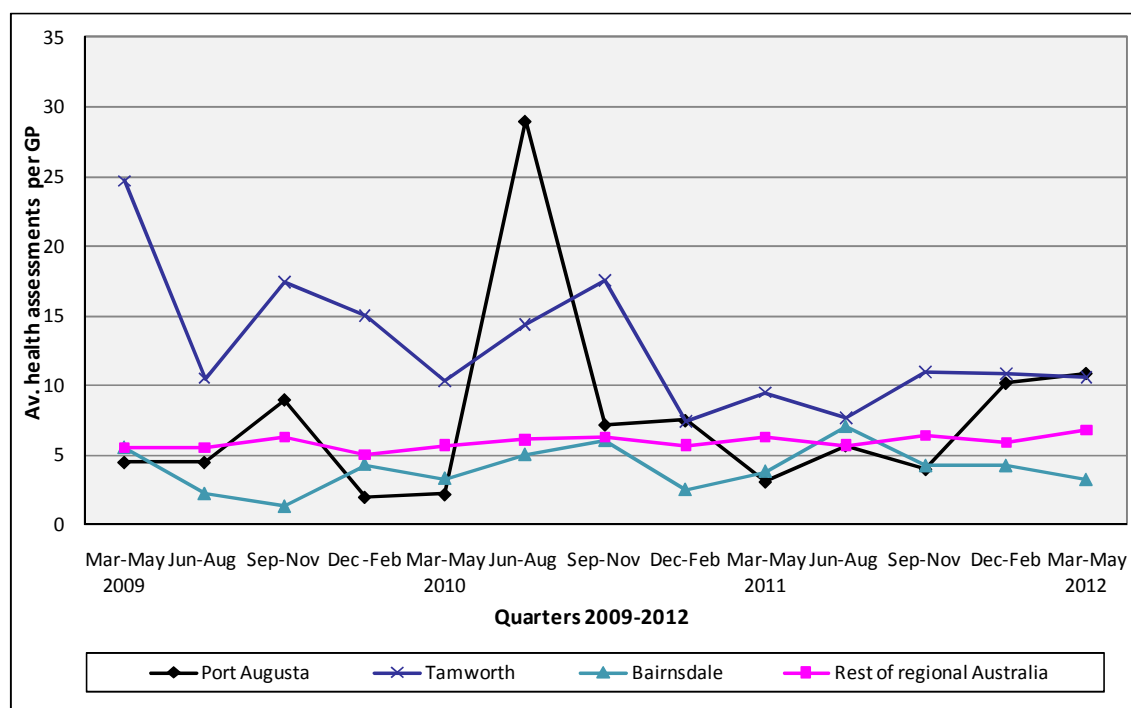


Figure 6.15: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP in case study regional Sentinel Sites, by quarter, March 2009 - May 2012

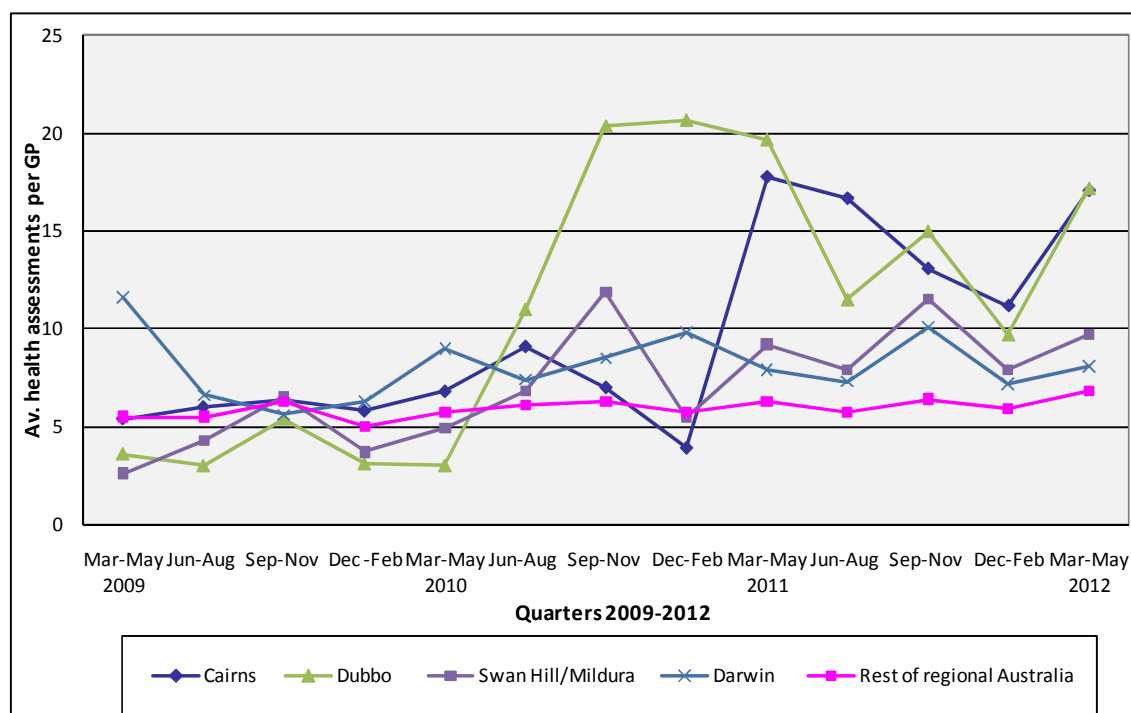


Figure 6.16: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP in enhanced tracking regional Sentinel Sites, by quarter, March 2009 - May 2012

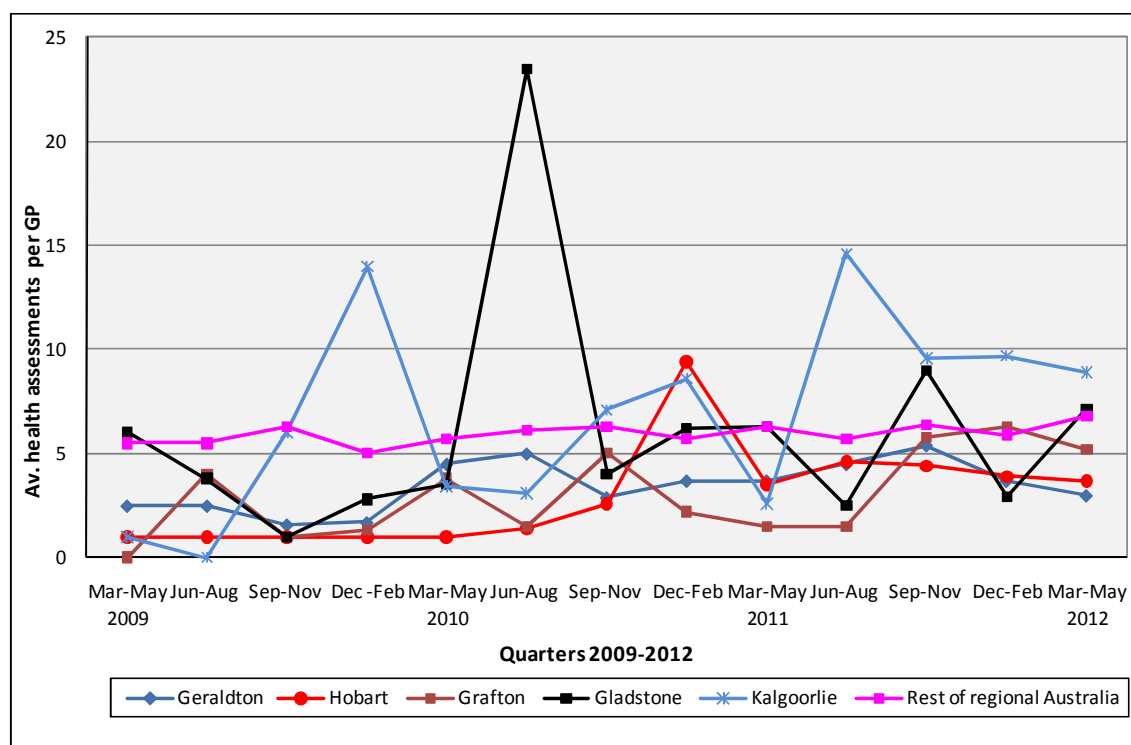


Figure 6.17: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP in tracking regional Sentinel Sites, by quarter, March 2009 - May 2012

Dubbo showed the highest overall number of adult health assessments per 100 people per quarter by the end of the evaluation period and an average of between 10 and about 20 adult health assessments per GP per 100 people over most of the period of ICDP implementation. As shown in Chapter 7, PIP Indigenous Health Incentive patient registrations also increased markedly in Dubbo between November 2010 and November 2011.

Cairns (along with Dubbo, Swan Hill/Mildura and Tamworth) also showed higher average rates of adult health assessments than the rest of regional Australia from March 2010 - May 2012. Cairns also showed high numbers of adult health per GP per quarter over the most recent three quarters of the period of evaluation.

There were relatively high rates of adult health assessments observed in Swan Hill/Mildura. This site also showed relatively high numbers of PIP Indigenous Health Incentive patient registrations during the same period.

The average number of adult health assessments per GP was very high in Tamworth in the baseline period (March 2009 - February 2010). High rates of adult health assessments continued throughout the implementation of the ICDP, although the level was not quite as high as in the baseline period.

Bairnsdale showed a decline in uptake of adult health assessments towards the end of the evaluation period. There were also decreased numbers of patients registered for the PIP Indigenous Health Incentive in this site over the same period.

For some sites showing spikes in numbers of health assessments in various quarters, external complementary initiatives were identified by interviewees as being responsible for some of these periods of high delivery. For example, in Darwin, some of the spikes in adult health assessments were reported to be due to the Expanding Health Service Delivery Initiative (EHSDI) in the NT, which provided increased resources for conducting child health checks during these periods, with flow on effects for adult health assessments.

Remote areas – illustrative patterns

The remote Sentinel Sites showed considerable differences in uptake of adult health assessments, GP participation and average number of adult health assessments per GP at baseline, with between 0 and 9 adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people per quarter and 0.1 to 0.7 GPs claiming per 100 people per quarter and 3 to 12 adult health assessments per GP per quarter (Figures 6.18–6.20).

Over the evaluation period, uptake of adult health assessments and number of GPs claiming for adult health assessments in the remote sites showed patterns of spikes and dips over time. Two of the sites showed an overall increasing trend in adult health assessments per population (Derby and East Pilbara). For Derby, this was associated with an overall increasing trend in number of GPs claiming for adult health assessments, and for East Pilbara, with an increase in the average number of adult health assessments claimed per GP. The remaining sites showed little change between baseline and the final evaluation cycle for adult health assessments, GP participation and average number of adult health assessments per GP (Figures 6.18–6.20). In particular, unlike for urban and regional sites, there was on average very little change in the number of GPs claiming adult health assessments in remote Sentinel Sites over the period covered by this report (Figure 6.19).

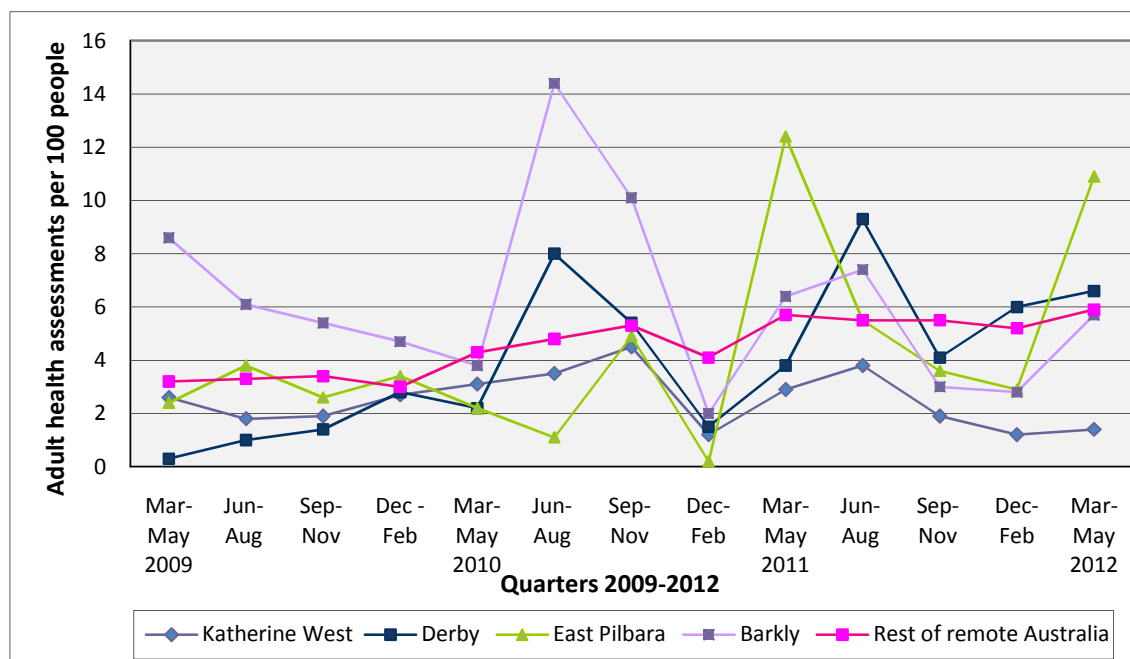


Figure 6.18: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years in remote Sentinel Sites and the rest of remote Australia, by site and quarter, March 2009 - May 2012

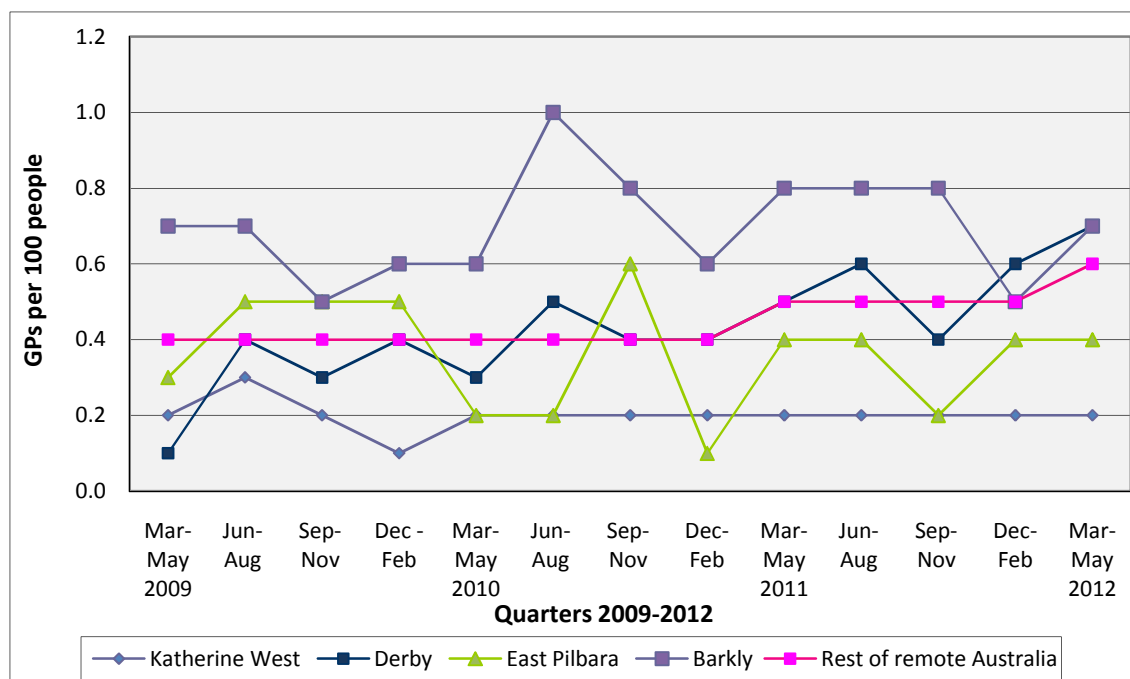


Figure 6.19: Number of GPs who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for remote Sentinel Sites, by quarter, March 2009 - May 2012

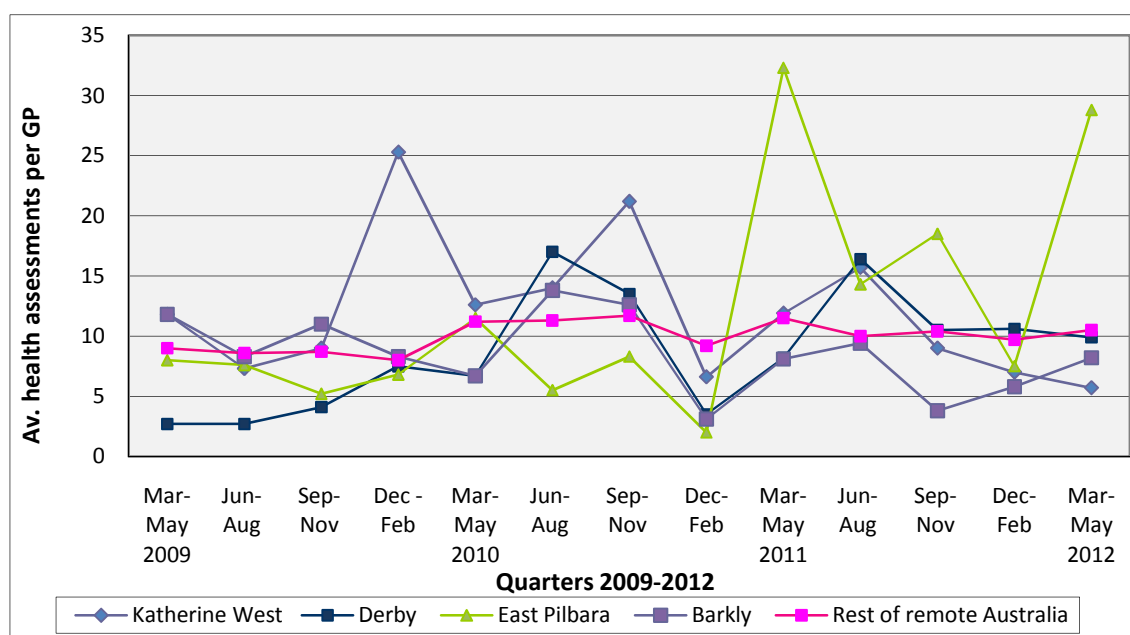


Figure 6.20: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP in remote Sentinel Sites, by quarter, March 2009 - May 2012

For all of the remote Sentinel Sites (and the rest of remote Australia), the decline in adult health assessments, GP participation and number of assessments per GP over the December 2010 - February 2011 quarter (and the December 2011 - February 2012 quarter for adult health assessments) was likely to be related to holidays and extreme weather events during this quarter. During this period staffing constraints were generally more acute, there was a greater use of locums and/or minimal staffing whilst staff took leave. Further, similar to the regional sites, external complementary interventions were sometimes noted to be responsible for the spikes in delivery of adult health assessments – for example, this was the case in Barkly where interviewees indicated that the spikes in the adult health assessments in the March - May 2009 and June - August 2010 coincide with periods of focus on undertaking adult health assessments by the NT intervention teams at the site.

East Pilbara, as one of the two sites that showed an overall increasing trend in adult health assessments per population (the other site being Derby), also showed an increase in the average number of adult health assessments claimed per GP, and was one of the two sites (along with Katherine West) in which the average number of adult health assessments per GP was generally above the level for the rest of remote Australia. Around the same time, PIP Indigenous Health Incentive registrations also peaked.

In Derby, the increased number of adult health assessments was driven by increased numbers of GPs billing adult health assessments (rather than increased adult health assessments per GP). In contrast to the increase in adult health assessments in Derby, this site showed decreased numbers of patients registered for the PIP Indigenous Health Incentive over the latter part of the evaluation, with lower levels of registration at the end of November 2011 compared to the previous year; by May 2012, there were no registrations in Derby.

Katherine West showed consistently low uptake of adult health assessments. However Katherine West was one of the two sites in which the average number of adult health assessments per GP was generally above the level for the rest of remote Australia (the other site with higher average number of adult health assessments per GP being the East Pilbara, discussed above). This suggests that there were insufficient numbers of GPs conducting adult health assessments in Katherine West. Katherine West did

not register any patients for the PIP Indigenous Health Incentive over the period covered by the evaluation.

The contrasting patterns between the four remote sites described above highlight the variation in the extent to which services in different sites engaged with different parts of the ICDP.

6.3.3. STRATEGIES TO INCREASE UPTAKE OF ADULT HEALTH ASSESSMENTS

KEY POINTS

- A range of strategies to increase uptake of adult health assessments were evident in Sentinel Sites; the imperative to increase Medicare revenue was a key driver across all of the strategies.
- Strategies were identified at local (Health Service level) and at regional or meso-level:
 - At Health Service level, Health Services described allocating dedicated time of GPs to complete adult health assessments; allocating time of other staff to commence adult health assessments, which could then be completed by GPs; changing systems to enable staggered completion of adult health assessments; alignment of clinical information and other systems to support optimal Medicare billing; and strategies to incentivise or motivate patients to undergo adult health assessments.
 - At regional level, DGPs, Medicare Locals and regional support organisations were engaged in employing and seconding staff to support uptake; providing or commencing adult health assessments directly; providing information; and providing organisational support to Health Services to maximise revenue and improve or expand service delivery.

Strategies adopted by Health Services

Dedicated time of GPs, nursing staff and Aboriginal Health Workers

Some Health Services had a policy of dedicated time set aside for adult health assessments. This was usually time of GPs, but sometimes included dedicated time for nursing staff or AHWs to do preparatory work for adult health assessments. This strategy was evident in some of the urban and regional sites showing high uptake of adult health assessments and increased number of GPs conducting adult health assessments. This strategy was evident in both AHSs and General Practices. Health Services implementing this strategy tended to have an organisational focus on optimising Medicare funding to strengthen service delivery.

Dedicating time of GPs and/or allocating time of other staff to complete adult health assessments was found to be most workable in situations where there were large numbers of Aboriginal and Torres Strait Islander patients, or where Aboriginal and Torres Strait Islander patients were in any case attending the Health Services more regularly.

In several Sentinel Sites, General Practices had set up their own dedicated Aboriginal health clinics as a way to increase uptake of adult health assessments (and also in some cases to increase care planning). Some interviewees noted that the money generated through the adult health assessment revenue, and the PIP Indigenous Health Incentive, had been used to employ nurses or AHWs, whose time was less easily covered by Medicare billing. Some of these General Practices had established links with ICDP funded Outreach Workers and Care Coordinators to support the Aboriginal health clinic. Some of these clinics had been discontinued due to poor patient attendance (for a variety of reasons).

Adult health assessments were noted to be a fairly significant income stream for many AHSs, allowing them to expand GP capacity, which created potential to increase revenue further, creating a positive feedback loop. The same situation was evident for some of the larger General Practices that had large numbers of Aboriginal and Torres Strait Islander patients accessing or with potential to access their services. This was not the case for small General Practices (who tended to have fewer resources for preventive care) or for those with small numbers of Aboriginal and Torres Strait Islander patients.

Changed systems to enable staggered completion

Strengthening systems to enable completion of the adult health assessment over a number of visits was adopted as a strategy to increase delivery of adult health assessments in one urban and one regional Sentinel Site. Staggered completion of the adult health assessment was believed to be beneficial to patients as they did not have to attend the service for the length of time required to complete the adult health assessment in one consultation (estimated to take 45 minutes to an hour). This involved setting up a good record keeping system that tracked the delivery of individual items required by the adult health assessment over subsequent visits, and was only possible in Health Services that had strong emphasis on efficient delivery system design and effective use of clinical information systems, supported by strong leadership. The generally poor state of development of the clinical information systems in the majority of Health Services (Appendix E) constrained more widespread use of this approach.

'As there are quite a few areas to cover in the health check we have developed an electronic template that can be partly filled in and is cumulative. We don't have to do the whole form today in one mad hit, but every time they come in the data is put into the computer system and if it is appropriate to the health check template it gets put into template. So height, weight, smoking status, family history, last pap smear, eyesight, dental - any of those examinations auto fill the template. You then get to the stage where the template is full even if we don't tie patient down for an hour and do one big giant health check – so over a few visits we will build up enough body of knowledge to claim a health check. Its working a charm.' (AHS, GP)

Use of the Medicare enquiry line and conducting adult health assessments 'just-in-case'

Some Health Services reported that they use the Medicare enquiry line to find out if an adult health assessment is still outstanding for particular patients when they present at the service, whereas other service providers stated that they find it more efficient to conduct the adult health assessments opportunistically, recognising that a proportion of their claims will be rejected. This is clearly sub-optimal, and represents inefficient use of time and resources for the patient and the service, with potential for dissatisfaction, frustration and disengagement.

The reasons underlying the adoption of the 'just-in-case' strategy included unfamiliarity with or difficulty accessing the required information from the Medicare enquiry line; inadequacy of the Health Service information system (sometimes it was reported that adult health assessments had been re-done, as they had not been properly recorded or the clinical information system was unable to retrieve the information when required); and adult health assessments being done by non-regular providers, without communication of the service delivery back to the regular service provider.

Creation of community demand and use of patient incentives

Interviewees and community focus groups across the evaluation period indicated that the access to free and/or subsidised medications through the PBS Co-payment measure acted as the 'carrot' for patients to sign up for the PIP Indigenous Health Incentive. Once registered for PBS (once-off sign up), there may be minimal incentive for patients to re-register as part of the PIP Indigenous Health Incentive (and relatively limited incentive to repeat the adult health assessment in subsequent years). There were

attempts reported by some Health Services to have patients undertake or book in for an adult health assessment at the time of signing on for PIP Indigenous Health Incentive. There were also indications, especially later in the evaluation period, that Health Services were directly incentivising adult health assessments through, for example, promotional material, t-shirts, water bottles and 'lucky draws'.

While some of these strategies may have worked for some individual services, the composite figures (Appendix B) that display the uptake of all administrative data items at a site level do not provide evidence that they were having an impact at a site level.

The following Vignette illustrates how a range of different strategies was used in a Health Service to increase uptake of adult health assessments.

Vignette – Successful use of adult health assessments to expand service delivery

A regional AHS, funded by DoHA for a single GP, has successfully used money available through Medicare billing for adult health assessments to expand local service delivery and their GP staff complement, using a combination of strategies.

Members of the AHW team, who know the community well, identify community members who may benefit from an adult health assessment, and encourage them to attend for this service item.

The nursing staff are responsible for most of the preparatory work for the adult health assessments, and commence with those individual items that do not require a GP - they have time set aside for this role. Each GP employed in the service also has time set aside for adult health assessments, averaging half a day per week, per GP. The service is also utilising advanced term registrars, who need minimal supervision, to focus on care planning and adult health assessments.

GPs are supportive of adult health assessments, as they recognise the value to patients in being able to access additional referral entitlements through Medicare following an adult health assessment.

The practice manager spends time with GPs to ensure they are aware of the Medicare items that can be billed and the appropriate item numbers. Modifications to the clinical information system require GPs to enter the Medicare item numbers into the information system so administrative staff can complete Medicare claims correctly. This is helping to create a culture of GPs taking responsibility for ensuring that their services are able to be billed to Medicare. The practice manager oversees billing to ensure billing opportunities are being used appropriately. This is seen to be an improvement on a previous system, whereby any gaps in communication between GPs and administrative staff regarding what to bill, meant that billing opportunities were sometimes missed.

Additional outreach activities are held periodically, such as health check days and child health assessments conducted in schools. Staff of non ICDP funded programs such as 'Healthy for Life' are used to optimise these opportunities and increase the number of health assessments.

Largely through the success of these strategies, the AHS has been able to expand its complement of GPs, creating a positive feedback loop. Future plans include employing a chronic disease nurse to do further health assessments and manage the TCA and GPMP processes – at the time of the final evaluation visit, the clinic team had prepared the business case for board consideration in support of this new position.

Strategies originating at meso- or regional level

At the meso- or regional level, the work of DGPs, Medicare Locals and regional umbrella organisations (such as the Institute for Urban Indigenous Health) appeared to be key influences on patterns of uptake of adult health assessments in several of the Sentinel Sites. For a number of years preceding the ICDP, national performance indicators for DGPs have included the number of Aboriginal and Torres Strait Islander health assessments completed, and DGPs have been required to report on activities aimed at increasing adult health assessments.⁸⁴ As part of the ICDP (Chapter 4) NACCHO affiliates and SBOs were funded to undertake projects to promote increased uptake of adult health assessments and follow-up items. There were also a number of initiatives from state-wide organisations (such as 'Healthy Heroes' funded through a NACCHO state affiliate – not ICDP specific funding) that offered materials such as t-shirts and 'pamper packs' to people who completed adult health assessments.

There was no clear evidence from the Sentinel Sites of the impact of these approaches at the site level. However, concerns were expressed by some stakeholders that these types of strategies did not consistently provide adequate links between patients and regular primary care service providers, and that follow-up care may be limited.

Provision and distribution of information

DGPs were engaged in promoting awareness of the Aboriginal and Torres Strait Islander specific MBS item numbers amongst GPs and communities through the work of IHPOs, OWs and Care Coordinators. These workers were at times linked to existing practice support teams. Specific activities included practice visits, working with practice support teams based within DGPs to develop 'cheat sheets' showing Medicare billing possibilities, development and/or dissemination of paper based and electronic adult health assessment templates to load onto GPs' information systems (Chapters 8, 13 & 14).

One example of work of a meso- or regional organisation in supporting uptake of the adult health assessments is described in the Vignette below. The Vignette also illustrates how this DGP took a lead role in developing promotional material around adult health assessments, and highlights roles undertaken by the ICDP workforce in relation to increasing uptake of adult health assessments – this aspect is outlined in the following sub-section considering the influence of the other ICDP measures.

Employment and secondment of staff

In addition to the roles of IHPOs and OWs in promoting uptake of adult health assessments, in at least one Sentinel Site a nurse was employed by the DGP or Medicare Local (not ICDP funded), and placed in the AHS to support the delivery of adult health assessments.

Direct involvement in service delivery

In one site, the staff at the DGP commenced doing part of the adult health assessment in community settings and at schools and then sending these to GPs (either General Practice or AHS GPs, depending on patients regular care provider) to complete. There were reports of similar situations where the AHS commenced adult health assessments and then referred the patients to their regular General Practice. These strategies were not always well received by staff of the regular service provider for the patients, whether AHS or General Practice, indicating inadequate consultation regarding this strategy.

⁸⁴ Katterl R, Moretti C, Kalucy E, Reinfeldt Kirkman N. (2010). Divisions Performance Indicator Report 2008-2009: Aboriginal and Torres Strait Islander Health Checks and Assessments. Adelaide: Primary Health Care Research & Information Service.

Vignette – A regional organisation uses a range of strategies to support Health Services in implementing adult health assessments

A DGP in an urban area has instituted a strategy to increase the uptake of adult health assessments, working primarily with General Practice. During the period of the evaluation, the DGP transitioned to a Medicare Local, which took over the activities.

The DGP used data on the uptake of the MBS item 715 in their area (which was low), as a way to motivate for greater attention to adult health assessments in General Practice. Funding (non-ICDP) previously provided to the DGP to increase uptake of adult health assessments had been used to obtain (or analyse) these data. DGP staff reported that, partly through advocacy using these data, there had been general organisational support within the DGP for improving uptake of adult health assessments. This was seen by the DGP staff to have provided a supportive environment for the work of the DGP-based IHPO and OW, who commenced employment subsequent to these foundational activities.

The IHPO and OW worked with the practice support teams to source electronic templates for the MBS 715 and loaded them onto GPs' clinical information systems.

The DGP/Medicare Local worked to create community demand for health assessments through developing promotional resources – the pamphlet 'MBS 715 it's great to be alive' was distributed extensively at community events.

Starting with a small number of practices, the IHPO and OW provided support in helping practices identify Aboriginal patients appropriately. In particular, GPs were guided to ask about Aboriginal and Torres Strait Islander identity within the consultation, as having this information requested at reception desks may have compromised a sense of privacy for some people, and made it seem relatively impersonal and more of an administrative concern than a health issue.

'If it is done at front counter it is more about geographical data such as your phone number and your address. If the GP does it patients report they feel safer and it also embeds the question in a health context.'

These strategies, largely focused on General Practice, were reported by the DGP staff as having led to an increase in the number of General Practices claiming for adult health assessments, and greater population coverage of adult health assessments in this urban site. However, analysis of the administrative data for this site provides little or no evidence to support the claims regarding the success of the process reported by the DGP staff.

Organisational support to Health Services

There is a history of support being provided, largely through DGPs, to Health Services to re-orientate their systems and organisations to support uptake of adult health assessments and follow-up. These strategies have generally shown limited success in relation to increasing uptake of adult health assessment for Aboriginal and Torres Strait Islander people.⁸⁵

The work of the IUIH provides an example of how ICDP-related funding has been used to enhance uptake of adult health assessments through providing organisational support in the AHS sector. The

⁸⁵ Urbis, ICDP Monitoring and Evaluation Framework, Vol 1, September 2010.

IUIH has developed a model of support for AHSs in their region that aims to change service delivery models to maximise revenue and reorientate patient flow to allow Health Services to have dedicated staffing time for adult health assessments and care planning.

'It's all about developing a business minded model of care that maximises the Medicare opportunities. The Institute is looking at how we can assist services to develop their business model – this may sometimes involve bringing a whole team in to up-skill the staff and develop systems. It's about looking at what the right mix of staff is for a particular service.' (AHS, GP)

There have been marked increases in uptake of adult health assessments in the two Sentinel Sites where the IUIH has been active over the period covered by the SSE. While not conclusive, this provides supportive evidence regarding the impact of the model used by the IUIH.

In contrast, an example in which there is a lack of system support and leadership in relation to adult health assessments and ICDP implementation is shown in the Vignette below. This Vignette illustrates the kinds of problems that can arise at local level when leadership and system support are lacking.

Vignette – Lack of leadership leading to duplication and frustration in delivery of adult health assessments

In one AHS, the adult health assessment delivery efforts of a motivated 'Healthy for Life' funded nurse and AHW are subject to changes in the whims and preferences of individual GPs working at the service, resulting in erratic outcomes.

The nurse and AHW conduct preparation for adult health assessments. Some GPs accept preparatory work, whereas others will re-do basic measures in the belief they may not have been done correctly.

'The doctor will re-do everything once the RN [registered nurse] and AHW have done the full health assessment. The patients are chronic disease patients that come in regularly and we probably know these patients better than the GP.'

Different GPs have different standards when completing and signing off on the adult health assessments – for example, some insist on a fasting bloods test, which is believed by the nurse and AHW (and some other GPs) to be unrealistic due to difficulties getting patients to return for this purpose.

Different GPs bill Medicare differently - some use incorrect item numbers, despite support from the nurse.

'We have different doctors that are happy to sign off on that item number. We have six doctors at the moment but we have three now that won't do it. ... the nurse writes what they are to claim but still they don't do it.'

There has been some reluctance expressed about Medicare billing by GPs, particularly GP registrars. Some believe that because they are salaried, it is not correct for them to bill Medicare – they are not at the service to 'make money'.

Within the clinical information system, staff record service delivery in different ways, making it difficult to ascertain who has received adult health assessments and who has not, and complicating follow-up. At times the nurse will liaise with reception staff to ensure correct Medicare billing, but GPs do not always record health assessment completion in the clinical information system, resulting in

inconsistencies between the clinical information system and Medicare claiming records.

The nurse and AHW take an active role in follow-up, including weekly chronic disease clinics and preparation of GPMPs and TCAs. However, lack of access to accurate information constrains follow-up efforts.

6.3.4. FOLLOW-UP SERVICES BY PRACTICE NURSES AND REGISTERED ABORIGINAL HEALTH WORKERS

KEY POINTS

- Uptake of follow-up services by practice nurses and registered AHWs increased over the evaluation period, but the number of claims was low over the duration of the SSE, especially considering that up to ten follow-up items could be claimed following an adult health assessment.
- Uptake of follow-up services by practice nurses and registered AHWs following an adult health assessment in all Sentinel Sites taken together increased more than 27-fold between the baseline and final evaluation period - from an average of 43 items claimed per quarter over the baseline period for the evaluation to 1162 items claimed in the final quarter of the evaluation period.
- Comparable data from the rest of Australia showed an approximate ten-fold increase over the evaluation period. This smaller increase in the rest of Australia is partially explained by the relatively smaller increase in the number of adult health assessments in the rest of Australia compared to Sentinel Sites.
- Relatively few claims for this item were made in urban locations compared to regional and remote locations, with steady increases in the number of claims over the evaluation period in the rest of urban, regional and remote Australia, and in urban and regional Sentinel Sites. The data for remote sites were more variable over time.
- Increases in uptake of follow-up services for males lagged behind that for females in the rest of Australia, but not in the Sentinel Sites. This difference is consistent with lower service utilisation in general for men.

Number of claims for follow-up services in relation to adult health assessments

The data below show the absolute numbers of claims for follow-up services. Because these item numbers cannot be claimed without prior delivery of a health assessment we also report the numbers expressed per 100 adult health assessments conducted. Since November 2009, up to 10 follow-up items could be claimed annually following an adult health assessment. Prior to November 2009, up to five items could be claimed.

Table 6.2 shows trends in numbers of claims for follow-up by a practice nurse or an AHW for Sentinel Sites and the rest of Australia. Figure 6.21 shows the numbers of claims for follow-up by a practice nurse or an AHW, expressed as a proportion of adult health assessments.

As indicated, at baseline there were approximately 5 claims per 100 adult health assessments, in both the Sentinel Sites and the rest of Australia. Over the period of the evaluation, this increased to 15-20

claims per 100 adult health assessments in Sentinel Sites, approximately half the 30-40 claims per 100 adult health assessments in the rest of Australia (Figure 6.21).

While there was an increase in claims over the period of evaluation, uptake of these items was low overall especially considering that up to 10 follow-up services could be claimed per adult health assessment.

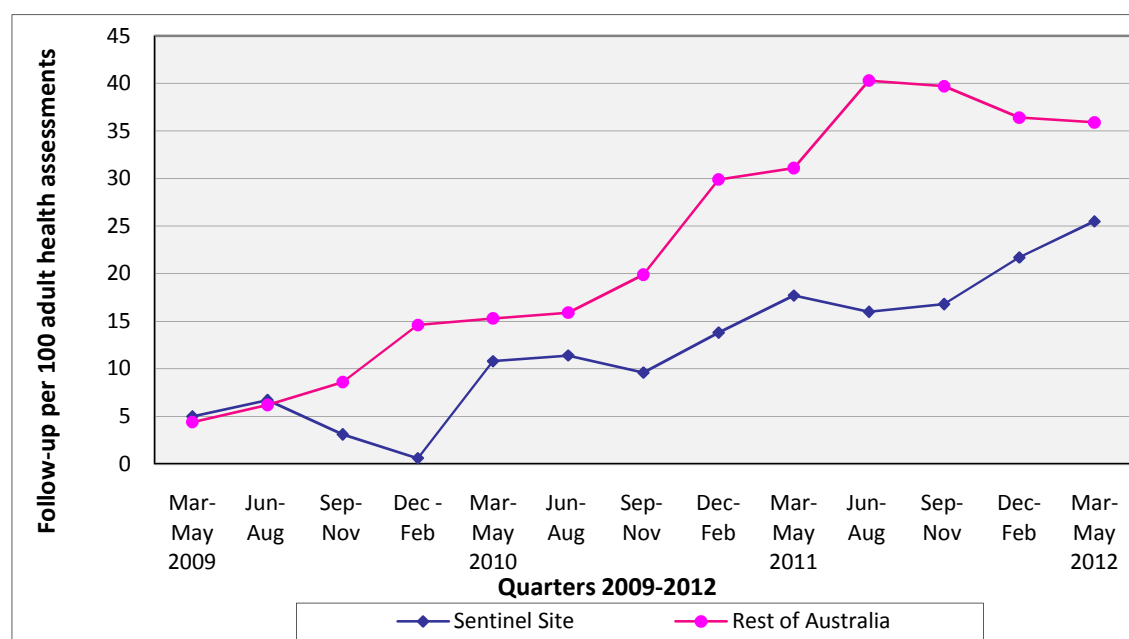


Figure 6.21: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Table 6.2: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker to Aboriginal and Torres Strait Islander people aged ≥15 years who received an adult health assessment (MBS items 10987), in Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Sentinel Sites/ Rest of Australia	Follow-up items claimed												
	2009				2010				2011				2012
	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May
Sentinel Sites	57	72	34	7	161	278	246	258	535	570	582	702	1162
Rest of Australia	244	338	511	749	1102	1416	1925	2407	3224	4072	4429	4264	5088

The Vignette below illustrates challenges faced by some Health Services in developing effective follow-up care – and implies that for some Health Services at least, the low uptake of follow-up items indicates difficulties following up patients likely to benefit from these services. This is clearly a concern, as without required follow-up, adult health assessments would be having limited effectiveness (if any) in improving prevention and management of chronic conditions.

Although the Vignette describes challenges to follow-up in a remote setting, there were no indications that follow-up in urban or regional locations was more straight forward – as shown below, uptake of follow-up items per 100 adult health assessments was lower in urban locations than in remote locations.

Vignette - Practical challenges to recalling patients for follow-up care

The AHS in one remote site needs to address a number of practical challenges in order to provide the patients and communities it serves with adequate follow-up care services.

Traditional culture is generally strong in the small, dispersed communities in which the AHS provides an outreach service. While two of the 16 Aboriginal languages of the region are widely spoken, many Elders speak up to five languages. The Aboriginal population of the region is transient for a variety of reasons - for example, to access services and resources in larger centres, to connect with family and attend cultural ceremonies in other communities.

Patient travel into the AHS or regional hospital for follow-up care is hindered by lack of public transport. Few patients have their own vehicles and the AHS has limited resources for transport, especially between the town and outlying communities. Some journeys take many hours, and many roads are in poor condition.

The AHS's clinical information system is fully computerised, but at the time of the evaluation interview the patient recall and reminder system was not functioning because patient lists were not current. Service staff highlighted that patient contact details are difficult to update and use. Many people do not have telephones and mobile phones are often shared between family members. There is no postal delivery to some communities. Many people have limited English language and literacy skills, which constrains their ability to respond to communications from Health Services.

These factors combine to result in a clinical information system that is of limited use to clinicians and limits the ability of the AHS to recall patients and provide follow-up services.

Trends by age and gender

Claims for follow-up services by practice nurses and registered AHWs (MBS item number 10987) per 100 adult health assessments were consistently higher for those aged 55 years and older compared to those aged 15-54 years (Figure 6.22).

Claims for follow-up services by practice nurses or registered AHWs were fairly similar overall for men and women in the Sentinel Sites, although claims for men fluctuated, with an overall increasing trend, whilst claims for women increased more steadily (Figure 6.23). The fluctuation in claims for men shown below in relation to the Sentinel Sites possibly reflects specific outreach activities targeting men in relation to uptake of adult health assessments. For the rest of Australia, claims for follow-up services for males per 100 adult health assessments increased steadily, but at a lower rate than for women.

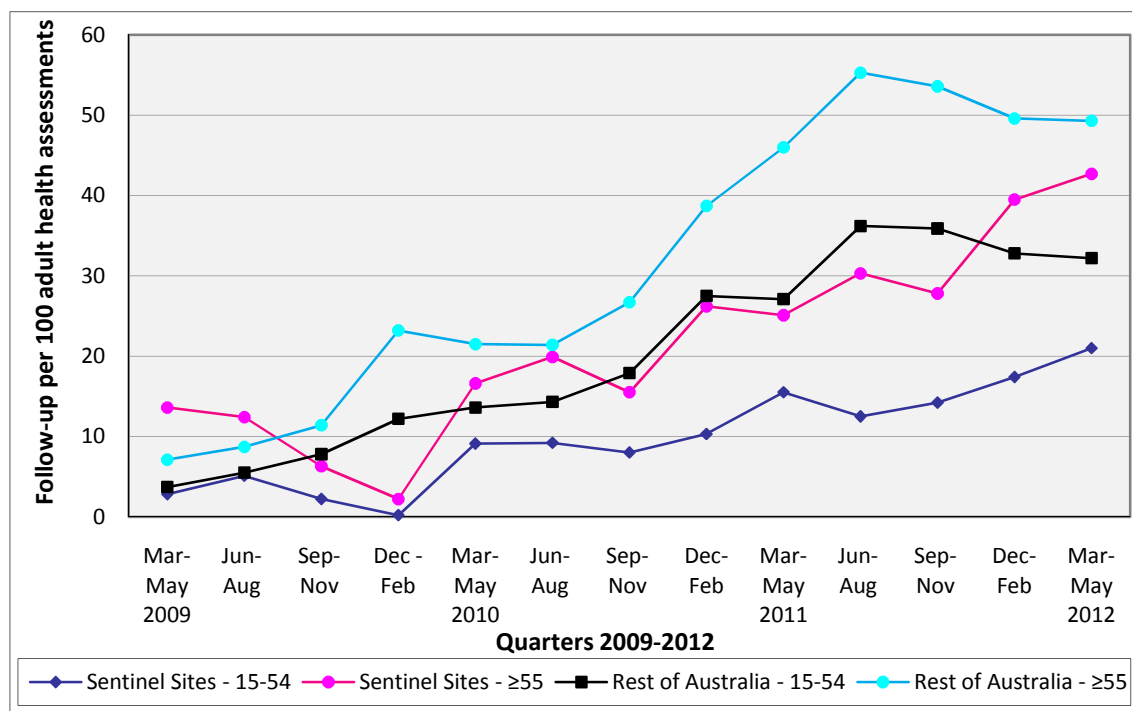


Figure 6.22: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - May 2012

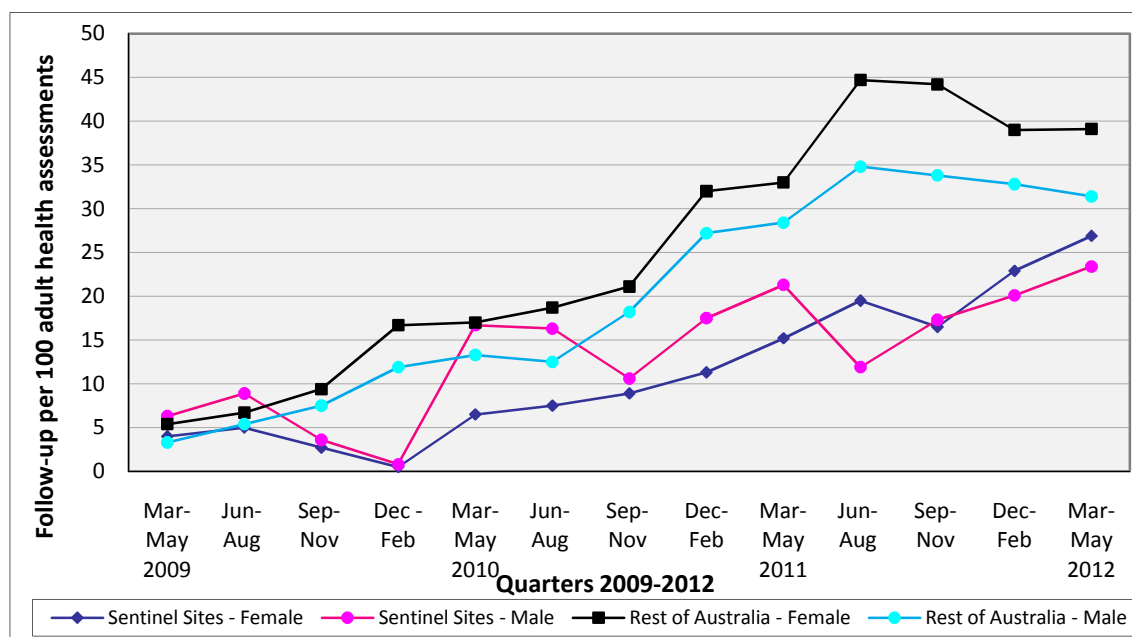


Figure 6.23: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by gender and quarter, March 2009 - May 2012

Variation by geographic location

Relatively few claims for this item were made in urban locations over the entire March 2010 - May 2012 period (urban Sentinel Sites = 3; rest of urban Australia = 3.6 per 100 Aboriginal and Torres Strait

Islander people), compared to regional locations (regional Sentinel Sites = 9.1; rest of regional Australia = 11.8 per 100 Aboriginal and Torres Strait Islander people) and remote locations (remote Sentinel Sites = 17.2; rest of remote Australia = 23.4 per 100 Aboriginal and Torres Strait Islander people) (Appendix G, Tables G11 and G12).

However, the data show steady increases in the number of claims for follow-up using this item per 100 Aboriginal and Torres Strait Islander people over the evaluation period in the rest of urban, regional and remote Australia, and in urban and regional Sentinel Sites. The data for remote Sentinel Sites were more variable over time.

The lower use of uptake of follow-up items in urban locations may partly relate to relatively greater use of AHSs by Aboriginal and Torres Strait Islander people in regional and remote locations compared to urban locations, and possibly more nurses and AHWs in these services. However, in the absence of firm data on the numbers and roles of nurses and AHWs in these services, this explanation is speculative.

There was also variation in uptake of follow-up items between specific Sentinel Sites, as shown in the figures presented in Appendix B.

6.3.5. FACTORS INFLUENCING UPTAKE OF FOLLOW-UP ITEM FOR PRACTICE NURSE OR ABORIGINAL HEALTH WORKER

KEY POINTS

- There was general lack of awareness of the follow-up item number and some confusion about eligibility of AHWs to claim.
- There was no evidence from the Sentinel Sites of patient demand or demand from Health Services driving uptake.
- Many Health Services indicated that they were providing follow-up care, and were working to improve follow-up, but were not systematically billing Medicare for the specific MBS item number.
- Nurses, particularly in remote settings, were often involved in acute care, and had been purposively selected for their interest in this area; AHWs often were unable to meet the formal registration requirements for claiming follow-up items, although changes in registration of AHWs that occurred in 2012 should expand the numbers of AHWs who are eligible to provide follow-up services under this item.
- Lack of systems to support follow-up after adult health assessments included lack of established recall and reminder systems, paucity of nurse-led clinics, lack of internal practice systems to refer patients to nurses based in practices and to support accurate billing.
- Strategies to increase uptake of these items were implemented by some DGPs – including collation and provision of information about MBS numbers.

Perceived complexity of processes required

Many service providers perceived the steps required for completion of follow-up by a practice nurse / AHW after an adult health assessment, and billing Medicare for the relevant item, as being complex. These steps appeared to demand a high level of organisation of clinic records and information flows. This perceived complexity and the requirements for change in work patterns and enhanced

functionality of information systems presented significant challenges to Health Services aiming to increase use of these items.

‘Follow-up, we are not doing many. It is hard to get the RN [registered nurse] and AHW to bill. The focus has been on health assessments.’ (AHS)

There was a general lack of awareness of the follow-up item number among Health Service staff. Use of the Aboriginal specific item number is only one way of obtaining reimbursement. Interviewees commonly cited that if follow-up services after a health assessment were being delivered it would generally be by the GP (opportunistically) who would bill against a standard consultation rather than a specific follow-up item number.

While many Health Services do aim to provide follow-up services for patients with chronic disease, many service providers in the Sentinel Sites indicated that low uptake of these item numbers was a reflection that follow-up services are often not effectively provided – and that this was partly due to limited availability of staff and lack of systems to support follow-up.

The impetus that could have been provided by the PIP Indigenous Health Incentive program to increase follow-up care by practice nurses or AHWs was not well realised. As shown in Chapter 7, few Tier 1 payments were triggered nationally or in the Sentinel Sites – possibly because the required re-orientation of existing systems towards nurse-led or AHW-led billing was not achieved within the time frame of the evaluation.

In general, more extensive use of the practice nurse / AHW follow-up items as envisaged by the ICDP would require greater re-orientation of systems than is currently evident. Contributing to the complexity and lack of awareness of the MBS item described above is the small numbers of Aboriginal patients of some General Practices and consequent reluctance to change systems (i.e. to effectively provide and to bill for follow-up care) for a small number of patients.

Availability of eligible providers

The employment of practice nurses has expanded in recent years. The latest national practice nurse survey indicated that 64% of Health Services employ at least one practice nurse, although there was variation between states (the lowest being 47% in one state).⁸⁶ However, it was noted that in many services that employed practice nurses, the nurses role was oriented to general or acute care rather than to prevention and management of chronic disease, and this limited their availability and interest in billing for follow-up services for chronic disease patients. In remote settings this was particularly the case as many nurses tended to have been employed specifically because of their skills and interest in acute care.

The limited number of AHWs able to bill for follow-up services for practice nurse and AHWs after adult health assessments also appeared to be limiting uptake. Throughout most of the evaluation period, only in the NT were Health Services able to bill for services provided by AHWs against the follow-up by nurse or AHW MBS item number. In all other jurisdictions Health Services could only bill for follow-up services provided by an AHW if provided in relation to his/her role as an allied health professional under a Team Care Arrangement and billed against the allied health professional follow-up item. Considerable confusion prevailed in Sentinel Sites regarding AHW billing, what services could be billed

⁸⁶ Australian Primary Health Care Research Institute, General Practice Nurse National Survey Report 2012 <http://www.amlalliance.com.au/data/assets/pdf_file/0003/46731/2012-General-Practice-Nurse-National-Survey-Report.pdf> (accessed 17 January 2013).

and by whom. Several interviewees highlighted that there were not at the time enough accredited AHWs to impact on care delivery using the MBS follow-up items. In the final evaluation cycle additional confusion was expressed with the introduction of national registration processes for AHWs and the Practice Nurse Incentive Program (PNIP) (as described in Section 6.1.2), and associated eligibility to claim for this item number.

‘There are a limited number of AHWs with cert IV, therefore although national registration has commenced from 1 July 2012 there are not yet enough accredited workers that can use the Medicare items.’ (AHS, feedback from enhanced tracking site)

Lack of demand for follow-up items from patients and referring GPs

There was no evidence from the Sentinel Sites of patient demand or demand from Health Services driving uptake of all follow-up items. In general, patients were not well informed about the need for follow-up, and for many, there were challenges to be overcome in order to attend services for follow-up appointments. Unlike for adult health assessments, where strategies to create community demand and patient incentives were identified, there was limited evidence of work to promote community awareness of the need for follow-up.

Lack of effective establishment and use of recall and reminder systems was also noted as a factor contributing to low attendance by patients at appointments, following referral to a practice nurse/AHW. It was commonly reported that the recall and reminder systems were not used effectively and that clinical information systems were not utilised optimally to support patient care (Appendix E). From the perspective of the Health Services, lack of patient attendance was a commonly cited factor believed to limit the potential for follow-up – setting up a ‘negative feedback loop.’

‘We do a lot of referrals but we don’t get many people turning up for their appointments for them. Therefore it’s not billed and therefore it doesn’t register as a service ... a failure to the system that is not coming through. When we are seeing and talking to people and spending that time one-on-one they are very enthused ... it’s a bit of a sales situation where the GP is suggesting referrals to allied health or practice staff for aspects of their care. They are keen ... but then don’t follow through.’ (General Practice, GP)

Strategies to increase uptake of follow-up items

Some of the strategies outlined in Section 6.3.3 focusing on increasing uptake of adult health assessments may have played some role in increasing uptake of follow-up items, but in general, it seemed that follow-up items received less attention. It appeared that services need to focus on achieving a limited number of specific changes at any time, and that increasing uptake of follow-up items was some way down the list (if the service was aware of these items at all).

Some of the regional organisations, including DGPs (or Medicare Locals) adopted specific strategies to try to promote follow-up by practice nurses and AHWs. IHPOs in some DGPs (at times in conjunction with practice support teams in the DGP) were involved in collation and provision of information about the Aboriginal and Torres Strait Islander specific MBS numbers for Health Services.

There was a clear role for Health Services to link with the funded OWs in DGPs and AHSs to assist with follow-up of care. It appeared that this function of the OWs was not being fully utilised.

Vignette – A remote AHS plans for increased billing against follow-up items by nurses and AHWs

A remote AHS has identified several steps they need to take in order to increase their billing of follow-up items by AHWs and nurses. These included completing paper work to ensure the AHWs and nurses have Medicare provider numbers, investing time in understanding what can be billed and developing systems in the Health Service to enable recording and claiming of the relevant services.

Management and dedicated nursing and AHW staff employed under 'Healthy for Life' program funding support the initiative.

6.3.6. FOLLOW-UP SERVICES BY ALLIED HEALTH PROFESSIONALS

KEY POINTS

- Uptake of follow-up services by allied health professionals was generally low, but increased over the evaluation period.
- Trends in uptake were similar to patterns in uptake of follow-up services by nurses and AHWs, with relatively higher uptake in older patients and among women. There were very few claims for follow-up services by allied health professionals in remote locations.
- Uptake of follow-up services by allied health professionals in all Sentinel Sites taken together increased around 20-fold between the baseline and final evaluation period - from approximately 37 items claimed per quarter to around 738 items claimed per quarter. Comparable data for the rest of Australia showed an increase of around five-fold between baseline and the final evaluation cycle.

Number of claims for follow-up services in relation to adult health assessments

Claims for follow-up services by allied health professionals (MBS items 81300-81360) differ from claims for the Aboriginal and Torres Strait Islander specific Medicare items discussed earlier in the chapter, in that these claims are not submitted by GPs, or for services delivered on behalf of a GP. Claims for these items require that primary care providers are able to identify the allied health related follow-up needs of patients, identify allied health professionals who can provide the required services, provide appropriate referrals to the allied health professional, and communicate effectively with the patient about the need for referral and the process regarding the referral, and what is required of the patient regarding completion of the referral process. The patient then needs to follow the appropriate process, and the allied health professional needs to deliver and bill Medicare using the Aboriginal and Torres Strait Islander - specific items. Thus, as for the item for follow-up services by a nurse or AHW, there are a number of points where the process can break down, and claims for the relevant follow-up item will not be made to Medicare.

There were small numbers of claims for follow-up by allied health professionals over the duration of the evaluation, in the Sentinel Sites and the rest of Australia (Table 6.3 and Appendix G, Table G13 and G14). Caution must be used in interpretation of these data owing to the small numbers.

The data in this section are presented as the absolute numbers of follow-up items claimed (as in Table 6.3) as well as the number of claims expressed as a proportion of adult health assessments (as in Figure 6.24).

In Sentinel Sites the number of claims for MBS items for follow-up by allied health professionals among Aboriginal and Torres Strait Islander people who had received an adult health assessment (MBS items 81300-81360) has shown a steady increase since the baseline period, with a minor peak in the March - May 2010 quarter (Table 6.3 and Figure 6.24). The number of items claimed in the March - May 2012 quarter (738) was about twenty times the number claimed on average per quarter in the baseline period (37) for the Sentinel Sites.

In the rest of Australia, the number of claims for MBS items for follow-up by allied health professionals among Aboriginal and Torres Strait Islander people who received an adult health assessment also increased since the baseline period. The number of items claimed in the March – May 2012 quarter was more than five times the number claimed on average in the baseline period for the rest of Australia (Table 6.3).

Table 6.3: Follow-up allied health services among Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) in Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Sentinel Sites/ Rest of Australia	Follow-up items claimed												
	2009				2010				2011				2012
	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May
Sentinel Sites	33	31	40	47	123	99	104	141	272	390	488	507	738
Rest of Australia	130	169	267	354	370	426	787	655	945	930	1207	970	1382

At baseline, there were 4-8 claims per quarter per 100 adult health assessments, increasing to around 8-11 and 14-18 claims per quarter per 100 adult health assessments in the rest of Australia and in Sentinel Sites respectively (Figure 6.24). There was a particularly marked increase in the Sentinel Sites from the March - May 2011 quarter onwards.

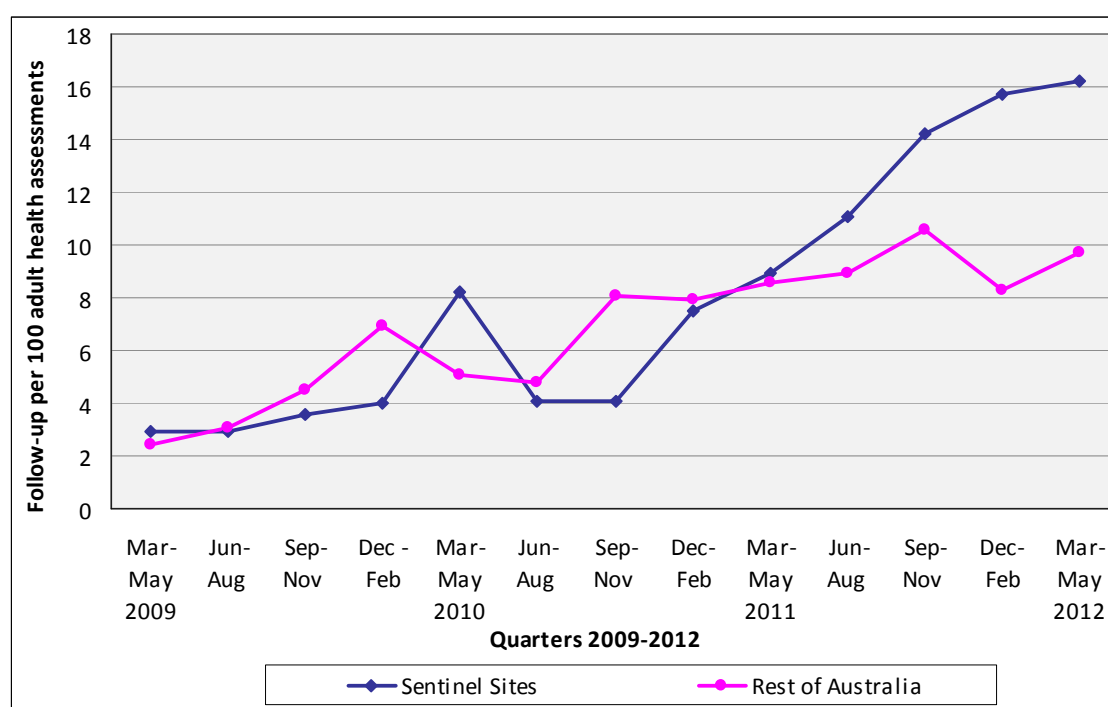


Figure 6.24: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years who have received an adult health assessment (MBS items 81300-81360) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2012

Trends by age, gender and geographic location

The trend in the number of MBS items claimed for follow-up by allied health professionals per 100 adult health assessments for the rest of Australia and for Sentinel Sites increased for people aged 15-54 and for those aged ≥ 55 years, with the number of claims for services to the older group being about two times greater than for the younger group (Figure 6.25). This is consistent with the greater burden of chronic illness and greater need for allied health services in the older age group. Increases for people aged ≥ 55 years in Sentinel Sites were greater than for all groups from the June - August 2011 quarter.

The trends in the number of MBS items claimed for follow-up by allied health professionals per 100 adult health assessments were similar for males and females, with the number of claims for services to females per 100 adult health assessments tending to be slightly higher than for males (Figure 6.26).

Data by urban, regional and remote locations are presented in the Appendix G, Table G14. Very few follow-up allied health items were claimed in remote locations in both Sentinel Sites and the rest of Australia.

The data on uptake of follow-up items in specific Sentinel Sites is shown in the figures presented in Appendix B.

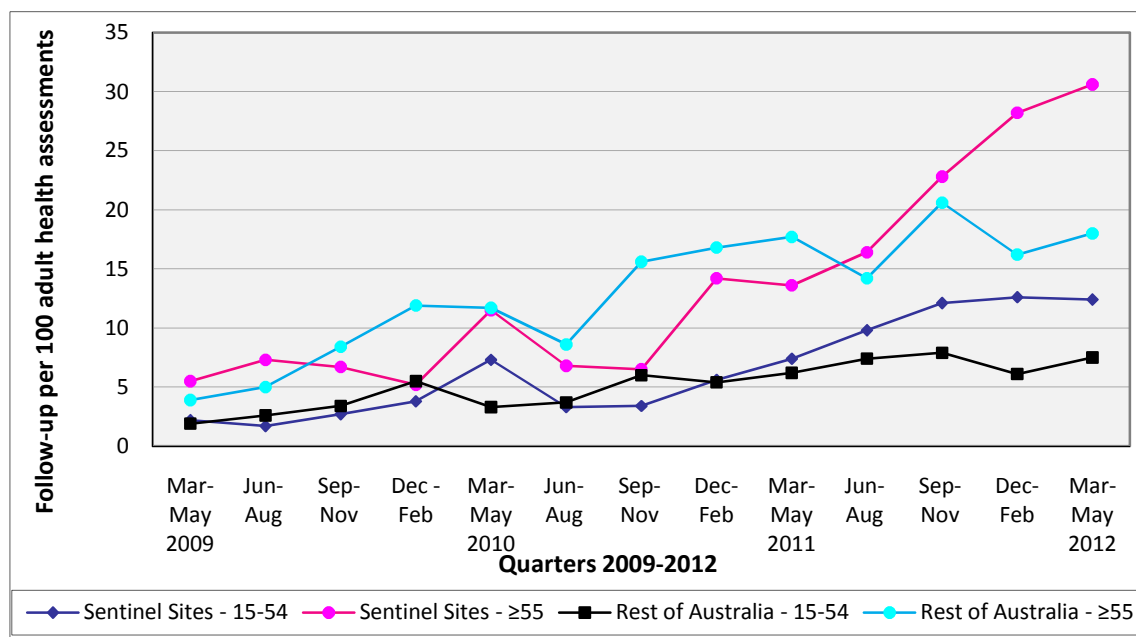


Figure 6.25: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - May 2012

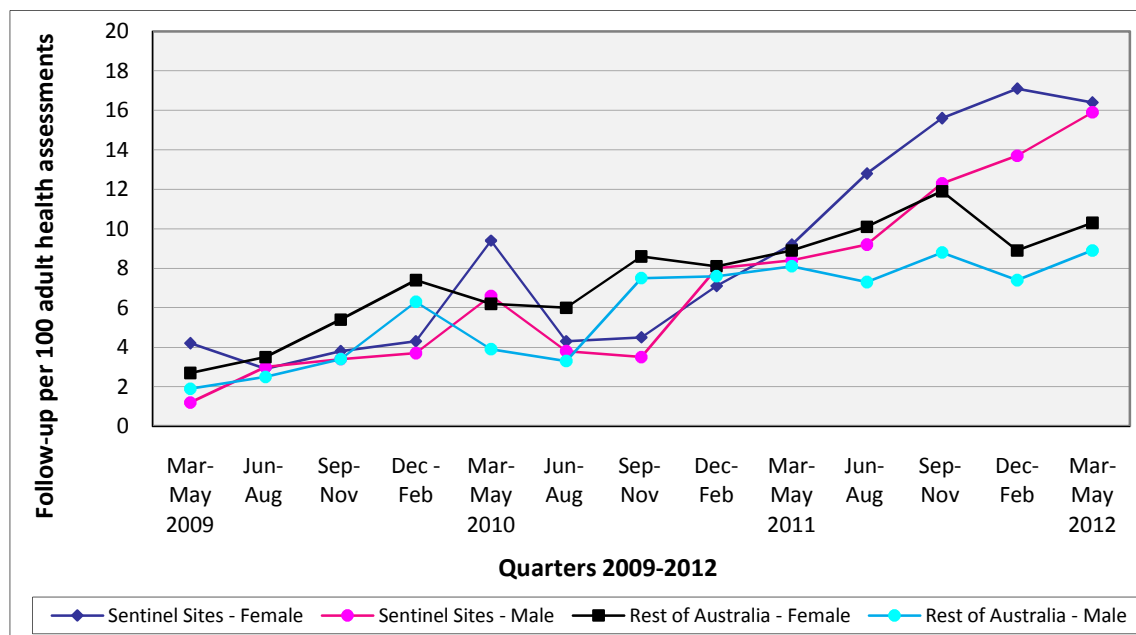


Figure 6.26: Follow-up by allied health professionals per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) for Sentinel Sites and the rest of Australia, by gender and quarter, March 2009 - May 2012

6.3.7. FACTORS INFLUENCING UPTAKE OF FOLLOW-UP ITEMS FOR ALLIED HEALTH PROFESSIONALS

KEY POINTS

- Interviewees reported limited numbers of allied health professionals available for referral; this meant that referrals were not made or were made to salaried or program funded allied health professionals, which would not be demonstrated in MBS data.
- In some areas there was a perception that referrals to available allied health professionals would not be appropriate, due to concerns about cultural safety for patients.
- At times, long waiting times for allied health professionals, and lack of transparency around their billing arrangements, discouraged providers from referring.
- Patient level factors including patient motivation may have constrained greater uptake in some settings – patients were reluctant to attend for allied health when the financial costs to be incurred were unknown.
- Lack of reminder systems (at both allied health professional and Health Service levels) were noted as factors contributing to low attendance by patients at appointments, once referred.
- Strategies to increase uptake of these items were implemented by some DGPs, including collation and provision of information about local service providers and referral networks and, in some cases, DGPs became involved in direct delivery of services through employment of allied health professionals in a blended payment model.

Perceived complexity of processes required

The steps required in order to bill for follow-up by an allied health professional following an adult health assessment were perceived by many service providers to be complex. There is a required level of organisation of Health Services with regard to effective use of clinical information systems to refer appropriately to an allied health professional.

Availability of eligible providers and their billing arrangements

Some of the low uptake of allied health professional follow-up items may be because follow-up services are being provided through other mechanisms, including non-Aboriginal and Torres Strait Islander specific Medicare items, such as those available for allied health services in general or for services delivered as part of a TCA or GPMP. In the Sentinel Sites, some allied health professionals to whom patients were referred following adult health assessments were funded through MSOAP-ICD, others were providers funded through DGPs or Medicare Locals, AHSs or special program funding particular to states/territories.

It would be assumed that when the number of eligible services is exhausted under the regular MBS items, there would then be motivation to use the Aboriginal and Torres Strait Islander-specific items so that patients can continue to receive rebates for care. However this additional care benefit was not mentioned in the sites, and the extent to which providers or patients were aware of the enhanced service provision available under the new items appeared to be limited.

Some GPs tended to refer to salaried service providers where these providers were available, particularly for allied health care, because of cost considerations for patients and accessibility due to paucity of private allied health professionals. To some extent, the low uptake of follow-up items may

reflect this alternate service provision, and therefore may not be an accurate reflection of the extent of follow-up allied health services provided following adult health assessments.

'They have to pay first and then claim that gap ... many patients can't afford the upfront payment ... we tend to utilise our own in-house allied health if we can and other public system allied health.' (Urban site, AHS)

However, in many cases, service providers in the Sentinel Sites suggested that low uptake of these item numbers was correctly reflecting low delivery of follow-up allied health services following health assessments.

'Health checks happen but nothing much happens after that. That's where it ends.' (GP, AHS)

In some areas, interviewees believed that there were limited numbers of allied health professionals to refer to, and this meant that referrals were not made. In other cases, it seemed that it was not just number of allied health professionals that limited referrals, but also the perception that referrals to the providers in the area would not be appropriate, because it was felt that they were not sufficiently orientated to issues of cultural safety. These uncertainties relating to cost and cultural safety were also noted to influence patient attendance following referrals, as described below.

For those service providers who were salaried by the AHSs, Medicare Locals or State health departments, ability and incentive to bill Medicare was noted to vary widely. Some interviewees believed that services delivered by these salaried professionals were ineligible for billing, whilst others noted that there was no incentive for these practitioners to bill, and some do not have Medicare provider numbers.

Interviewees noted that different professionals had different eligibility to bill, and it is difficult, (from the Health Service perspective) particularly for remote sites with many outreach professionals, to ascertain billing requirements.

'In regards to the allied health claiming I do not have any idea. A female visiting GP comes in and goes around the communities claiming for the Royal Flying Doctor Service. The visiting optician next week will be claiming themselves. Also the regular visits from speech and physio therapy come out of WA Country Health Service - I do not know if or how they claim.' (AHS, GP)

Lack of demand for follow-up items from patients and referring GPs – related to cost and other access barriers

As reported in the section on follow-up by practice nurse/AHW there was no evidence from the Sentinel Sites of patient-demand driving uptake of follow-up by allied health professionals.

Lack of transport, long waiting times for appointments (due to provider shortage) and lack of reminder systems at allied health professional level and Health Service levels were highlighted as factors contributing to low attendance by patients at appointments, once referred. From the perspective of the Health Services, a lack of patient attendance was a commonly cited factor believed to limit the potential for follow-up – setting up a 'negative feedback loop.'

Some providers recognised the difficulties faced by patients in accessing transport, and remaining cost barriers for patients attending for follow-up. Whilst these factors differed to an extent in different areas, a common issue experienced by patients was the lack of transparency around billing patterns and the fear that services would be unaffordable.

The lack of transparency around gap payments, and the perception that services would be expensive and require numerous repeat visits were a barrier to accessing allied health services – both for patients in following through on referrals and for providers in making referrals. Health Service staff indicated it was difficult to know which allied health professionals would bulk-bill on request and they did not generally have the capacity to contact providers beforehand to request bulk-billing. This was identified as a major disincentive for patients to use these services, and once perceptions were entrenched, it was difficult to displace them. This issue was identified by interviewees in both the General Practice and AHS sectors.

‘Many allied health providers have been a source of frustration as ... generally in the region [they] are not aware of and are resistant to the special MBS item numbers for follow-up care for Aboriginal patients, and even when informed of them by Aboriginal clients say ‘well I don’t know about that and I don’t bulk-bill so here’s the bill - pay up’. This approach then has a very negative effect on the patient and their willingness to seek further allied health services.’ (DGP, Care Coordinator)

‘I refer a lot for physio under a health check. They still charge a gap payment and they charge upfront even if I do a referral.’ (AHS, GP)

As indicated above, a lack of awareness on the part of allied health professionals may have contributed to this situation, but it was likely to be more complex than awareness alone.

Strategies to increase uptake of follow-up items

Some of the strategies outlined in Sections 6.3.3 and 6.3.5 (focusing on increasing uptake of adult health assessments and follow-up by a practice nurse/AHW respectively), may have played some role in increasing uptake of follow-up items. However, in general, it was clear that follow-up items were receiving less attention.

Some of the regional support organisations (including DGPs or Medicare Locals) adopted specific strategies to promote these item numbers. IHPOs in some of the DGPs were involved in collation and provision of information about the Aboriginal and Torres Strait Islander MBS numbers to Health Services and allied health professionals; collation and provision of information about local allied health professionals and referral networks and, as outlined below, in some cases these organisations became involved in direct care delivery, accessing these item numbers themselves.

One of the factors that may have driven DGP involvement in this area is the inclusion of the number of follow-up items claimed by allied health professionals as a key performance indicator for IHPOs based in DGPs. Over the evaluation a number of interviewees queried why this had been singled out as an indicator as it differed from other key performance indicators, which were more qualitative. Underlying this concern may have been recognition that uptake of this item may not be a good indicator of follow-up, since some follow-up care may be provided through other funding mechanisms, including other Medicare items and salaried allied health professionals.

‘Low claiming of practice nurse and allied health numbers is possibly because the item numbers are used that are for general population. Same for allied health ... why use an Aboriginal specific one ... there is no incentive for them to ... they are not paid any extra and so just use mainstream item number. Why create confusion with item numbers?’ (DGP, program manager)

Whatever the source of concern, it was evident in the Sentinel Sites that DGPs – and other regional support organisations - were beginning to invest some resources into trying to increase uptake of follow-up services delivered by allied health professionals and billed to this item.

Some DGPs that were transitioning to Medicare Locals were exploring how to continue to fund the allied health professionals employed by the DGP and were considering a blended payment system (to partly fund the position through Medicare claims).

ICDP funded Care Coordinators often reported that they were spending time creating connections with allied health professionals and providing information about the available MBS item numbers. A Care Coordinator based in a DGP noted her role in provision of information about Aboriginal and Torres Strait Islander-specific follow-up item numbers to General Practices, and also that she had identified allied health professionals who would bulk-bill electronically, and would refer only to these providers.

'We have been successful in educating the GPs about the Aboriginal specific MBS item numbers but the allied health providers are not willing to take it on. I've had patients ring me up saying the provider has billed them even though they have been referred under a team care arrangement [or follow-up item number], even though they've got the appropriate form – it's been my biggest struggle. To get around it I refer to the providers that have the machine to swipe the Medicare card so they don't actually bill the patient at all.' (DGP, Care Coordinator)

6.3.8. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Streamlining of relevant MBS item claiming, and Health Services' promotion of health assessments as part of a patient 'package', encouraged recognition among Health Service staff of the importance of health assessments and follow-up care.
- Strong management and leadership support was an important enabler to changing norms about primary health care practice in Health Services.
- GP-centric models of care, high staff turnover, high use of locum staff, entrenched billing habits and financial prerogatives as primary drivers to increasing health assessments constrained re-orientation of Health Services to systematic delivery of health assessments and follow-up care.
- Sustained complementary programs such as 'Healthy for Life' enabled a culture of quality improvement that was linked with higher uptake of adult health assessments (while short term programs/events resulted in short-lived increases in uptake).
- Functioning of the measure at site level was enabled by involvement of both General Practice and AHSs in achieving higher coverage. Effective involvement required clear communication, a shared understanding of processes for local implementation, and good team functioning within services.
- Limitations in clinical information systems and patient referral mechanisms and/or staff capacity to use these systems constrained effective uptake of health assessments and follow-up in many sites.
- Lack of eligible and appropriate practice nurses, AHWs, and allied health professionals constrained use of follow-up services, as did concerns about cultural safety and uncertainty regarding costs for patients for allied health services.
- Service re-orientation from acute care to a comprehensive and long term approach to primary health care was required. It was supported by capacity to use funding in ways consistent with the organisation's values and styles of care delivery, and flexibility in interpreting guidelines.

- Proactive roles by regional support organisations were mostly enabling in service re-orientation, but could be constraining if there were divergent understandings about the role of adult health assessments in primary health care, and in regular service provider/patient relationships.
- The ICDP workforce had complementary and enabling roles in awareness raising about health assessment and follow-up items, billing, production and dissemination of resources and patient transport to appointments. Adult health assessments complemented the care coordination measure, Supplementary Services funding, and could improve quality of care through, for example, increased delivery of smoking and healthy lifestyle brief interventions (usually in an ad hoc rather than integrated way).

There was no program logic identified for this measure that was suitable for defining ‘success’ for the purposes of this evaluation. The measure was designed to cover the costs of increased costs to Medicare as a result of various ICDP related activities, including encouraging uptake of health assessments and follow-up items – which is the focus of the analysis presented in this chapter. Based on the ICDP overall aims and program logic for the overall package, we suggest that effective implementation of this measure at a local level would result in high population coverage of adult health assessments, with early detection and effective management, including appropriate follow-up, of health problems that are priorities in the community, and resulting in strengthening of local health care delivery systems. This chapter has identified a range of enablers and constraints that influenced the extent to which increases in effective use of health assessments and follow-up items could be achieved at local level.

As is evident from the data presented above, progress has varied substantially between different Sentinel Sites. It is clear from the evaluation that this variation in progress with implementation cannot be simply attributed to geographic location or any other specific characteristic of specific sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective use of health assessments and follow-up items can be achieved and the influences that enable and constrain the operation of these mechanisms.

An overarching consideration is that for health assessments and follow-up items to have a population impact at site level, the activities would need to reach a high proportion of Aboriginal and Torres Strait Islander people with or at risk of chronic disease, in particular those with relatively poor access to appropriate care, and therefore most likely to suffer the effects of chronic illness.

Our analysis identified four main mechanisms through which there was increased use of health assessments and follow-up items in a way that contributed to improved quality of care in different contexts. These are shown in the central boxes in Figure 6.27 below. Enablers and constraints related to each of these main mechanisms are shown in the Figure, and described below.

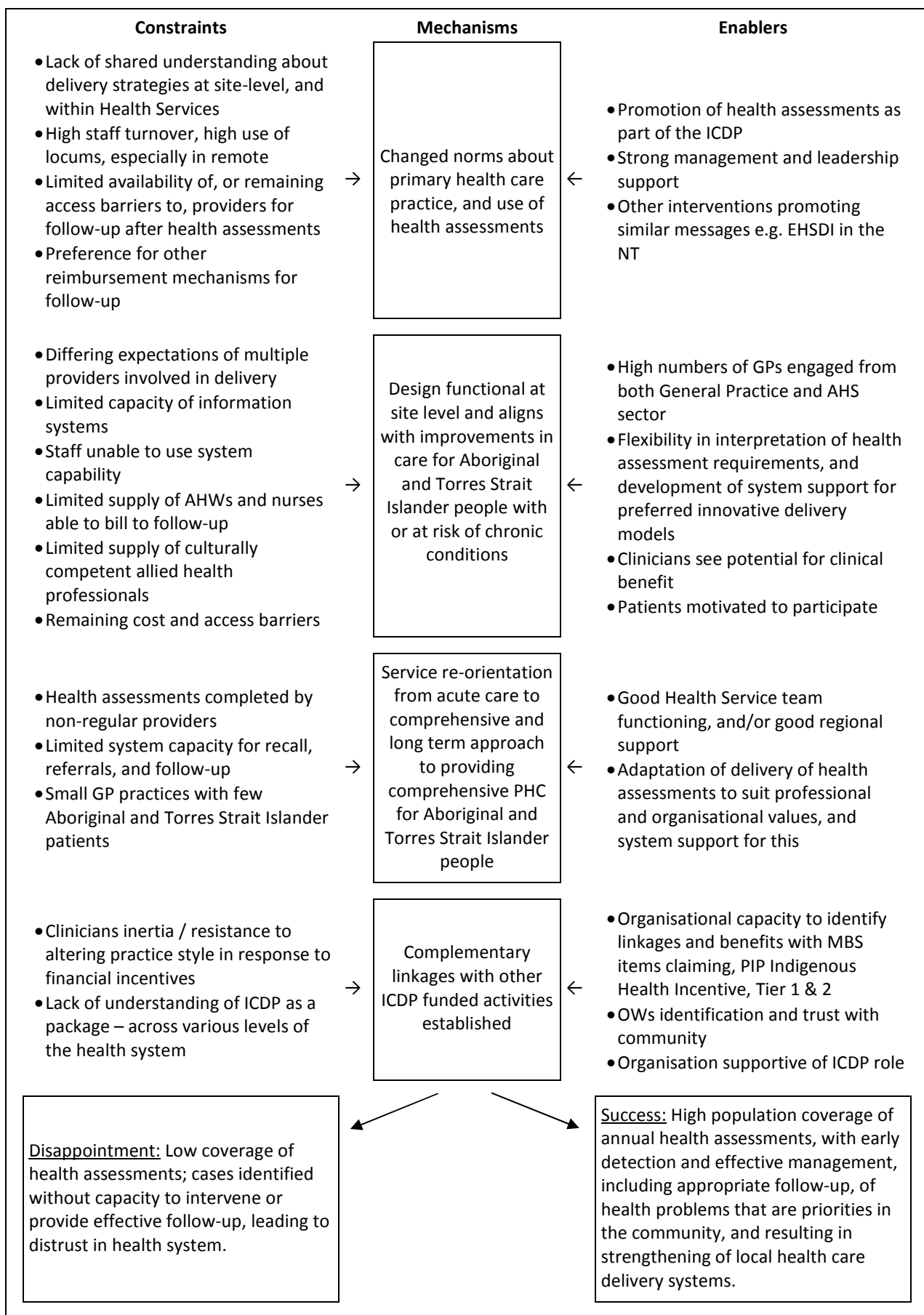


Figure 6.27: Enablers and constraints to effective implementation of adult health assessments and follow-up

Changed norms about primary health care practice

One of the ways in which enhanced uptake of health assessments and follow-up items worked (or failed to work) at local level, was through changed norms about primary health care practice – in other words, in some contexts, the enhanced uptake appeared to work to improve care, through a greater general acceptance and expectation that health assessments and follow-up are an important part of care.

A number of different changes at national level occurring together are likely to have contributed to changed norms about primary health care practice at local level. These included streamlining of the Medicare reimbursement arrangements to include streamlining of MBS adult health assessment items into a single item and allowing annual claiming for a health assessment in all adult age groups. Streamlining processes in relation to claiming of service delivery in general by nurses (through the PNIP), and wider recognition and professional registration of AHWs across the states/territories are also expected to contribute to changed norms.

An important enabler for changed norms about primary health care practice was the way in which the streamlining of the MBS items for adult health assessments was promoted together with other components of the ICDP at site level. Interviewees across the sites spoke of implementation of adult health assessments as ‘part of a package’ including access to the PBS Co-payment measure, and PIP Indigenous Health Incentive registration as locally initiated enablers. This ‘package deal’ enabled Health Services to implement health assessments, as ‘the package’ was more financially attractive than previously, and patients were incentivised to participate through linkages to the PBS Co-payment measure. In some Health Services, interviewees spoke about the ICDP as providing much needed access to adult health assessments – this was despite the fact that these items had been available for some years – indicating a shift in norms or expectations about health assessments. The follow-up items were possibly less closely linked to the ‘package’ as described here – and there was evidence that in some contexts, the alternate reimbursement mechanisms available for follow-up through the ICDP (such as salaried allied health professionals, use of Supplementary Services funding through the care coordination program, and use of TCAs and GPMPs, promoted through PIP Indigenous Health Incentive, which also have separate MBS follow-up items available and non Aboriginal specific MBS items) may have been preferred sources of reimbursement for follow-up in some sites (as described earlier in this chapter).

Strong management and leadership support in relation to delivery of adult health assessments – as reflected for example in strategic decisions to set aside dedicated time for clinicians to conduct adult health assessments and attend to follow-up - was an important enabler in changing norms at a local level about the role of adult health assessments in primary care. For some Health Services, management and leadership support was provided through affiliation with regional support organisations, including DGPs or Medicare Locals, and, for South East Queensland, the IUIH.

Where management and leadership support was weak, coupled with a strong GP-centric model of care, it was more difficult to achieve changes in norms regarding health assessments and follow-up items. For example, in one Health Service in which there was lacked clarity about roles in relation to adult health assessments and follow-up, nurses or AHWs would commence adult health assessments only to have the GP coming in and re-doing all the items due to a lack of trust that they had been correctly completed. This resulted in duplication of effort and frustration on the part of nursing staff who were trying to increase uptake.

It was also evident that higher uptake of adult health assessments was not always associated with changed (desired) norms around primary care practice and their integration into a care continuum. In some instances, higher uptake of adult health assessments may have been driven primarily by the financial benefit available to service providers – with little or no improvement in quality of care. This

was in contrast to some other (urban) sites, which showed strong participation in other aspects of the ICDP, such as PIP registrations, but had low uptake of adult health assessments – and in these cases, although there were other contributing factors, this was at least partly due to a strategic decision by the AHSs in these sites to focus resources on good follow-up and chronic disease management in preference to adult health assessments.

In some sites, the role of external events, such as the EHSDI in the NT, were noted as having been important influences on increased uptake of adult health assessments during certain periods. These initiatives were noted by interviewees as providing a focus on health assessments, and increasing their delivery as a part of care - for a defined period of time. However these effects were often temporary, with drop offs in delivery of adult health assessments in these areas after the external drive/program had finished. In other sites, more sustained funding, predominantly the Healthy for Life program funding available to some Health Services, was noted to have helped to create a culture of quality improvement in Health Service organisations, and enabled higher uptake of adult health assessments and to a lesser extent, delivery of follow-up services. Peaks in delivery of adult health assessments, and other aspects of the ICDP, in some sites that were known to be associated with visiting staff with dedicated time, illustrated the importance of staff capacity for implementation of several ICDP measures. However these short-term events have limited potential to contribute to the kind of sustained change in practice that is needed to improve health outcomes.

Other constraining factors included high staff turnover, and high use of locum staff (both nursing and GP), with different GPs having different understanding of the role of primary care and different levels of knowledge and skill in accessing appropriate Medicare items and working with the Health Service team. These factors to an extent influenced operation of all of the mechanisms. In relation to changed norms about primary health care, it seemed that fluctuating staffing coupled with lack of clear leadership and management in relation to delivery of adult health assessments, made it challenging for organisations to develop and retain a consistent understanding of how health assessments fitted in to the work of the organisation, and to ensure that GPs shared that understanding. Limited capacity for follow-up was also an important constraint in some sites – limited availability of GPs for follow-up appointments, as well as limited availability of nurses, AHWs and allied health professionals, constrained uptake not only of the follow-up items, but also of the ability of Health Services to re-focus their expectations about primary health care, including greater acceptance of the value of health assessments.

The current evidence on the health benefits of adult health assessments is important to the acceptance of their value. While a Cochrane systematic review published in 2012 shows that general health checks do not have an impact on morbidity and mortality,⁸⁷ this review has limited relevance to the aim of the Aboriginal and Torres Strait Islander adult health check 'to help ensure that Aboriginal and Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and mortality'.⁸⁸ There are many reasons, largely related to the social determinants of health, why improved quality of care may not translate into improvements in morbidity and mortality. This should spur on efforts to address other determinants of health, but should not detract from efforts to improve quality of health care.

More pertinent is Burgess' review of the evidence base for the mandatory items included in the Aboriginal and Torres Strait Islander adult health assessment, and his argument that the evidence for a number of these items in the Aboriginal and Torres Strait Islander primary health care context is limited, and that there are major constraints to the type of follow-up care that is required for health

⁸⁷ Krogsbøll LT, et al. 'General health checks in adults for reducing morbidity and mortality from disease.' Cochrane Database of Systematic Reviews 2012, Issue 10.

⁸⁸ DoHA, Practice Detail Card - Aboriginal and Torres Strait Islander Health Assessments. Op cit.

assessments to provide real health benefits.⁸⁹ Consistent with the evidence that the effectiveness of financial incentives depends to some extent on their alignment with professional perspectives of good quality care,⁹⁰ Burgess argues for health professionals to have more discretion regarding the content and process for health assessments as relevant to their local context. Burgess also provides evidence that systematic implementation of adult health assessments in a way that is designed to suit the local remote community context can result in improved quality of care. There is similar evidence from research in an urban Aboriginal and Torres Strait Islander primary health care setting.⁹¹ This evidence is consistent with views expressed during the SSE by practitioners with extensive experience of primary health care in the Aboriginal and Torres Strait context, and has important implications for acceptance of the value of the adult health assessment among primary health care service providers.

Design functional at site level and aligns with improvements in care for Aboriginal people with or at risk of chronic conditions

Implementation of the adult health assessment and follow-up items differed in different contexts, with different outcomes. Key factors that appeared to influence effective functioning of the measure at site level are outlined below.

First, high population coverage of adult health assessments required the involvement of both General Practice and AHSs in delivery, with high numbers of GPs claiming for adult health assessments. This is not to say that the sectors necessarily worked together towards this goal, but that GPs from both sectors needed to be engaged, in order to achieve good population coverage. This was particularly evident for urban and regional locations, where there were larger numbers of providers involved in care for Aboriginal and Torres Strait Islander people. Involvement of multiple service providers within the site in delivery of adult health assessments enabled functional design in situations where providers shared an understanding about how to enhance effective delivery of health assessments and follow-up in their site.

Involvement of multiple service providers, if coupled with lack of clear communication, and lack of a shared understanding of how to enhance effective delivery of health assessments and follow-up, acted as a constraint to effective implementation. For example, in one site, the staff at the Medicare Local had commenced doing part of the adult health assessment in community settings and at schools and then sent these to GPs to complete. This was met with resistance from GPs in the AHS as they felt they had to do the work again and did not trust the service had been done completely.

'The Medicare Local is commencing health assessments in the community but we [GPs in AHS] are not liking this as we are not sure if all the issues have been adequately covered as we just see a tick box that sexual history for example has been discussed ... ' (AHS, GP)

At the Health Service level, good team functioning (described below) was a further enabler for effective delivery of health assessments and follow-up, and also for service re-orientation from acute care to more comprehensive and long-term approaches to care. Reliance on GPs to deliver all aspects of health assessments and follow-up restricted the potential to reach a significant proportion of the population in most sites, due to shortage of GPs and competing priorities – this was illustrated by the inability of sites

⁸⁹ Burgess, C, 2011. Where the dreaming changed shape: The Aboriginal and Torres Strait Islander adult health check in a remote Aboriginal community. PhD Thesis, Menzies School of Health Research.

⁹⁰ Campbell, S. M. and T. Eriksson (2011). "Multiple strategies for quality improvement and patient safety—money alone is not the answer, nor is trust. Conclusions of the 6th EQuIP Invitational conference April 2011." *European Journal of General Practice* 17(4): 238-240.

⁹¹ Spurling, G, Hayman, N and Cooney A. Adult health checks for Indigenous Australians: the first year's experience from the Inala Indigenous Health Service. *Med J Aust* 2009; 190 (10): 562-564).

with high numbers of health assessments per GP, but low numbers of GPs billing for health assessments, to reach adequate proportions of the population.

Limited support by clinical information systems, and in some cases limited capacity of Health Service staff to use information systems effectively, constrained the workability of the effective delivery of health assessments and follow-up in some sites. In some cases Health Services reported that they did not have records available that allowed them to ascertain whether or not a patient was due for a health assessment, and that they conducted adult health assessments opportunistically, recognising that a proportion of claims would be rejected by Medicare. Limited capacity of information systems to support delivery of adult health assessments and appropriate follow-up also constrained the ability of services to follow-up, and to institute recall and reminder systems. The state of development of clinical information systems in relation to recall and follow-up is described in relation to the PIP Indigenous Health Incentive in Chapter 7.

Upstream factors that influence GP availability and commitment were also important constraints, particularly in remote areas. For example, lack of suitable accommodation for GPs coupled with high staff turnover were cited as factors influencing the ability of Health Services to deliver adult health assessments and to claim for them appropriately through Medicare.

There were no clear examples in the Sentinel Sites demonstrating a functional design in the use of follow-up items - this limited the ability of the analysis to identify enabling factors. However lack of eligible and appropriate practice nurses, AHWs, and allied health professionals were identified as factors explaining low uptake of follow-up services, and their low Medicare billing – this has been discussed in Sections 6.3.5 and 6.3.7 above. Uncertainty over cost implications for patients in relation to follow-up services by allied health professionals, and uncertainty over how patients would be treated by allied providers was a further factor influencing uptake of allied health follow-up items. These factors made it less likely that GPs would refer to these services, and also made it less likely that patients would attend appointments if referred.

Service re-orientation from acute care to comprehensive and long-term approaches to primary health care

A key mechanism through which this delivery of health assessments and follow-up could deliver benefits at a local level appeared to be through the potential to encourage orientation of service delivery in primary health care for Aboriginal and Torres Strait Islander people to a comprehensive health promoting model of primary health care. Where this worked, Health Services became more proactive in preventive health, and strengthened their systems to support care for chronic conditions, including for example recall and reminder systems, clinical information systems and care planning.

Flexibility in interpreting guidelines and capacity to use funding in a way that was consistent with the organisation's values and styles of care delivery was a further influence on the extent to which services were able to re-orientate towards a more health promoting and comprehensive model of service delivery. For example, where Health Services found ways to use the Medicare items in ways that were consistent with their values and service delivery approaches, they were able to keep service providers, primarily GPs, motivated to increase billing against these items, and showed high uptake of items. In these Health Services, the attention to and funding for health assessments and follow-up were valued for the potential to support delivery of high quality care, not just the potential to generating funding. For example, in one Health Service, a decision was taken to deliver adult health assessments over a period of time, rather than in a single consultation. A system was set up to support this approach, and once there was a record that all components of the health assessment were delivered, the claim was made – this has been described in Section 6.3.3.

This was related to the delivery of innovative models of care, often extending the roles of nurses and AHWs in delivery of adult health assessments and follow-up (Section 6.3.3), and required good team functioning, and strong leadership and management.

Conversely where service providers focused on the deficiencies in the system, rather than the opportunities presented, effective operation of this mechanism was constrained. For example, some interviewees commented that delivery of adult health assessments did not constitute improved care, and therefore were an inappropriate indicator of performance. Underlying some of this may have been the feeling that the wrong kinds of behaviour were being rewarded – that behaviour to ‘tick the box’ was financially lucrative, whereas provider behaviour that was more patient-centred, for example, responding to patient’s readiness for different aspects of health checks at different times, and use of clinical discretion about when different services were appropriate to the patient’s stage of change or risk, was not rewarded.

Where team functioning was weak, this sometimes was related to a culture of GP autonomy, where different GPs visiting the Health Service (or working in the Health Service, sometimes temporarily) adopted their own styles and ‘rules’ about what they signed off on and what they didn’t, without any overarching leadership evident for a standard organisation-wide approach – this hampered the ability of the rest of the team to fulfil their potential roles in relation to health assessments and follow-up, and constrained the ability of the service to re-orientate to comprehensive and long term approaches to primary care.

Other constraining factors included limited resources for team-building (especially evident in small Health Services) coupled with few Aboriginal and Torres Strait Islander patients, and limited regional or other support in relation to re-orientation of care.

In response to this, some regional support organisations took on more proactive roles in delivery of adult health assessments and coordination of follow-up, and whilst this sometimes seemed to function well, in other cases, particularly where there were divergent understandings about the role of adult health assessments in primary health care, and implementation models that included adult health assessments being done by non-regular providers, it appeared to act as a constraint to effective implementation. Some health care providers, in objecting to a model of health assessments being rolled out in their community, whereby another organisation was commencing health assessments and then referring to the regular provider for completion, noted that one of the intended benefits of the health assessment, from their perspective, was to help to support a regular relationship between a service provider and patient – and that this was being undermined.

‘The health assessment should be done in the practice or with staff from the patients regular practice to encourage attendance and regular patient care rather than creating a relationship with another individual ... Sexual history taken, tick box. I don’t trust it when someone else has done it.’ (AHS, GP)

In another site, lack of access to the medical history, duplication of services, lack of relationship context hindering quality of the adult health assessment and limited ability to follow-up were noted as disadvantages to this model of delivery. It would also be expected that delivery by non-regular providers would limit the operation of the mechanism of service re-orientation, since the involvement of services is more limited.

‘This is not good continuity of care. They were really patients of here. The health check needs to be done by the service they attend. There is a broad variety of how health checks are done and quality and education is a key component of education and develops a bit of rapport.’ (AHS, GP)

There were different perceptions evident in different Health Services about how increases in health assessments and follow-up items could be achieved. For some, adult health assessments seemed to be a ‘tick the box and make the claim’ exercise – with a focus on high population coverage - whereas others expected a more carefully considered process, and wanted assurance that health assessments were being delivered within the context of established provider-patient relationships, that patient-centred approaches were respected, and there was continuity of care provided. Since both ‘quantity’ and ‘quality’ are important, caution should be used when considering quantitative measures of uptake alone as measures of success.

Other constraints to this mechanism included scepticism about the value or relevance of adult health assessments, and a perceived conflict in values between the type of care rewarded through some local models of implementation (seen by some as formulaic, or lacking patient centeredness), and the type of care they aspired to deliver. In addition, some providers were sceptical about the appropriateness of changing the way that they worked in order to bill Medicare, since they had chosen to be salaried professionals in order to avoid the fee-for-service model, which does not always fit well with a more holistic and patient-centred approach to care. In general, in relation to the adult health assessment in particular, if clinicians did not see the potential for the clinical benefit of the service, they would not prioritise it effectively – and the successful implementation of health assessments and follow-up, depended on the cooperation of clinicians.

Weaknesses in the health system, including lack of adequate patient referral mechanisms, lack of recall, difficulties accessing transport for patients, and inadequately developed communication between providers, were seen to constrain the ability of health service providers to value the adult health assessment (if it did not lead anywhere, and follow-up was not available, what was the point?), and also constrained the ability of service providers to deliver coordinated care, and to use the MBS items for this purpose.

Related to this, were constraints on the supply of health providers for follow-up, including limited capacity of GPs to take on more care, and limited availability of practice nurses, AHWs, and allied health professionals with the skills to provide follow-up together with ability to claim Medicare rebates. In both regional and remote sites, Health Services noted the lack of allied health professionals who were both available and prepared to bulk-bill, and the inability of patients to cover gap payments.

Complementary linkages with other ICDP funded activities established

Adult health assessments and follow-up items were linked to several other ICDP measures in different ways – these items could contribute to Medicare service items to trigger Tier 2 payments for patients registered for the PIP Indigenous Health Incentive – and as noted in other points in this chapter – adult health assessments were often offered ‘as a package’ together with PIP Indigenous Health Incentive registration and access to the PBS Co-payment measure. This provided patients with motivation to undergo adult health assessments, and Health Service providers with motivation to offer them (since there was perceived benefit to patients and generated income).

The relationship between other ICDP measures and follow-up items was more complex; in general there was low uptake of follow-up items, and whilst some of this was likely to be related to poor development of systems to support follow-up, recall and reminder (as shown in Appendix E), alternate reimbursement mechanisms may also have been a factor – for example, there were reports of some referrals following adult health assessments being covered by MSOAP-ICD providers, rather than using the Medicare reimbursement channel. Greater use of TCAs and GPMPs was promoted by the ICDP care coordination measure.

The influence of the ICDP workforce on patterns of uptake of adult health assessments and uptake of follow-up items at a local level is complex. Interview data indicated that the workforce had diverse roles in relation to adult health assessments. However there was no evidence in the Sentinel Sites of a clear linear relationship between employment of the ICDP workforce and uptake of adult health assessments, follow-up items (or other ICDP measures) in specific sites (Appendix B). The various roles that ICDP workforce took on in relation to adult health assessments and follow-up are outlined below, along with a summary of the extent to which they may have had an impact on effective implementation of health assessments and follow-up items.

IHPOs in DGPs (and subsequently also Care Coordinators) took an active role in promoting awareness of the Aboriginal specific MBS item numbers amongst GPs. Specific activities included practice visits, working with practice support teams based within DGPs, development of 'cheat sheets' which show the Medicare billing possibilities, development and/or dissemination of adult health assessment templates both paper based and electronic templates to load on GPs' information systems.

OWs, TAWs and HLWs (and to a lesser extent IHPOs) were involved in raising awareness of various aspects of the ICDP at community level, including awareness of the MBS item numbers, bringing people into Health Services for health assessments, and raising awareness in the community about the value of adult health assessments.

Healthy Community Days funded under measure A3 (Chapter 4) were required to promote the uptake of adult health assessments and in many cases health assessments were being conducted on the day.

Care Coordinators took on roles in attempting to increase use of allied health services, through the team care arrangements for their patients – for example, developing registers or lists of local allied health professionals who were expected to provide a culturally safe service to Aboriginal and Torres Strait Islander people. Both IHPOs and Care Coordinators (in the latter part of the evaluation) identified the need to ascertain which allied health professionals in their locality would be prepared to bulk-bill Aboriginal and Torres Strait Islander patients – those workers who had commenced this noted that it was time-consuming as each provider needed to be contacted, and the information needed to be disseminated to Health Services. Such 'lists' would also need updating periodically as providers change their practices, and locality. The IHPOs and Care Coordinators believed that allied health professionals are not necessarily well oriented to claiming for Medicare items and in some cases noted that they were providing information directly to allied health professionals about the availability of these MBS item numbers, and Medicare billing in general. Some Care Coordinators were involved in promoting bulk-billing to allied health professionals, although the effectiveness of this as a strategy was unclear.

Care Coordinators, and to a lesser extent IHPOs and OWs considered that they needed to identify allied health professionals who were considered culturally aware, and ensure that these providers were known.

'A lot of allied health people don't understand the needs of the Aboriginal community from a cultural awareness perspective.' (Feedback from enhanced tracking site)

It seemed plausible that adult health assessments, together with the OWs, may play a role in motivating access to Health Services for some groups. As shown in this chapter, uptake of adult health assessments among men tended to be lower overall than that for women. There was a perception in some sites with complementary men's outreach work, sometimes initiated by the employment of a male OW, that uptake of adult health assessments for men increased at a rate comparable with, or exceeding uptake by women. These perceptions were not always backed by available data on numbers of health assessment for men and women. Increased uptake of male adult health assessments was noted in remote and to some extent in regional sites, but not urban sites. Further, increased uptake of

adult health assessments may have had a role in promoting use of the care coordination measure, and Supplementary Services funding, and in improving quality of care, through for example, increased delivery of brief interventions for smoking, obesity and other lifestyle risk factors, health advice and chronic disease care planning. Evidence from the Sentinel Sites suggests that this occurred to an extent, but in a limited ad hoc way with a general lack of integration of adult health assessments into the care continuum in many sites.

6.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the SSE in relation to the expected uptake of the adult health assessment and follow-up in the absence of a program logic within the National Framework. This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

6.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

Unlike the other ICDP measures, no program logic was developed in relation to this measure in the National Framework. However, a Fact Sheet published by DoHA explains that the measure is to ‘fund the increased MBS and PBS costs associated with parts of the Indigenous Chronic Disease Package’.⁹² This includes increased costs related to: the Practice Incentive Program; increased access to and utilisation of Health Services; the CCSS program; and to increasing the allowable number of follow-up services by a practice nurse or Aboriginal Health Worker per patient per calendar year for Aboriginal and Torres Strait Islander patients who have received a health assessment.

Under the heading ‘How this will help Indigenous Australians’, the factsheet explains:

- This measure funds the increased use of specific Medicare Aboriginal and Torres Strait Islander health assessment items with around 45% of the adult Aboriginal and Torres Strait Islander population expected to receive a health check over the four years to 2012-2013.
- Aboriginal and Torres Strait islander people will be provided with an estimated 400 000 additional chronic disease management services provided through the MBS over four years.
- They will also have their condition(s) managed better through significant additional referrals to specialist and other services.

This chapter has focussed on uptake of adult health assessments and follow-up items because these aspects of the ICDP are not a specific focus of other ICDP measures. The PIP Indigenous Health Incentive, issues of access to Health Services, the CCSS program and access to specialists and allied health services through USOAP and MSOAP are covered in other chapters of this report.

In the absence of a defined program logic for promoting increased uptake of health assessments and follow-up items, and in the absence of defined outcomes, early and medium term results as described for other measures in the National Framework, we have limited our assessment in this section to the evidence on the extent to which coverage of health assessments has increased in relation to the expectation specified in the DoHA fact sheet. MBS administrative data provided through DoHA indicate that about 12% of eligible Aboriginal and Torres Strait Islander people had adult health assessments

⁹² DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, op cit.

billed during the 12 month period from June 2011 to May 2012, the most recent year for which data were available for the SSE. These data indicate that while there have been increases in uptake of adult health assessment over the course of implementation of the ICDP, the expectation that 45% of the adult Aboriginal and Torres Strait Islander population should receive a health check over the four years to 2012-2013 will not be achieved. At least partly related to the lower than expected uptake of health assessments, there have only been small increases in uptake of follow-up items by a nurse or AHW and follow-up items by allied health professionals.

6.4.2. SUMMARY OF KEY FINDINGS

This section provides a summary of the key findings in relation to the higher utilisation costs for MBS and PBS Co-payment measure.

Adult health assessments

Uptake of adult health assessments in all Sentinel Sites taken together increased almost four-fold over the evaluation period, and two-fold in the rest of Australia (possibly reflecting different patterns of service utilisation and/or service providers).

The number of GPs who claimed one or more adult health assessments increased in the Sentinel Sites, and in the rest of Australia; number of adult health assessments conducted per GP remained relatively stable.

Uptake of adult health assessments increased for both older (consistently higher uptake) and younger age groups (slower but more sustained), and females and males. Comparatively slower increase for males than females probably reflects lower service utilisation in general.

In the final SSE quarter the number of adult health assessments per 100 Aboriginal and Torres Strait Islander people was highest in regional Sentinel Sites and the rest of regional Australia, and lowest in the rest of urban Australia.

There was wide variation in uptake of health assessments between sites, and this was evident in urban, regional and remote sites. There was an overall increase (per 100 people) in urban, regional and remote sites over the evaluation period, although trends in the remote Sentinel Sites were highly variable. The highest levels of uptake were achieved where there were high numbers of GPs conducting health assessments and, to a lesser extent, high numbers of assessments being done by each GP. Uptake in regional sites increased fairly steadily, with slightly higher uptake in regional Sentinel Sites than in the rest of regional Australia, increased numbers of GPs conducting health assessments and increased number of assessments per GP. The number of GPs claiming adult health assessments per 100 people increased substantially in urban and regional locations but showed little change in remote locations. Remote Sentinel Sites showed no evidence of an increased number of GPs conducting health assessments, with trends being driven by changes in the number of adult health assessments completed per GP.

A range of strategies to increase uptake of adult health assessments were evident in Sentinel Sites. The imperative to increase Medicare revenue was a key driver for increasing uptake of health assessments in many service organisations.

At Health Service level, strategies included dedicating time of GPs to complete, and allocating time of other staff to commence adult health assessments; changing systems to enable staggered completion; alignment of clinical information and other systems to support Medicare billing, and strategies to incentivise or motivate patients to undergo assessments.

At regional level, DGPs, Medicare Locals and regional support organisations employed and seconded staff to support uptake; provide or commence adult health assessments; provide information and organisational support to Health Services to maximise revenue and improve or expand service delivery.

The development and implementation of the inappropriate approaches to increasing uptake of health assessments that were evident in some Sentinel Sites may to some extent be a reflection of the absence of clear and explicit program logic to guide initiatives to increase uptake of adult health assessment at various levels of the health system. This is relevant to approaches for increasing uptake of health assessments that appeared more focussed on generating income for Health Services than providing benefits to patients, where there was inadequate engagement with clinicians, and where there were inadequate processes to ensure appropriate follow-up care.

Follow-up services by practice nurses and registered Aboriginal Health Workers

Uptake of follow-up services by practice nurses and registered AHWs increased, but the number of claims was low over the duration of the SSE. Uptake in all Sentinel Sites taken together increased more than 27-fold between the baseline and final evaluation period, while comparable data from the rest of Australia showed an increase of around 10-fold. Increases in urban locations were less than in regional and remote locations; increases for males was less than for females in the rest of Australia, but not in the Sentinel Sites.

There was general lack of awareness of the follow-up item number, confusion about eligibility for AHWs to claim, and no evidence from the Sentinel Sites of patient demand or demand from Health Services driving uptake of follow-up items. Many Health Services reported difficulty with accurately billing Medicare for the specific MBS item number. Strategies to increase uptake were implemented by some DGPs.

An important reason for low uptake of these follow-up items was that nurses and AHWs in many services were not well oriented to delivery of high quality chronic illness care, partly because the service systems within which they worked were not well oriented to delivery of high quality chronic illness care, and partly because many nurses and AHWs lacked specific knowledge and skills in this area, and partly, particularly in remote settings, because of other demands on their time. Health Services generally lacked systems to effectively support follow-up in terms of recall and reminder systems, nurse-led clinics, internal organisational systems for referring a patient to a nurse or AHW or to bill accurately. In addition, many AHWs did not meet the formal registration requirements to be eligible to bill Medicare (particularly prior to changes in registration in most states introduced on 1 July 2012).

Follow-up services by allied health professionals

Uptake of follow-up services by allied health professionals increased over the evaluation period, and showed similar patterns of uptake to follow-up services by nurses and AHWs. Uptake in all Sentinel Sites taken together increased around 20-fold between the baseline and final evaluation periods. Comparable data for the rest of Australia showed about a five-fold increase.

Interviewees reported there were limited numbers of allied health professionals to refer to, therefore referrals were often not made, or were made to salaried or program funded allied health professionals (and these services were not reflected in MBS data). Long waiting periods for appointments, lack of transparency in billing arrangements and concerns about cultural safety discouraged providers from referring, and patients from attending. Lack of reminder systems (at both allied health professional level and Health Service level) contributed to low patient attendance, once referred.

Strategies to increase uptake of these items implemented by some DGPs included collation and provision of information about local service providers and referral networks. Some organisations employed allied professionals directly, and some were testing funding models where positions were partly salaried and partly dependent on billing Medicare for specific services.

Enablers and constraints to effective implementation

Overall, the SSE identified a number of constraints to implementing the health assessment and follow-up items, as follows.

Streamlining of relevant MBS item claiming and Health Services' promotion of adult health assessments as part of a patient 'package' supported acceptance. Strong management and leadership support was important for changing norms about primary health care practice in Health Services. Sustained complementary programs such as 'Healthy for Life' enabled a culture of quality improvement linked with higher uptake, while GP-centric models of care, high staff turnover, high use of locum staff, entrenched billing habits and increased income as a motivator constrained reorientation of Health Services. Service reorientation from acute care to a comprehensive approach to primary health care was required. It was supported by capacity to use funding in ways consistent with the organisation's values and styles of care delivery, and flexibility in interpreting guidelines.

Site level functioning was enabled by involvement of both General Practice and AHSs, and high numbers of GPs claiming for assessments – supported by clear communication, shared understanding of how to roll out the measure and good team functioning within services. Limitations in clinical information systems, patient referral mechanisms and/or staff capacity to use these systems constrained the workability in some sites.

Lack of eligible and appropriate practice nurses, AHWs, and allied health professionals constrained use of follow-up services, as did perceived and actual up-front and gap costs for patients and cultural safety issues.

Proactive roles by regional support organisations were mostly enabling, but could be constraining if there were divergent understandings about the role of adult health assessments in primary health care, and in regular provider/patient relationships.

The ICDP workforce had a complementary and enabling role in raising awareness about the measure and billing processes, resource production and dissemination and patient transport to appointments. Adult health assessments complemented the care coordination measure, Supplementary Services funding, and could improve quality of care through, for example, increased delivery of smoking and healthy lifestyle brief interventions.

6.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) There appears to be a need to clearly enunciate and communicate a logic by which health assessments are expected to deliver improved health outcomes for Aboriginal and Torres Strait Islander people, and for the design and funding arrangements for health assessments to be reviewed specifically with a view to ensuring that efforts to increase uptake, and the processes for conducting health assessments, are consistent with the logic by which health assessments are expected to deliver health benefits and are complementary to and supported by other components of the ICDP.

- b) There is a need for initiatives that are more specifically focussed on re-orientation of primary health care service delivery system design, and primary health care clinical information systems, to support delivery of high quality population-based and patient-centred chronic illness care, specifically including through enabling nurses and AHWs to provide high quality follow-up care.
- c) There is a need to gain a better understanding of the priority gaps in availability of allied health services, the processes by which required allied health services can most efficiently and effectively be provided to patients with chronic illness, the most efficient and effective models for funding such care, and developing systems for monitoring and evaluation of allied health services.

7. SUPPORTING PRIMARY CARE PROVIDERS TO COORDINATE CHRONIC DISEASE MANAGEMENT (*MEASURE B3 PART A*)

7.1. Description of measure

The Practice Incentives Program (PIP) Indigenous Health Incentive is one of 12 incentive areas available to Health Services registered as PIP practices. Accreditation with the Royal Australian College of General Practitioners (RACGP) Standards for General Practice is a requirement for registration as a PIP practice. These incentive areas provide a more flexible payment model and are intended to influence both short and long term changes in service delivery. Improving accountability, reporting and data collection on selected health issues were implicit objectives of the overall PIP program, as demonstrated by the introduction of an incentive payment for information management/information technology (later evolved to eHealth). Once registered for the overall PIP program, Health Services elect to participate in particular incentive areas – not all areas are related to performance, and some take the form of conditional cash transfers to practices upon implementation of certain services.

7.1.1. REQUIREMENTS

Participation by Health Services in the PIP Indigenous Health Incentive requires that Health Services participate in annotation of PBS prescriptions for eligible patients in accordance with the ICDP PBS Co-payment measure; gain patient consent for individual-level registration to the PIP Indigenous Health Incentive; institute systems for follow-up and recall of patients and - for General Practices - send a minimum of two staff members, one of whom must be a GP, to accredited cultural awareness training within 12 months of sign up.

The requirement for Health Services to be registered with the overall PIP program may be waived for AHSs (on application).

7.1.2. PAYMENT COMPONENTS

There are three payment components available to Health Services through the PIP Indigenous Health Incentive:

- sign-on payment: a one-off payment of \$1000 to Health Services that register for this incentive and agree to undertake specified activities to improve the provision of care to their Aboriginal and Torres Strait Islander patients with chronic disease (as described above)
- patient registration payment: an annual payment to Health Services of \$250 for each Aboriginal and Torres Strait Islander patient aged fifteen years and over, registered for chronic disease management with the Health Service over the course of the calendar year.
- 'outcomes' payments: these are quarterly payments, triggered automatically and contingent on Medicare billing for PIP Indigenous Health incentive registered patients, as outlined below.
 - Tier 1 - \$100 to Health Services for each registered patient for whom a target level of care is provided by the Health Service in a calendar year. Tier 1 relates to the development and review of a GP Management Plan (GPMP) or Team Care Arrangement

(TCA).⁹³ To receive this payment, Health Services need to have prepared a GPMP (MBS item 721) or coordinated the development of a TCA (MBS item 723), or undertaken two reviews of the patient's GPMP or TCA, or contributed to a review of a multi-disciplinary care plan for a registered patient in a Residential Aged Care Facility (MBS item 731) on two occasions during the year.

- Tier 2 - \$150 to Health Services for each registered patient for whom the majority of care is provided by the Health Service within a calendar year regardless of where the patient is initially registered.⁹⁴ Majority of care refers to the provision of the majority of eligible MBS services, with a minimum of five eligible MBS services through the calendar year. Items such as commonly used GP attendance items and Chronic Disease Management items are included.⁹⁵

The payments described above are in addition to the usual fee-for-service reimbursement provided through Medicare. Health Services may receive 'outcomes' payments, even if the patient is registered for the PIP Indigenous Health Incentive at another Health Service. Payment is made to Health Services in the quarter following completion of the required services.

7.1.3. DIRECT BENEFITS TO PATIENTS

The benefits potentially available to patients through the PIP Indigenous Health Incentive registration include:

- Ability to access the PBS Co-payment measure through the PIP registered practices being allowed to annotate prescriptions accordingly and committing to do so
- Ability to be referred to the ICDP Care Coordination and Supplementary Services program (only available to PIP registered patients with complex chronic disease care needs – see Chapter 8)
- Improved chronic disease management through Health Services investing in improved systems to support prevention and management of chronic illness care
- More culturally appropriate care resulting from staff undertaking required cultural awareness training

7.2. State of implementation – national context

Health Services and patients began signing on to the PIP Indigenous Health Incentive in March 2010. The first payments were made to Health Services in May 2010.⁹⁶ Prior to and during the evaluation period, DoHA developed and refined systems to support implementation and streamlining of the incentive – key points related to progress with implementation are outlined below. This is followed by key points about ways in which the incentive was streamlined over the period of the evaluation to better support implementation including: processes for patient registration; development of a system for easier identification by patients of PIP registered practices; support to meet requirements for

⁹³ DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010 <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/indigenous-health-incentive-guidelines.pdf>> (accessed 23 October 2012).

⁹⁴ DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/\\$file/DHA6136%20B3%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf)> (accessed 23 October 2012).

⁹⁵ DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010, op cit.

⁹⁶ DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet, op cit.

cultural awareness training; communication about the incentive and other adjustments. These adjustments are important to note as they provide context for the trends in uptake reported later in the chapter.

- Communication about the PIP Indigenous Health Incentive to both PIP registered Health Services and non-PIP registered AHSs commenced during December 2009/January 2010.
- Formal letters of invitation, along with documentation required for registration for the PIP Indigenous Health Incentive and the PBS Co-payment measure were sent to Health Services during March 2010. Documentation sent to Health Services included guidelines: forms for health service application, patient consent, withdrawal of patient consent and registration; patient information sheets. Documentation was also made available on the Medicare Australia website⁹⁷ and the DoHA 'Tackling Chronic Diseases' website.⁹⁸
- Uptake of Health Service sign-on and patient registration was fairly rapid. By 30 June 2010, around 850 Health Services had joined the incentive, and around 2900 patients had been registered.⁹⁹ During 2010, approximately 26 000 patients were registered and as at 30 April 2011, 2100 Health Services had received sign-on payments.¹⁰⁰
- Data from DoHA for 2010 indicated that, nationally, Tier 2 payments had been triggered by Medicare billing for 95% of registered patients (24 796 of 26 073 patients registered during 2010).
- In contrast, in 2010, Tier 1 payments were triggered for 5.3% of registered patients (1387 of 26 073).

During 2010-2012, several processes were streamlined in response to feedback about the registration of patients on the PIP Indigenous Health Incentive, and in response to feedback about difficulties patients experienced in identifying Health Services registered with the PIP Indigenous Health Incentive. These included development of:

- A single form that made it possible to register multiple patients at a time, and required only one signature from a GP and service-authorized contact. This multiple patient form was developed from mid-late 2010, uploaded onto the PIP website in August 2011 and publicised in November 2011 via the 'PIP News Update'.¹⁰¹ A further simplified registration and re-registration form was developed and made available in November 2012.¹⁰²
- An 'opt in' register of participating Health Services, searchable by PIP enquiry line staff. The intention was to make it easier for patients to identify Health Services registered with the incentive (and from whom they could receive PBS Co-payment annotated prescriptions). As of July 2012, almost 60% of Health Services registered with the PIP Indigenous Health Incentive had opted for inclusion in the register.¹⁰³

⁹⁷ Medicare Australia [website], Practice Incentives Program <www.medicareaustralia.gov.au/provider/incentives/pip/forms-guides.jsp> (accessed 12 December 2012).

⁹⁸ DoHA, Tackling Chronic Diseases [website] <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-incentives-program/\\$file/PIP-FAQ.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/practice-incentives-program/$file/PIP-FAQ.pdf)> (accessed 24 October 2012).

⁹⁹ DoHA, Tackling Chronic Diseases [website] Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report <<http://www.health.gov.au/tackling-chronic-disease>> (accessed 24 October 2012).

¹⁰⁰ DoHA, Tackling Chronic Diseases [website] Indigenous Chronic Disease Package in 2010-11 - Annual Progress Report. Op cit.

¹⁰¹ Medicare Australia [website] PIP News Archives <<http://www.medicareaustralia.gov.au/provider/incentives/pip/news-archive.jsp>> (accessed 23 October 2012).

¹⁰² Medicare Australia [website] PIP News Archives <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/8646-1211-pip-news-november.rtf>> (accessed 16 November 2012).

¹⁰³ DoHA, Supporting Primary Care providers to Coordinate Chronic Disease Management, 3 August, 2012.

Over the period of the evaluation several initiatives to increase access to the required accredited cultural awareness training by staff in participating Health Services were implemented. These included:

- **Development of online cultural awareness training modules;** the module 'Introduction to Aboriginal and Torres Strait Islander cultural awareness in General Practice' was made available in April 2011, developed through the RACGP Quality Improvement and Continuing Professional Development program¹⁰⁴. In addition, the Australian College for Rural and Remote Medicine launched an accredited online training module, available from February 2011.¹⁰⁵
- **Development and accreditation of face-to-face cultural awareness training;** initiated through DGPs and SBOs during the period of 2010 to 2012.
- **Incorporation of some flexibility in time to meet cultural awareness training requirements;** since the development of training had taken longer than anticipated, DoHA extended the timeframe for Health Services to meet the training requirement – with the new requirement being that Health Services needed to complete the training within a 12 month period of health service registration, with the 12 month period commencing no earlier than April 2011. DoHA also indicated that if unable to access the required training, Health Services should keep relevant documentation that could be produced in the event of an audit.¹⁰⁶

Information about the PIP Indigenous Health Incentive was communicated to Health Services through a range of online, postal and face-to-face channels. These included:

- 'PIP News Update', a quarterly newsletter distributed to Health Services with their payment summaries and also available on the Medicare Australia website
- PIP program website, PIP phone enquiry line, and email enquiry service¹⁰⁷
- Communication to AGPN and SBOs, who disseminate information to their members
- Face-to-face communication through IHPOs, OWs and Medicare Liaison Officers for Indigenous Access.

Finally, over the period of the evaluation, changes were made regarding storage of patient consent forms. Patient consent forms signed before 1 July 2011 did not need to be submitted to Medicare, but were to be kept on file at the practice for auditing purposes. From 1 July 2011, to comply with privacy legislation, the PIP Indigenous Health Incentive patient consent forms were also required to be sent, by Health Services, to the PIP processing area in Medicare.¹⁰⁸ This was communicated through the February 2011 and May 2011 'PIP News Update' and the patient consent form was updated to reflect the changed requirements. Consent forms were required to be faxed or mailed to Medicare, or scanned and emailed by Health Services using Health Professional Online Services. This process has since been modified so that those Health Services using online registration no longer need to submit forms to Medicare, but retain them on file at the Health Service.

¹⁰⁴ Medicare Australia [website] PIP News Archives, <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/4719_-_PIP_news_update-May_2011.pdf> (accessed 16 November 2012).

¹⁰⁵ Medicare Australia [website] PIP News Update May 2011 <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/4719_-_PIP_news_update-May_2011.pdf> (accessed 23 October 2012).

¹⁰⁶ General Practice NSW, Closing-the -Gap e-communication, 13 April 2012.

¹⁰⁷ Medicare Australia [website] PIP News Update <<http://www.medicareaustralia.gov.au/provider/incentives/pip/news-archive.jsp>> (accessed 24 October 2012).

¹⁰⁸ Medicare Australia [website]. PIP News Archives <<http://www.medicareaustralia.gov.au/provider/incentives/pip/files/pip-news-update-february-2011.pdf>> (accessed 23 October 2012).

7.3. Findings from the Sentinel Sites

The findings from the SSE should be interpreted with an understanding of the evaluation methods and associated limitations which are described briefly in the Introduction (Chapter 2) and in more detail in Appendix C.

7.3.1. AWARENESS, SOURCES OF INFORMATION AND EMERGING COMMUNICATION ISSUES

KEY POINTS

- High levels of awareness of the PIP Indigenous Health Incentive were evident in urban and regional sites, with lower but increasing awareness in remote sites.
- For General Practice, linkages with established practice support teams in DGPs were effective channels of communication about the measure, with IHPOs in DGPs, and to a lesser extent Care Coordinators, using these and other channels to communicate with General Practice.
- For the AHS sector, the NACCHO affiliates, Medicare Liaison Officers, the Aboriginal and Torres Strait Islander Access Line (referred to colloquially as the Medicare Indigenous Hotline), and PIP Enquiry Hotline were noted as providing information about the measure. Mixed experiences were reported regarding the usefulness of the Medicare and PIP Hotlines, with some users satisfied and others reporting that they had received inconsistent information from these different sources.
- Both sectors also relied on word-of-mouth, and used their networks to source more detailed information about implementation. Opportunities for face-to-face communication and information sharing were highly valued.
- Community focus group members were in general poorly informed about the measure and its intent. Community members in general believed that registration with the PIP Indigenous Health Incentive was necessary in order to gain access to the PBS Co-payment measure. Linkage of these two measures made it particularly difficult for Health Services and patients to understand the rationale behind annual re-registration.
- High levels of staff turnover in many of the participating Health Services and regional support organisations, along with Health Services being at varying stages of implementation, indicates a requirement for ongoing responsive communication about the measure.
- Ways in which the resources available through the measure could be used to enhance care for Aboriginal and Torres Strait Islander patients were generally not well understood or developed at local level.

Overall awareness

From the commencement of the evaluation, awareness of the PIP Indigenous Health Incentive amongst the stakeholders interviewed in Sentinel Sites was high, with universal awareness amongst interviewees in urban and regional sites since the first evaluation cycle and near universal awareness amongst remote site interviewees by the final evaluation cycle. This near universal awareness of the measure cannot be generalised to all Health Services in the site – the interviewees were selected based on their interest in Aboriginal and Torres Strait Islander health.

Although the PIP Indigenous Health Incentive is directed at the Health Services, rather than at communities, patient understanding is required for the measure to be successfully implemented. Patients need to provide consent to be registered, with an understanding that the Health Service with which they are registered should be their regular service provider. Community focus group participants in the Sentinel Sites had low awareness of the measure and its intention - there were indications of slight increases in awareness in the final evaluation cycle, possibly partly because of engagement by the evaluation team in the sites. Amongst those aware of the measure, levels of understanding differed, with some community members with chronic disease being uncertain whether or not they were registered, and others aware of their registration, and its ramifications, and having received letters regarding re-registration. Community focus group participants generally indicated that they had been asked to sign up for the 'Closing the Gap' program rather than the PIP Indigenous Health Incentive specifically. This is consistent with information provided by many of the Health Services, who indicated that they were signing patients up to the PIP Indigenous Health Incentive as part of a 'package', including the PBS Co-payment measure, and often an adult health assessment.

In the final evaluation cycle, community focus group members and Health Service interviewees questioned the logic behind re-registration, noting that re-registration was inconsistent with the once-off registration required by the PBS Co-payment measure. Most respondents regarded the two measures as linked.

Sources of information

The General Practice and AHS sector obtained information about the PIP Indigenous Health Incentive from various sources.

General Practice interviewees generally acknowledged the role of the IHPOs based in DGPs as an important source of information, and to a lesser extent (and in later evaluation cycles), the Care Coordinators. The IHPOs (and to some extent Care Coordinators) linked with established practice support teams in the DGPs to incorporate the PIP information into their 'suite of information', developed flow charts, information sheets, and incorporated information about the measures into existing education workshops for clinical and practice staff. Linkages with the established practice support teams within the DGPs were considered critical to the success of these approaches. These activities by ICDP staff within DGPs were largely consistent with the historical role of DGPs in assisting General Practice to register for the overall PIP program, and providing other support to system development in General Practice.

DGP staff noted the role of SBOs in providing information about the PIP Indigenous Health Incentive, together with information about the PBS Co-payment measure, and support through provision of opportunities to attend workshops and distribution of information through email lists. Practice managers and clinicians also referred to the GP practice kits developed by DoHA from the third evaluation cycle onwards, which provided information about the new measures. These were generally perceived to be helpful in understanding the measures.

AHSs reported the role of Medicare Liaison Officers, Aboriginal and Torres Strait Islander Access Line and the PIP Enquiry Hotline as important in providing them with information about the measure. The information role of NACCHO affiliates was considered important in some jurisdictions.

'Don't know how services would cope without our support because you are ringing the PIP line and getting all this incorrect information and all these situations that are happening within the services with patients, you won't get that (help) from the PIP line. IHPO provides information to all [state name] Aboriginal Health Services.' (NACCHO affiliate)

In the one instance identified where a NACCHO affiliate was not valued as a source of information, it appeared to be due to lack of clarity about roles, with the IHPO based in the affiliate being focussed on Tobacco Action and Healthy Lifestyle work, and support of OWs, and lack of clear allocation of responsibility for the role of supporting AHSs to access the PIP Indigenous Health Incentive.

The SSE team was also identified as an important source of information for many Health Services in the Sentinel Sites, with some stating that the SSE team was the main source of information about the measure.

'[Information has been] largely from Menzies. I know of coordinators of [NACCHO affiliate name] but have never seen or spoken to them. We have had no information from anywhere besides what we have picked up from the evaluation team.' (AHS, medical director)

Across the evaluation period, there was some frustration expressed about inconsistent information - both SBOs and NACCHO affiliates identified this as a concern being expressed by their members, and this predominately related to information provided by the hotlines.

'When you ring the number you get someone new, each time you ring about the same patient you get different information. [Name of Care Coordinator] says one thing, Medicare says another, it's ... painful. The supports I find contradictory from Medicare, Care Coordinator, help lines ... we ring Medicare and they give the wrong information, for example Medicare said a year from registration date for re-registration, Medicare also said from the financial year and from 1 January.' (General Practice, nurse)

Informal networking and requests for support and information, including (to a lesser extent) communication between General Practice and the AHS sector were used by both sectors to understand how to implement the measure.

'We've spent a lot of time on the phone speaking to other Aboriginal Medical Services to find out how they run their PIP Program and they were in the same boat, didn't really know what they were doing.' (AHS, practice manager)

For both sectors, opportunities for face-to-face communication were highly valued, particularly where information sources were trusted and able to discuss the whole of the ICDP, including the financial ramifications of participation in the various ICDP components. Both the SSE team and IHPOs were identified by interviewees as fulfilling this role to a large extent.

'We need everything to be simplified. It's a complex package with lots of nuances. GPs don't have time to read through all the promotional material and the finer Medicare details. Materials developed just gather cobwebs. Need a face-to-face presence to discuss and bring to their attention.' (Feedback from tracking site)

Emerging issues related to communication

The communication needs about the measure have evolved since early implementation. High levels of awareness have been developed and in general, structures have developed or are evolving to support the details of implementation and access to the measure. Two issues emerged related to future communication needs.

First, there is a need for continued responsive communication about the measure. For example, interviewees referred to emerging issues concerning re-registration of patients, ways to optimise Tier 1 and Tier 2 payments and ongoing staff turnover within Health Services, as requiring ongoing opportunities for dialogue and information sharing.

Second, a clear need became apparent, not only for information about how to access the measure, but also for greater guidance in how to use the available resources to enhance care for Aboriginal and Torres Strait Islander communities. Although some pockets of good practice were identified, many interviewees raised concerns that the PIP Indigenous Health Incentive was a paperwork exercise that was not changing anything for patients. Although part of the intent of the PIP Indigenous Health Incentive (along with the other incentives available through PIP program) is to enable Health Services to develop systems for better population based care, many Health Services seemed unclear about how this could be achieved and, particularly in General Practice, how to develop responsive and equity-oriented systems for delivering high quality care to Aboriginal and Torres Strait Islander people.

7.3.2. PARTICIPATION BY HEALTH SERVICES

KEY POINTS

- Registration of Health Services with the PIP Indigenous Health Incentive has been high with 60% of PIP participating Health Services in Sentinel Sites and 55% of PIP participating Health Services in the rest of Australia registered for the incentive by May 2012.
- Of all sign-on payments received by the end of May 2012 in the Sentinel Sites and in the rest of Australia combined, 94% (2806/2955) were payments made to General Practices, and 5% (149/2955) were payments made to AHSs. This reflects the greater numbers of General Practices compared to AHSs in Australia, and is in contrast to the number of patients registered per sector proportional to population, which was approximately equivalent in each sector in the rest of Australia – and substantially higher for AHSs in the Sentinel Sites.
- AHSs tended to sign on earlier than General Practices. Nationally, apparently all (or almost all) PIP eligible AHSs had registered for the PIP Indigenous Health Incentive by May 2011.
- Registration of General Practices has levelled off during 2012. Over 40% of PIP eligible General Practices had signed on for the PIP Indigenous Health Incentive by May 2012 in both Sentinel Sites and the rest of Australia. More than 40% of these had not registered any patients.
- The percentage of eligible Health Services signed on for the incentive was highest in remote locations (63% of PIP registered practices signed onto the incentive in remote Sentinel Sites and 95% in the rest of remote Australia, followed by regional locations (75% and 69% respectively) and urban locations (55% and 45% respectively). Underlying these differences are the inverse geographic differences in numbers of eligible Health Services – there are higher numbers of Health Services registered with the overall PIP program (meeting eligibility criteria) in urban and to a lesser extent in regional, compared to remote locations.
- The reason General Practices did not sign up for the incentive appeared predominantly to relate low numbers of Aboriginal and Torres Strait Islander patients or potential patients, the need to develop local Health Service systems to support implementation of the measure, and uncertainty about the time commitment required for cultural awareness training.
- Concerns were expressed about perceived administrative burden, particularly by small remote Health Services with limited internal capacity for administration, and limited access to higher level divisional or regional support.

Uptake of the Health Service sign-on payment by sector

There was high uptake of the PIP Indigenous Health Incentive sign-on payment overall and by Health Services in both the General Practice and the AHS sectors. Of all Health Services participating in the overall PIP program, some 40% had received the PIP Indigenous Health Incentive sign-on payment by May 2012 (Figure 7.1).

With regards to participation by AHSs, all (or almost all) AHSs that were registered with the overall PIP program had received the PIP Indigenous Health Incentive sign-on payment by the end of May 2012. There is potential to exceed 100% since a few AHSs are exempt from the requirement to participate in the overall PIP program in order to access the PIP Indigenous Health Incentive. Uptake by AHSs was more rapid than that by General Practices, possibly due to earlier knowledge of the measure by AHSs through their focus on provision of care to Aboriginal and Torres Strait Islander people.

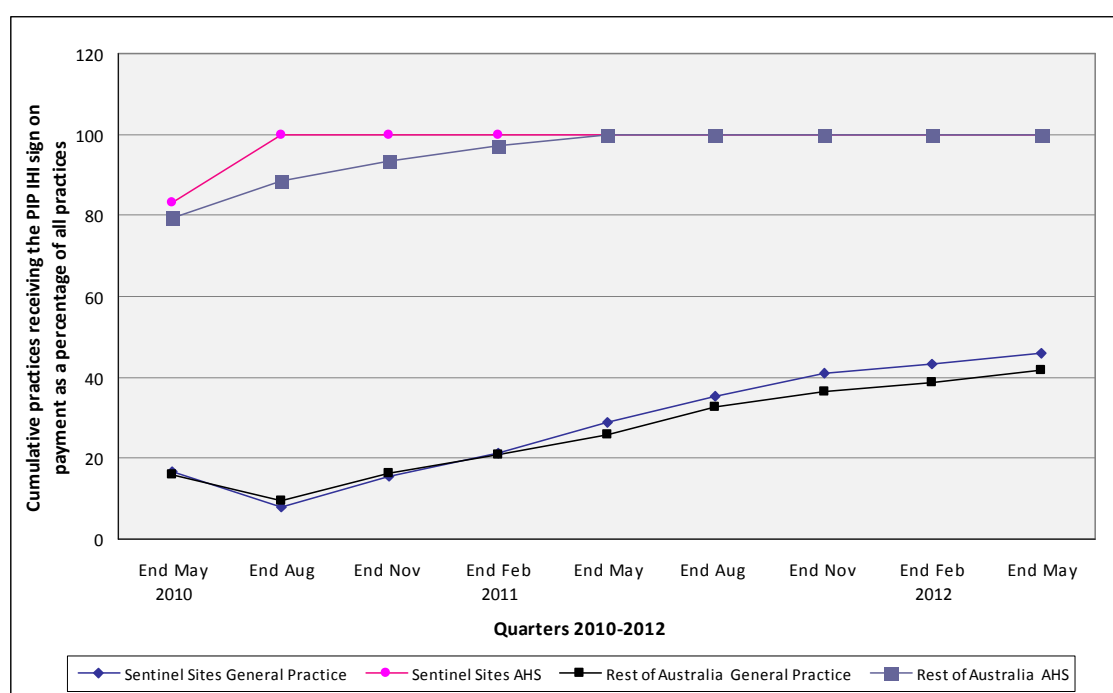


Figure 7.1: Health Services that have received the PIP Indigenous Health Incentive sign-on payment (as a percentage of all PIP registered Health Services during the evaluation period) for Sentinel Sites and the rest of Australia, by sector and by quarter 2010-2012

The numbers of Health Services registered for the PIP Indigenous Health Incentive over time and by sector provide a different way of considering uptake of the measure (Table 7.1). As shown in Table 7.1, a large proportion of Health Services that had signed up by May 2012 had been signed up for at least a year. For example, of the 330 General Practices in urban Sentinel Sites that were registered for the PIP Indigenous Health Incentive sign-on payment, 225 had been signed on for a year or more. This suggested that implementation of the requirements of the PIP Indigenous Health Incentive, such as participation in the PBS Co-payment measure; sign up of individuals for the PIP Indigenous Health Incentive (which further has potential to trigger the Tier 1 and Tier 2 payments); and instituting follow-up arrangements for patients with chronic disease would be well underway by the final evaluation period. Evidence from the Sentinel Sites regarding the extent to which implementation of requirements of PIP Indigenous Health Incentive participation were being met is outlined in sections 7.3.5 and 7.3.8 below.

Also indicated by Table 7.1 is that, of all sign-on payments received by the end of May 2012 in the Sentinel Sites and in the rest of Australia, 94% (2806/2955) were payments made to General Practice,

and 5% (149/2955) were payments made to AHSs. This reflects the large numbers of General Practices relative to AHSs in Australia. However this comparison is interesting to consider in relation to the numbers of patients registered with the incentive by sector (see Section 7.3.3)– which shows almost twice as many patient registrations per 100 people in the AHS sector compared to in the General Practice sector in Sentinel Sites, and similar numbers of patient registrations in the rest of Australia, and in relation to data from DoHA which indicates that by November 2011, more than 40% of Health Services registered for the incentive had not yet registered any patients. Table 7.1 also shows the uptake of the sign-on payment by location, discussed in the section below.

Table 7.1: Number of Health Services that have received the payment for the PIP Indigenous Health Incentive sign-on payment for Sentinel Sites and the rest of Australia by urban, regional or remote location, sector, and quarter, March 2010 - May 2012

Sentinel Sites/ Rest of Australia	Health Service	No. of Health Services registered (PIP Indigenous Health Incentive sign-on payment)									
		Mar - May 2010	Jun - Aug 2010	Sep - Nov 2010	Dec 2010 -Feb 2011	Mar - May 2011	Jun - Aug 2011	Sep - Nov 2011	Dec 2011 -Feb 2012	Mar - May 2012	Total
Urban											
Sentinel Sites	General Practice	85	42	31	33	34	41	31	16	17	330
	AHS	<5	<5	<5	<5	<5	<5	<5	<5	<5	7
	Both	89	43	31	33	34	42	31	17	17	337
Rest of Australia	General Practice	362	225	140	100	99	171	97	63	84	1341
	AHS	11	<5	<5	<5	<5	<5	<5	<5	<5	14
	Both	373	226	141	100	99	172	97	63	84	1355
Regional											
Sentinel Sites	General Practice	36	16	24	11	14	10	11	5	7	134
	AHS	11	<5	<5	<5	<5	<5	<5	<5	<5	16
	Both	47	19	25	12	14	10	11	5	7	150
Rest of Australia	General Practice	236	160	116	76	75	99	55	33	56	906
	AHS	42	5	5	<5	<5	<5	<5	<5	<5	59
	Both	278	165	121	79	76	100	56	34	56	965
Remote											
Sentinel Sites	General Practice	<5	<5	<5	<5	<5	<5	<5	<5	<5	<5
	AHS	<5	<5	<5	<5	<5	<5	<5	<5	<5	7
	Both	5	<5	<5	<5	<5	<5	<5	<5	<5	8
Rest of Australia	General Practice	47	5	14	8	5	6	5	<5	<5	94
	AHS	14	13	6	<5	<5	5	<5	<5	<5	46
	Both	61	18	20	12	5	11	6	<5	<5	140
Total											
Sentinel Sites	General Practice	122	58	55	44	48	51	42	21	24	465
	AHS	19	5	<5	<5	<5	<5	<5	<5	<5	30
	Both	141	63	57	45	48	52	42	22	25	495
Rest of Australia	General Practice	645	390	270	184	179	276	157	97	143	2341
	AHS	67	19	12	7	<5	7	<5	<5	<5	119
	Both	712	409	282	191	180	283	159	100	144	2460

Note: <5 means that there were less than five, and for confidentially reasons the data are not presented.

Uptake of the Health Service sign-on payment by geographic location

Sign-on for the PIP Indigenous Health Incentive amongst Health Services participating in the PIP program was highest in remote locations (63% in remote Sentinel Sites and 95% in the rest of remote Australia), followed by regional locations (75% and 69% for Sentinel Sites and the rest of regional Australia respectively) and urban locations (55% and 45% for Sentinel Sites and the rest of urban Australia respectively). The higher proportion of eligible services signing up for the PIP Indigenous Health Incentive in remote locations may be partly a reflection of the lower proportion of total Health Services in remote locations and regional locations that participate in the PIP program and the greater role played by AHSs in primary health care delivery for Aboriginal and Torres Strait Islander people in remote locations – with these services more oriented to ICDP participation.

In terms of absolute numbers there were large numbers of Health Services in urban locations that received the sign-on payment. This was because there are larger numbers of Health Services in urban locations, and larger numbers of Health Services participating in the PIP program.

Accessibility of registered Health Services

The number of Health Services registered with the PIP Indigenous Health Incentive per 1000 people may provide an indication of accessibility, or at least provider choice for Aboriginal and Torres Strait Islander people. This is an important issue because patients can only access the PBS Co-payment measure through obtaining annotated prescriptions, and these prescriptions can only be provided by a PIP Indigenous Health Incentive registered Health Service.

As indicated in Figure 7.2, in relation to numbers of Aboriginal and Torres Strait Islander people in the population, there are a larger number of Health Services available to provide PIP Indigenous Health Incentive-related services in urban locations compared to regional, and a larger number in regional compared to remote locations. There are also larger numbers of Health Services available to provide these services in the rest of Australia, compared to the Sentinel Sites (Figure 7.2).

The number of Health Services signed up for the PIP Indigenous Health Incentive per 1000 Aboriginal and Torres Strait Islander people was 13, five and one in urban, regional and remote Sentinel Sites respectively, and 17, nine and one Health Service per 1000 Aboriginal and Torres Strait Islander people in the rest of urban, regional and remote locations in Australia respectively. These numbers suggest that provider choice for PIP Indigenous Health Incentive providers will be greater in urban locations; in reality however, the more complex provider environment in urban locations may make it more difficult for urban residents to identify participating Health Services.

Generally lower numbers of PIP Indigenous Health Incentive practices in the Sentinel Sites proportional to population may reflect the fairly strong role played by AHSs in Sentinel Sites (which were selected contingent on the presence of an AHS in the site).

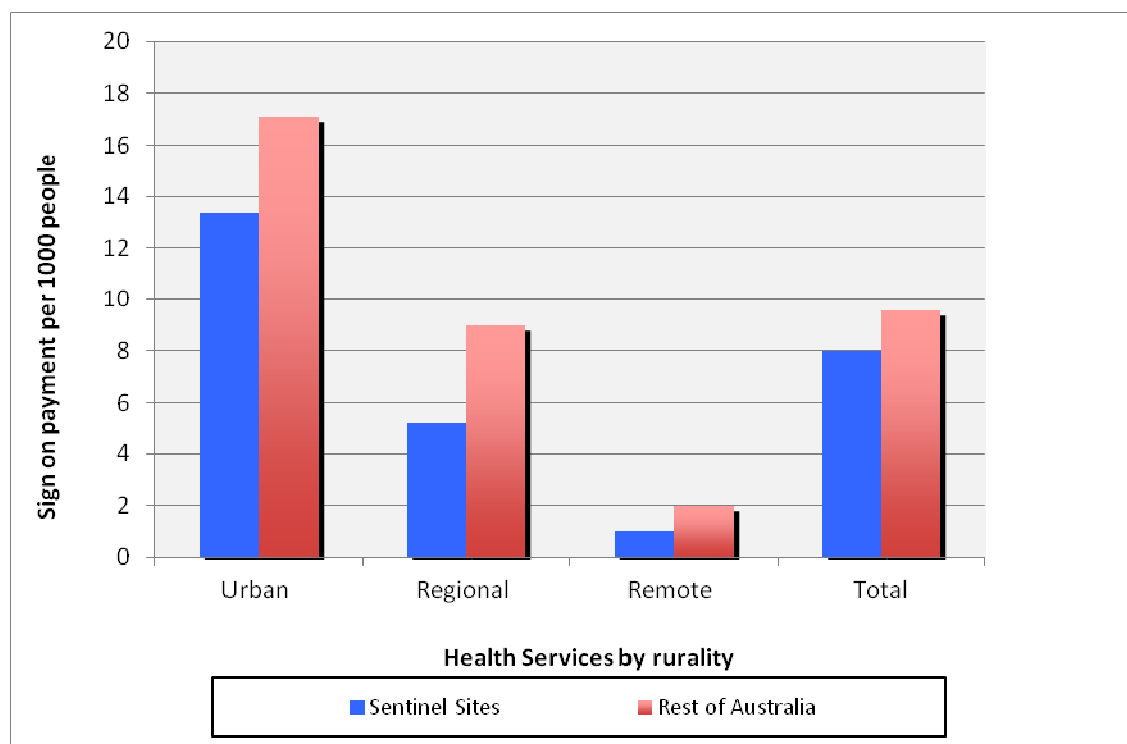


Figure 7.2: Number of Health Services receiving the PIP Indigenous Health Incentive sign-on payment per 1000 Aboriginal and Torres Strait Islander people aged ≥ 15 years in Sentinel Sites and the rest of Australia, by urban, regional and remote locations, May 2012

Barriers to Health Services signing up

For those General Practices not participating in the overall PIP program (around 30% of all practices), the most likely reason is their lack of administrative capacity to do so – previous evaluation of the PIP program has shown that participation is difficult for small General Practices, because some economies of scale are required to make the investment in administration worthwhile.

Similarly, in the SSE, where Health Services had not signed up to the PIP Indigenous Health Incentive, one of the barriers cited by interviewees was the perceived administrative burden. However for these services in the Sentinel Sites, it was unclear where the problem lay – whether at the point of accreditation, overall PIP registration, or registration for the PIP Indigenous Health Incentive specifically. Overall, smaller services without higher level support to assist in meeting administrative requirements (such as some in remote locations), found each stage leading to the incentive difficult, whereas other Health Services specifically noted the PIP Indigenous Health Incentive as being a source of difficulty – possibly relating to the lack of capacity to take on something that appeared at face value to be complex.

For those General Practices participating in the overall PIP program and not signed up for the PIP Indigenous Health Incentive (approximately 60%), reasons may have related to the low numbers (or perceived absence) of Aboriginal and Torres Strait people using (or wanting to use) their service. Particularly noted in the Sentinel Sites was uncertainty about the time commitment required for meeting the cultural awareness training requirement of the incentive – with interviewees indicating that they did not know (or had not had the time to find out) what was expected. This was identified by some Health Service interviewees as a disincentive to signing up. Where this lack of understanding was coupled with low numbers of potential Aboriginal and Torres Strait Islander patients, Health Services did not give further consideration to participation.

7.3.3. PATIENT REGISTRATION

KEY POINTS

- The number of people registered for the PIP Indigenous Health Incentive has increased over the evaluation period – with earlier patient participation coming mainly from the AHSs, and more recent increases in participation primarily driven by increased registration from General Practice.
- Registration per 100 people in 2011 was broadly similar for AHSs and General Practice in the rest of Australia, at around 5-7 registrations completed per 100 people at the end of 2011. AHSs in Sentinel Sites achieved particularly high registration overall at around 10 registrations per 100 at the end of 2011.
- Most people registered for the PIP Indigenous Health Incentive are likely to be registered for the PBS Co-payment measure, as this was generally used as a patient incentive to encourage registration.
- There was an approximately 50% increase in the number of people registered for the PIP Indigenous Health Incentive in 2011 compared to 2010. Most registrations in 2011 were first time registrations (about 30% were people who had been registered in 2010). This suggests that registration for the PBS Co-payment measure was continuing to have a major influence on registration for the PIP Indigenous Health Incentive.
- A limited proportion of patients registered in one year have been re-registered in the following year (between 30 and 40% overall). Re-registrations have been relatively higher in the AHS sector, but have declined in the most recent period covered by the SSE, while those in General Practice have increased. This may be related to the earlier participation in the PIP Indigenous Health Incentive by the AHS sector.
- Strategies used by Health Services to promote registration have included letters to patients, registration 'drives' and promoting access to the PBS Co-payment measure.
- Lack of understanding of the intent of the measure by community focus group members was evident, as was uncertainty amongst health service providers about how to explain to their patients why they needed to register for the PIP Indigenous Health Incentive.
- Positive perceptions about ease of organising patient registration have increased over time, with some evidence of development of local systems for registering patients, particularly in larger AHSs. Lack of development of systems at Health Service level appears to underlie the remaining frustrations in working out if patients are registered and what services they require, with some duplication of effort and service delivery evident.

Number of Aboriginal and Torres Strait Islander people registered annually

Overall, numbers of PIP Indigenous Health Incentive registrations have increased over time, with no apparent drop off evident. Since commencement of the measure, registration of individuals has increased in both sectors, with earlier registration evident in the AHS sector. The cumulative number of registrations in 2011 was 49% greater than in 2010 in Sentinel Sites and 42% greater than in 2010 in the rest of Australia. In general, General Practice has shown the greatest increase in registrations during 2011, with annual cumulative registrations in General Practice increasing more than two and a half times in Sentinel Sites and almost doubling in the rest of Australia (Figure 7.3).

Within the Sentinel Sites, by the end of November 2011, AHSs had completed 10 registrations per 100 Aboriginal and Torres Strait Islander people, and General Practice had completed just over 4

registrations per 100 people (Figure 7.3). Registrations per 100 people in the same period in the rest of Australia were similar for the AHS and General Practice sectors at between 5 and 6 per 100 people.

There were differences in trends over time between the Sentinel Sites and the rest of Australia, and between sectors in the Sentinel Sites (Figure 7.3). From early 2011 the trends for General Practice and AHSs in the rest of Australia were very similar. For AHSs in Sentinel Sites the number of registrations per 100 people at the end of May 2012 is very similar to the number of registrations at the same time in 2011 the Sentinel Sites, while the number of registrations in General Practices in the Sentinel Sites is relatively low throughout 2010, and increases substantially through 2011 and early 2012. The overall increase in registrations in the Sentinel Sites was driven by an increase in registrations in General Practice.

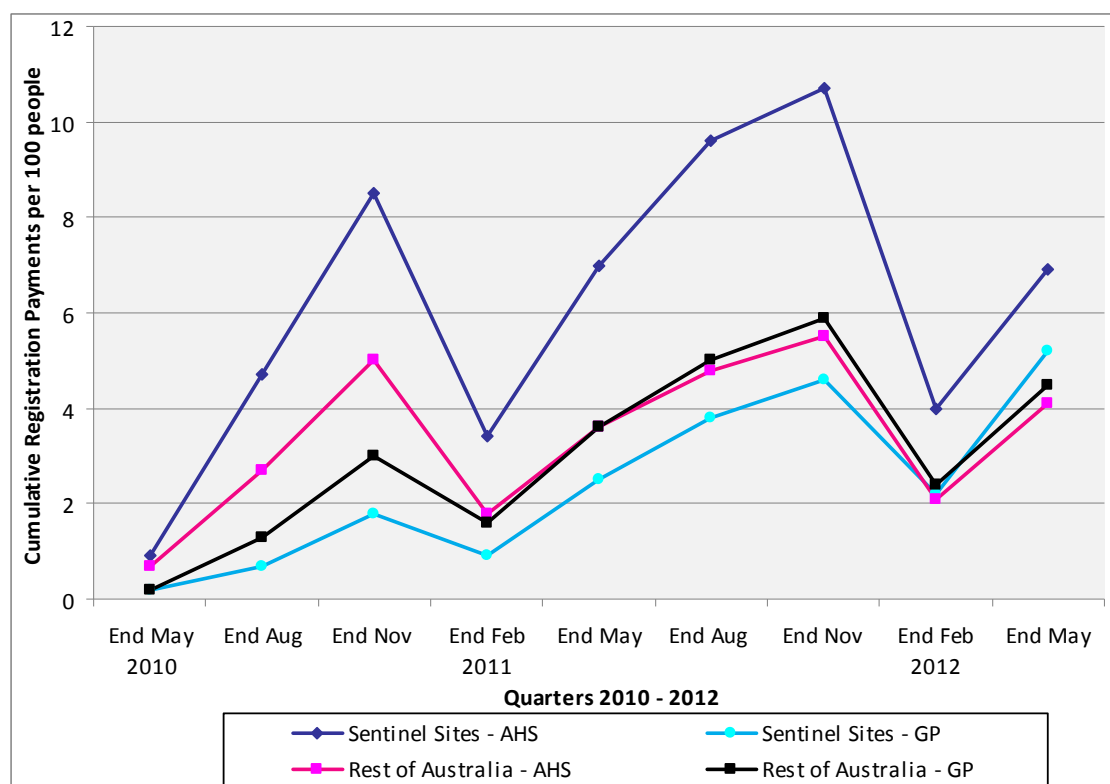


Figure 7.3: Cumulative number of people registering for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for Sentinel Sites and the rest of Australia, by health sector, and quarter March 2010 - May 2012

We also compared numbers registered for the PIP Indigenous Health Incentive by gender and location. This is shown in Appendix H, Table H1. The table also shows numbers of people registered for the PBS Co-payment measure by gender and location. Women were disproportionately registered for the PIP Indigenous Health Incentive, with women comprising 60% of PIP registrants in urban Sentinel Sites and in the rest of urban Australia; 57-58% in regional Sentinel Sites and the rest of regional Australia and 67% in remote Sentinel Sites and 59% in the rest of remote Australia. These patterns appear consistent with known gender differences in patterns of health service utilisation, and possibly higher use of medications for chronic conditions amongst women (making access to the PBS Co-payment measure more attractive for women).

Relationship between PIP Indigenous Health Incentive registration and access to the PBS Co-payment measure

The number of people accessing medicines through the PBS Co-payment measure in the December 2011 – February 2012 quarter was about 50% greater than the number of people registered for PIP Indigenous Health Incentive at the end of November 2011 in both Sentinel Sites and the rest of Australia. This provides an estimate of the extent to which registration for the PBS Co-payment measure exceeds registration for the PIP Indigenous Health Incentive. The estimate is conservative because people accessing medicines through the PBS Co-payment measure in any one quarter would be expected to be lower than the number of people registered for the PBS Co-payment measure, and because the number of people accessing medicines in any one quarter would be expected to underestimate the number of people accessing the PBS Co-payment over a whole year. As processes for patient registration for these two measures are virtually identical (with patient registration on the same form), this is likely to reflect greater patient and health service provider motivation in registering for something that has direct and immediate patient benefit, through reduction in cost barriers.

It was evident from the Sentinel Sites that many interviewees regarded these two measures as being closely linked – as indicated earlier in the section on ‘awareness’, some community focus group members believed that they were required to register for the PIP Indigenous Health Incentive in order to access the PBS Co-payment measure, and health service providers were using access to PBS Co-payment measure as a strategy to encourage patient registration for the PIP Indigenous Health Incentive. However, there were many instances in which people were being signed up for the PBS Co-payment measure, but not registered for PIP Indigenous Health Incentive. This generally did not occur in remote Sentinel Sites, where there were more people registered for the PIP Indigenous Health Incentive than were registered for the PBS Co-payment measure. This is likely to be related to availability of \$100 supply arrangements for pharmaceuticals in remote areas.

Gender differences in uptake of the PBS Co-payment measure were almost identical to those outlined above for the PIP Indigenous Health Incentive, reflecting the extent to which implementation of these two ICDP measures were linked with one another (Appendix H, Table H1).

Some community members and Health Services expressed difficulties in ascertaining which Health Services were PIP Indigenous Health Incentive registered, and where they could access PBS Co-payment measure prescriptions. This has been discussed in Chapter 5. Whilst the DoHA has developed an opt-in register accessible to patients and Health Services via the PIP enquiry line, the SSE did not find any evidence of Health Service staff knowing about this facility, or using it.

Strategies used by Health Services to promote patient registration

Within the Sentinel Sites, it was evident that Health Services were using a number of different strategies for promoting patient registration. These included:

- Requesting patient consent for registration on an opportunistic basis as patients presented at the Health Service
- Undertaking specific drives to promote registration, for example in community venues or linked to other outreach activities and
- Sending out letters asking patients to come in to the Health Service for registration.

The common thread running through all of these strategies, was the incentive promoted to patients, that by signing on to the PIP Indigenous Health Incentive they could gain access to the PBS Co-payment measure– that it was ‘part of the package’.

From the perspective of community focus group members, benefits of registration (apart from access to the PBS Co-payment measure) were in general not well understood.

'We just go to the doctors and told to sign this.' (Community focus group)

Some Health Service staff attempted to explain to patients the underlying reason for the PIP Indigenous Health Incentive, but many clinician interviewees reflected on how challenging this had been - acknowledging that in a sense, the program had more relevance for the Health Services than for the patients.

'The CtG [PBS Co-payment measure] is a clear selling point to patients and they love it! PIP is harder to sell to patients ... [we say] this gives us a bit of extra money to coordinate your care ... In the back of my mind is that we should be coordinating their care anyway. For AHS there is a definite large amount of patients and most AHS see it as a funding stream ... for private GPs it is not worthwhile as they often have a smaller patient load that are eligible.' (AHS, GP)

'It's quite tricky really, the PBS Co-payment is easy to explain, the PIP itself is more complex to explain to the patient. Basically we explain that we are your regular provider for chronic disease care and the registration process will provide us with the means to provide you with quality care. It does try to encourage patients to stay with the one service for continuity of care.' (AHS, GP)

Other Health Service staff indicated that in their explanations for asking patients to sign PIP Indigenous Health Incentive registration forms they pointed out the benefits of access to health assessments in describing the package. However, since health assessment items predated the ICDP, and in any case, entitlements for adult health assessment (or indeed for the PBS Co-payment measure) were not linked to patient PIP Indigenous Health Incentive registration, this was not entirely accurate.

In general, there was not a good understanding by Health Services or patients in Sentinel Sites, that patients should be registered at the place they received most care. The financial incentives associated with registration appears to have driven some inappropriate registration of patients. This is tied in with the lack of patient awareness and understanding of the incentive and associated restrictions and entitlements.

'We've found that the AMS registered a lot of patients who don't use it as a regular thing ... I don't think we've had any payments for our Aboriginal clients because they'd all been done prior, even though we are their regular practice ... there should be some way [of checking] who is their regular practice.' (General Practice, GP)

There were some instances identified (primarily in regional sites), where patients presenting for registration at one Health Service (seeking to access the PBS Co-payment measure) were assisted to go to the service where they ordinarily attended for registration. This occurred in the context of health care providers having a good knowledge of the patient, and good working relationships and trust between the different health service providers.

Re-registration as a proportion of total registrations

The PIP Indigenous Health Incentive requires annual registration and one of the major challenges for the PIP Indigenous Health Incentive is maintaining registration levels in each year.

Figure 7.4 shows the proportion of registrations that are re-registrations for the six-month period from December 2010 to May 2011 compared to the corresponding period for the following year. This comparison takes account of variation in registrations across the calendar year and provides a basis for

examining trends over time at this early stage of registration of patients for the PIP Indigenous Health Incentive. Of all PIP Indigenous Health Incentive registrations that took place during the six-month period December 2011 to May 2012, approximately 30 to 40% were re-registrations. The percentage of re-registrations in the AHS sector was around 40% for both the Sentinel Sites and the rest of Australia. The percentage of re-registrations in the General Practice was just over 30% in Sentinel Sites, and about 35% in the rest of Australia (Figure 7.4). Higher re-registration in the AHS sector appears to be at least partly due to the earlier participation in the program by the AHS sector (shown in the previous section), but may also relate to other features of the service environment.

The percent of re-registrations changed in different ways for the two sectors over the course of the SSE - during the six-month period December 2010 to May 2011, approximately 25% to 45% of registrations were re-registrations, with the percentage of re-registrations in AHSs declining slightly from around 45% to around 40% and the percentage of re-registrations in General Practice increasing slightly from around 27% to around 35% in the rest of Australia and remaining fairly static in the Sentinel Sites.

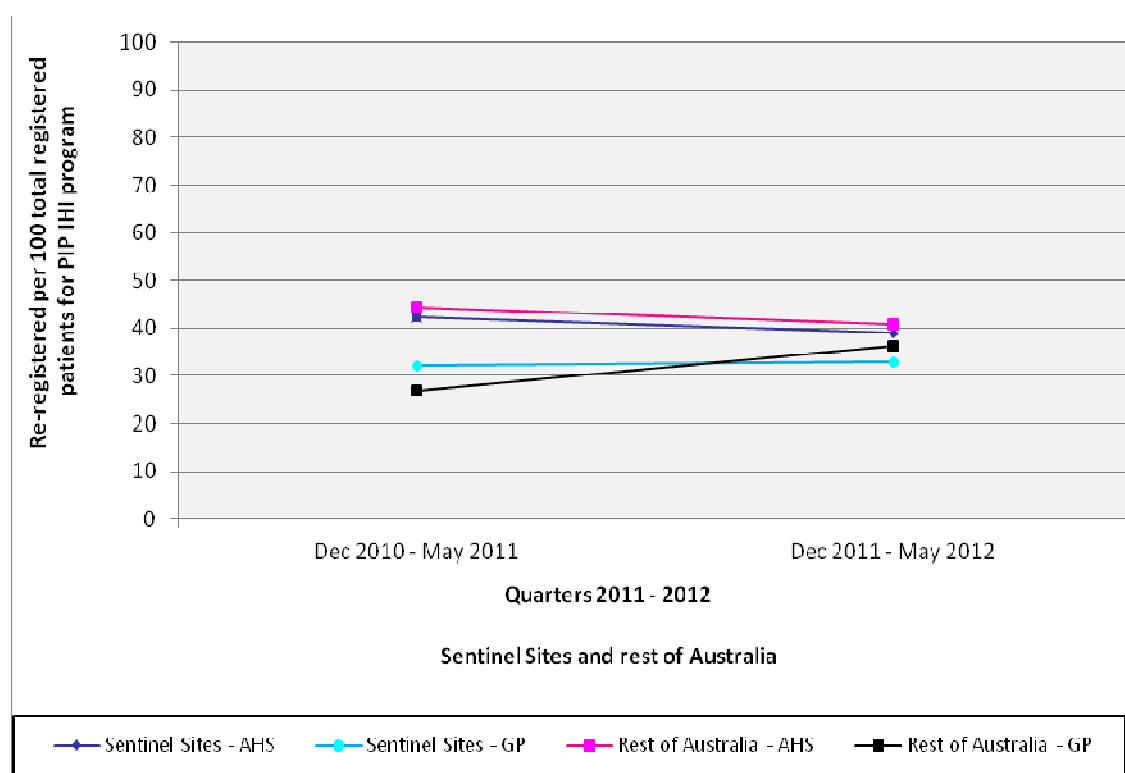


Figure 7.4: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012 by Sentinel Sites and the rest of Australia, by sector

It is possible that these data may be an overestimate of re-registrations if extrapolated to the full calendar year. This would be the case, for example, if Health Services have particular drives for re-registrations at the beginning of a calendar year. The extent to which this was occurring was not able to be ascertained in the Sentinel Sites. However there were isolated reports of Health Services registering patients both 'prospectively' and 'retrospectively' during November – which may have made re-registration 'easier' than would ordinarily be the case (when systems such as deliberate recall of patients to obtain re-registration consent may be needed).

Administrative barriers to patient registration and re-registration

Across all evaluation cycles, some concerns were evident about the administrative requirements of the PIP Indigenous Health Incentive. At later stages of implementation (evident in the fourth and fifth evaluation cycles), the main administrative concern related to issues of re-registration, and determining whether or not a patient was already registered prior to commencing the paperwork for registration. This was not just an issue for payments related to this incentive, but had more general resonance - for example, interviewees recounted conducting health assessments only to find their claims rejected by Medicare, and completing 'just in case' registration of patients for the PBS Co-payment measure while being unclear whether or not it represented duplication of effort.

'It takes extra time to find out if someone needs to be re-registered and registering them. I am unsure of the current recording system after the reception staff started doing it. Initially the actual hard copies were filed and it was required to flick through the hard copies when the patients have been registered.' (AHS, GP)

Underlying these difficulties was a general lack of efficient information systems that can be used to identify eligible patients in a Health Service, and those that need initial registration or recall for re-registration.

'Yes [we have had] a few challenges, it has not been too easy ... some Doctors had not been recording in the system, like doubles ... sending out forms for one patient and Medicare ending up ringing and saying that person is already registered - and you look on the systems [to find] they were not marked off ... it's been trial and error all the way, getting the team to follow a system that is systematic and works for everybody.' (AHS, GP)

These issues are discussed in more detail in Section 7.3.8.

Possibly due to the streamlining of registration processes, Health Service interviewees overall increasingly held positive perceptions about the ease of organising access to the PIP Indigenous Health Incentive – as shown below. By the final evaluation period, over three-quarters [79% (62/78)] of interviewees overall agreed with the statement '*organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy*' (Table 7.2). This represents a substantial increase since the first evaluation cycle. The percent of interviewees agreeing with this statement in remote sites was lower than for urban and regional sites, possibly reflecting greater staffing constraints experienced in remote locations.

Table 7.2: Trends in perceptions of ease of access to the PIP Indigenous Health Incentive (% who responded 'strongly agree' or 'partly agree'), overall and by location

	Evaluation cycles					
		One	Two	Three	Four	Five
Organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy. MS, CS, OW, PM ^a	Overall	46% (n=35)	47% (n=77)	51% (n=91)	70% (n=89)	79 % (n=78)
	Remote	0% (n=7)	8% (n=12)	25% (n=20)	56% (n=18)	64% (n=11)
	Regional	57% (n=14)	44% (n=39)	44% (n=36)	70% (n=33)	74% (n=27)
	Urban	57% (n=13)	69% (n=26)	71% (n=35)	76% (n=38)	88% (n=40)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

The proportion of clinicians and practice managers in the Aboriginal Health and the General Practice sector who agreed with the statement that '*organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy*' increased in recent evaluation cycles, and was generally higher in AHSs compared to General Practice (Figure 7.5).

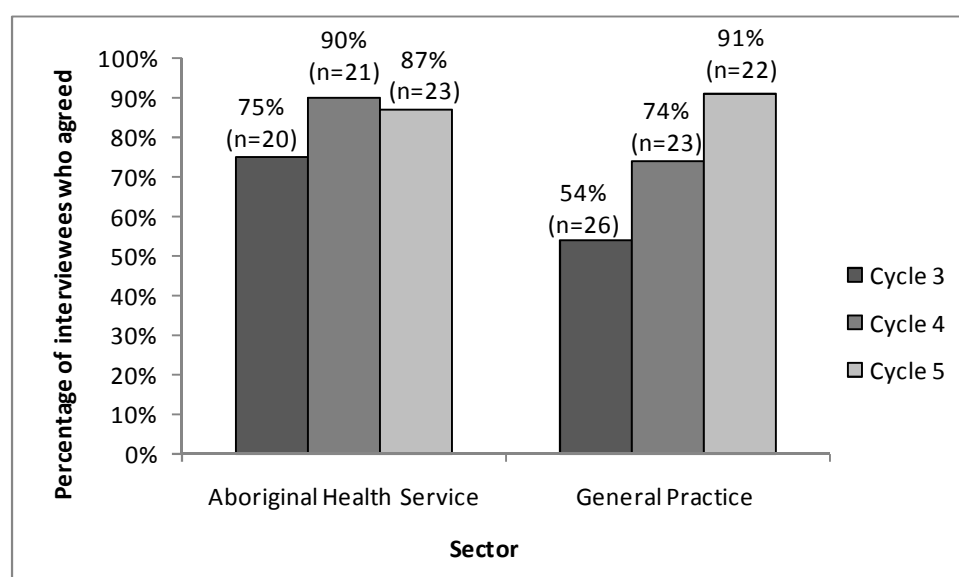


Figure 7.5: Clinicians' and practice managers' response to the statement 'Organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy' (% who strongly or partly agreed), by sector

Over the duration of the evaluation between 40% and 60% of interviewees have 'strongly or partly agreed' with the statement '*the PIP Indigenous Health Incentive has caused a large administrative workload*' (Table 7.3) with no clear increasing or declining trend. Patterns were generally similar across remote, regional and urban sites, but with wider variation between cycles due to small numbers of interviewees in each location.

Table 7.3: Trends in perceptions of the new PIP Indigenous Health Incentive as causing a large administrative workload (% who responded 'strongly agree' or 'partly agree'), overall and by location

	Evaluation cycles					
		One	Two	Three	Four	Five
The PIP Indigenous Health Incentive has caused a large administrative workload. MS, CS, PM ^a	Overall	59% (n=34)	42% (n=74)	45% (n=83)	55% (n=77)	46% (n=69)
	Remote	57% (n=7)	67% (n=12)	37% (n=19)	53% (n=15)	64% (n=11)
	Regional	57% (n=14)	29% (n=38)	42% (n=33)	45% (n=29)	52% (n=23)
	Urban	62% (n=13)	50% (n=24)	52% (n=31)	64% (n=33)	37% (n=35)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

By the final evaluation cycle, a greater proportion of practice managers [67% (10/15)] than clinicians [48% (14/29)] interviewed agreed with the statement that the PIP Indigenous Health Incentive had caused a large administrative workload. Qualitative comments indicated that determining whether or not people had been previously registered was a significant factor underlying the perceived workload. Clinicians spoke about how the reception staff and practice managers were bearing the responsibility of registration (and re-registration), and different categories of interviewees noted that in general the practice managers were responsible for the paperwork and developing systems to manage the registration process for patients. There was some frustration about GPs having to sign registration forms; however it was also reported that once the multiple registration form had been developed by DoHA and disseminated (as described in section 7.2) this burden was eased.

In general, over the last few evaluation cycles, the proportion of AHS interviewees agreeing that patient registration posed an administrative burden decreased, and the proportion of interviewees from General Practice agreeing with this statement increased (Figure 7.6) – this corresponds to the greater numbers of registrations in General Practice in recent evaluation cycles. It also may reflect the greater motivation for AHSs to set up systems to manage registrations, since they tend to have larger numbers of eligible patients and the more substantial income stream potentially available through patient registration is sufficient to warrant investing in system development.

'PIP-IHI has definitely got easier. People are now used to it and it has been embedded into their systems.' (AHS, CEO)

'Initially the paperwork was done by the doctors, now the reception staff. Re-registration is an administrative burden on the clinic reception staff.' (AHS, GP)

In General Practices with smaller numbers of eligible patients, it was noted by interviewees that there was relatively little incentive to develop practice systems specific to this measure due to the small numbers involved.

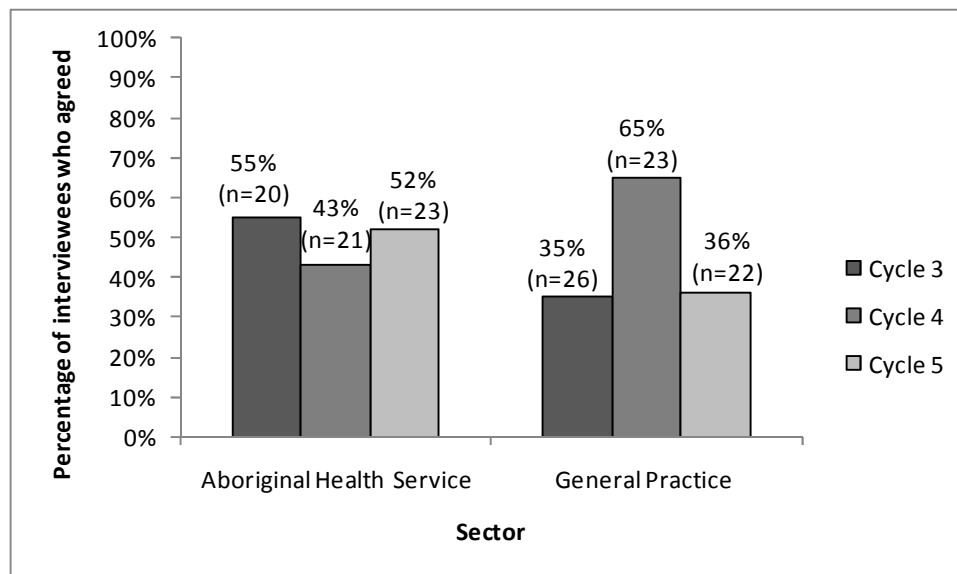


Figure 7.6: Clinicians' and practice managers' response to the statement 'The PIP Indigenous Health Incentive has caused a large administrative workload' (% who responded 'strongly agree' or 'partly agree'), by sector

Although the data presented above suggest that overall the administrative requirements associated with the PIP Indigenous Health Incentive patient registration were manageable for Health Services, some of the qualitative data from the Sentinel Sites suggest that the way implementation was being rolled out was not optimally efficient at Health Service level. Much of this related to the lack of systems to manage patient information, or lack of capacity amongst staff to use existing systems. As implementation progressed, issues of potential duplication of effort became more apparent. Interviewees expressed frustration regarding the challenge of determining whether or not an eligible person had already been registered both within the service and at another service. We found no evidence in the Sentinel Sites of Health Service staff being aware of and using the functionality available through the online patient registration system, which provides immediate at-point-of-registration notification of whether or not patients are registered elsewhere. The lack of service systems to track registration status may be due to the relatively recent introduction of this facility, or the general limited capacity of staff to manage and use information and online systems optimally, or other factors.

'The PIP isn't easy. We do the [registration] work and don't get paid, the patient doesn't know they've done it before.' (General Practice, GP)

In contrast, Health Services were in general aware of the option of enquiring about patient registration through the PIP telephone enquiry line. However, interviewees reported that enquiries through the PIP enquiry line were too time consuming for use in a busy clinical practice, and it took less time to register the patient opportunistically, 'just in case'.

'Too much paperwork, it makes a large administrative workload and more burden for the staff. The simple reason is that without calling Medicare there's no way to simply check whether the patients have been registered in any other practice or not. It's difficult ... needing to call up every time and wait, especially if they have registered with other practice and sometimes they need to know the dates is the main issue. It would be nice to just have this [checking] process simpler ... than going through the whole process again. Part of the money from the incentive is therefore being used to assist with this administrative burden.' (General Practice, GP)

Overall, it was apparent in the Sentinel Sites that whilst there were some instances of systems being set up to manage administrative aspects of the PIP Indigenous Health Incentive at Health Service level, these are not well embedded into or strengthening existing systems, and in general seem to be more

focused on gaining efficiency in accessing revenue, rather than improving systems to support better quality of care. The administrative aspects of the measure are currently not well integrated into or being used to systematically strengthen recall and follow-up of Aboriginal and Torres Strait Islander patients with chronic disease.

The following section describes some of the differences in uptake of the measure by location, and by specific sites. These differences in uptake and associated qualitative data from the Sentinel Sites provide a basis for understanding how context has affected implementation of the incentive.

7.3.4. VARIATION IN PATIENT REGISTRATION BY SECTOR, GEOGRAPHIC LOCATION AND BETWEEN SENTINEL SITES

KEY POINTS

- Wide variation in the number of registrations per 100 Aboriginal and Torres Strait Islander people was evident between specific Sentinel Sites and across urban, regional and remote locations.
- Registration per 100 people in 2011 was broadly similar for AHSs and General Practices in the Sentinel Sites and in the rest of Australia for urban and regional locations, at around 5-7 per 100 people at the end of November 2011. The exception was registration by General Practice in regional Sentinel Sites, which was around 17 per 100 people at the end of November 2011. Registration in remote locations was relatively low, particularly in AHSs in the rest of remote Australia, and with a recent decline to similarly very low levels in AHSs in remote Sentinel Sites.
- Around 30-40% of registrations in the first part of 2012 in urban sites were re-registrations, with slightly higher rates of re-registrations in the AHS sector, consistent with earlier participation in the measure by AHSs.
- There was greater variation in the percentage of re-registrations in December 2011 - May 2012 compared to the previous years in regional Sentinel Sites than urban Sentinel Sites.
- Registrations increased over the evaluation period in two of the four remote Sentinel Sites and in the rest of remote Australia up to the end of November 2011. Three of the four remote Sentinel Sites had no registrations between the end of November 2011 and the end of May 2012. Since patients in remote locations are covered by S100 supply arrangements for medications, the need for PBS Co-payment measure, and the opportunity to obtain the PIP Indigenous Health Incentive may be less highly valued in some remote sites.
- The variation in number of registrations per 100 people between sites is due to a complex mix of local, regional and national influences, some of which vary over time. An analysis of these influences is presented later in this chapter.

Similarities and differences in uptake and re-registration in urban, regional and remote locations and different Sentinel Sites

Registrations per 100 Aboriginal and Torres Strait Islander people were highest in regional locations, and lowest in remote locations (Appendix H, Tables H2-H3 and Figures 7.7-7.9). These patterns were broadly similar to those described for access to the PBS Co-payment measure. They differed from the patterns described for Health Service sign-on payments, where uptake was highest in urban locations and lowest in remote locations. This reflects the wide difference in numbers of Health Services in different locations, and the wide difference in numbers of Aboriginal and Torres Strait Islander people using each service.

For all geographic locations, there were wide variations in uptake and re-registration evident in different Sentinel Sites. As for progress with implementation of most of the measures, it is clear from the evaluation that this variation in registrations for the PIP Indigenous Health Incentive cannot be simply attributed to geographic location or any other specific characteristic of specific sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. An analysis of these influences is presented later in this chapter.

Urban areas – illustrative patterns

Different patterns evident for different sectors in urban areas

For urban locations, there was earlier involvement of the AHSs in patient registration, compared to General Practice, with registration of patients by AHSs approximately double that of General Practice at the end of November 2010 (Figure 7.7).

At the end of 2011, the number of patient registrations per 100 people in AHSs was broadly similar to those in General Practice across the urban Sentinel Sites and the rest of urban Australia, with between 5-6 registrations per 100 people.

The data available for the first several months of 2012 indicated that for both sectors, registrations achieved during 2012 (up until May 2012), were similar to those achieved at the comparable period in 2011 for all groups, except for the General Practice sector in Sentinel Sites, where patient registrations had increased more than two-fold since the same period the previous year. By the end of May 2012 the number of registrations in General Practice was higher than for AHSs in urban Sentinel Sites. In the rest of urban Australia there were similar numbers of registrations per 100 people in AHSs and General Practice in 2011 but in 2012 registrations in General Practice also overtook those in AHSs. This needs to be interpreted in the light of the far greater number of General Practices signed up to the PIP Indigenous Health Incentive compared to AHSs (around 95% of all sign-on payments have been received by General Practice), most with considerably lower numbers of patients per General Practice than per AHS.

Across Health Services in urban locations, around 30-40% of registrations in the first part of 2012 were re-registrations. Consistent with earlier participation by AHSs in urban locations, the proportion of registrations that were re-registrations was slightly higher in AHSs than in General Practice in 2012 (35-40% and 28-35% respectively for urban Sentinel Sites and the rest of urban Australia)(Figure 7.8).

As outlined in more detail below, there was wide variation in patient registration, and in the proportion of registrants who were re-registrants in the different urban Sentinel Sites.

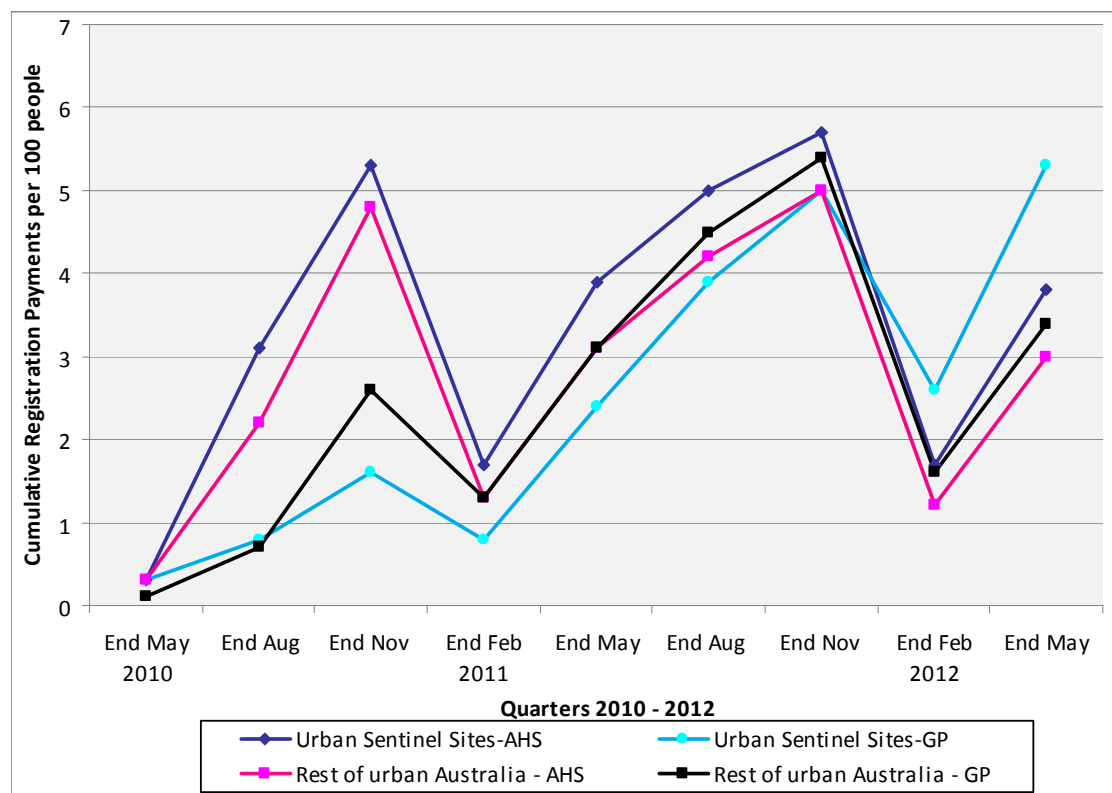


Figure 7.7: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by sector, and quarter March 2010 - May 2012

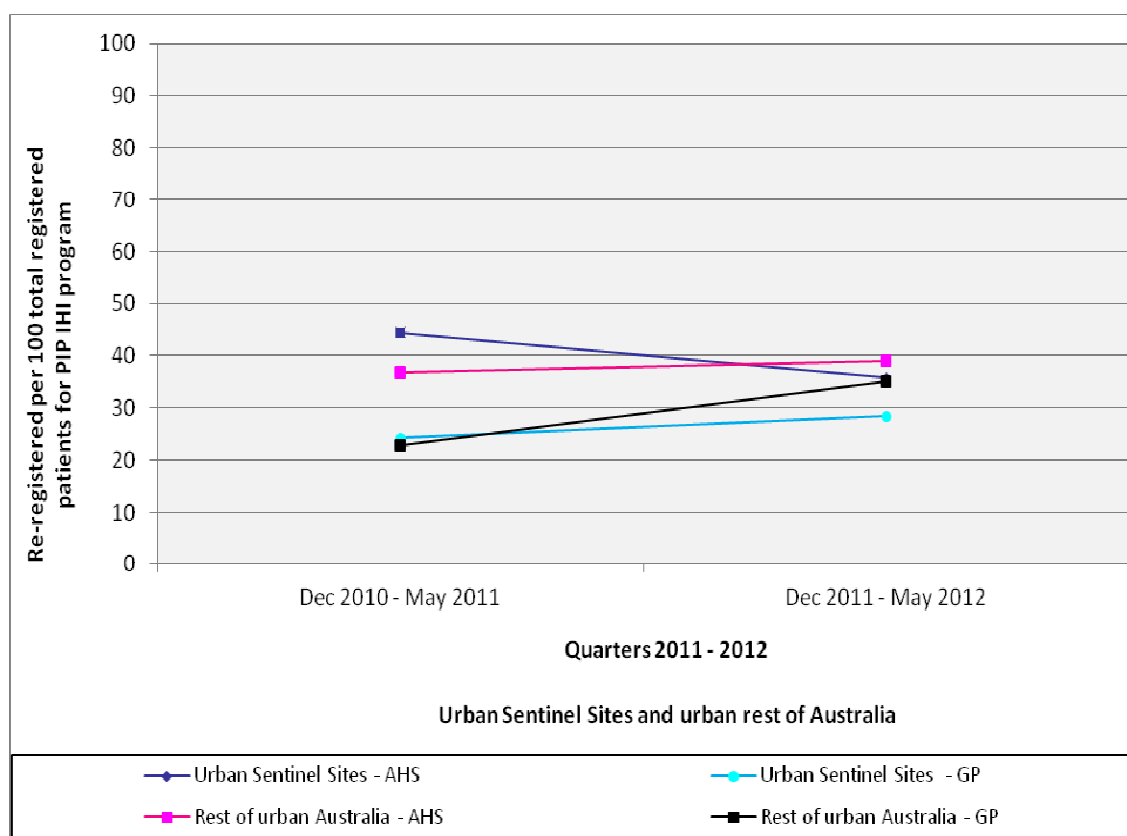


Figure 7.8: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012 by urban Sentinel Sites and the rest of urban Australia, by sector

Variation in registration and re-registrations between urban Sentinel Sites

In the urban Sentinel Sites of Brisbane South, Campbelltown and Canberra, the number of registrations per 100 Aboriginal and Torres Strait Islander people was greater than for the rest of urban Australia at the end of November 2010. At the end of November 2011 the numbers of registrations per 100 people at Brisbane South, Canberra, Elizabeth and Logan/Woodridge sites were greater than for the rest of urban Australia. There were particularly large increases in numbers of registrations in the Logan/Woodridge and Elizabeth sites. Note that the data on registration for the PIP Indigenous Health Incentive for these two sites does not include patients registered with the AHS in the site, as these data were attributed to a 'head office' outside of the site boundary (see Appendix C). The data for these sites reflect registrations by General Practices only. The data on PIP registrations by sector in urban sites reported above are also affected by the exclusion of the AHS data for these sites, and mean the reported data for urban AHSs is an underestimate of the situation for urban sites overall. At the end of May 2012 numbers of registrations per 100 people at Brisbane South, Campbelltown, Elizabeth, Logan/Woodridge and North Lakes/Caboolture were greater than for the rest of urban Australia. There were particularly large increases in numbers of registrations in North Lakes/Caboolture from the end of February 2012 to the end of May 2012.

The number of registrations per 100 Aboriginal and Torres Strait Islander people in Dandenong site was particularly low compared to other urban Sentinel Sites and to the average for the rest of urban Australia over most of the evaluation period, with little sign of any increase over time. The remainder of the urban Sentinel Sites had similar numbers of registrations per 100 Aboriginal and Torres Strait Islander people over the time frame of the report (Figure 7.9).

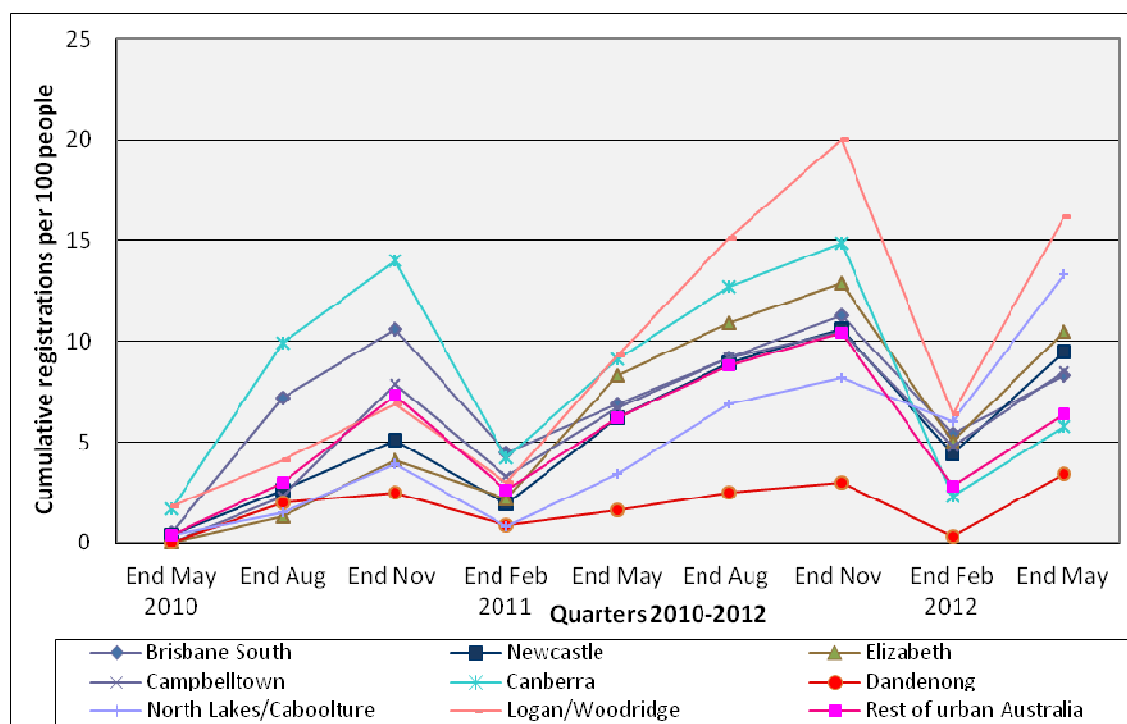


Figure 7.9: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia and quarter, March 2010 - May 2012

The proportion of registrations that were re-registrations ranged between 20 and 40% in the different urban Sentinel Sites.

There was some variation between urban sites in levels of re-registrations between December 2011 and May 2012 compared to the corresponding period of the previous year, with notable increases in

Elizabeth and Dandenong, and decreases in North Lakes/Caboolture and Campbelltown. Re-registrations in other Sentinel Sites remained relatively steady between these time periods. For the rest of urban Australia there was an increase of around 7% in re-registrations over this time period.

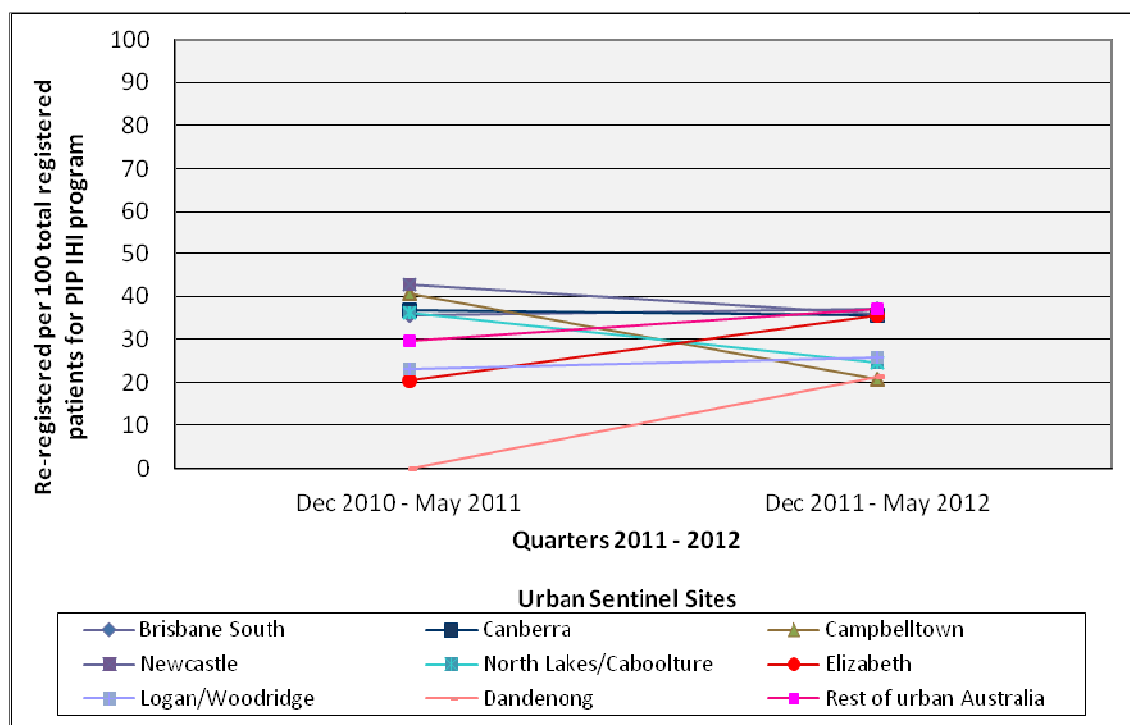


Figure 7.10: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012, by urban Sentinel Sites and rest of urban Australia

Regional areas – illustrative patterns

Different patterns evident for different sectors in regional areas

Similar to urban locations, regional locations recorded earlier involvement of the AHSs in patient registration, compared to General Practice, with registration of patients by AHSs approximately double that of General Practice at the end of November 2010 (Figure 7.11).

The number of registrations per 100 Aboriginal and Torres Strait Islander people in regional Sentinel Sites at the end of November 2011 exceeded the number of registrations at the end of November 2010. Over this time period the number increased by approximately a third in the AHSs in Sentinel Sites and more than doubled in General Practices in Sentinel Sites. The number of registrations per 100 people was similar in AHSs in Sentinel Sites at the end of May 2012 compared to the end of May 2011, but doubled in General Practice over the same time period. Numbers of registrations per 100 people in General Practice in the rest of regional Australia increased by about 40% at the end of May 2012 compared to the end of May 2011, with little change in registrations in AHSs in the rest of regional Australia for the same time periods (Figure 7.11). It appears from these data that in regional locations there has been a continuing increase in registrations in General Practice over the past two years, while registrations in AHSs appear to have levelled off in the second half of the period covered by the SSE.

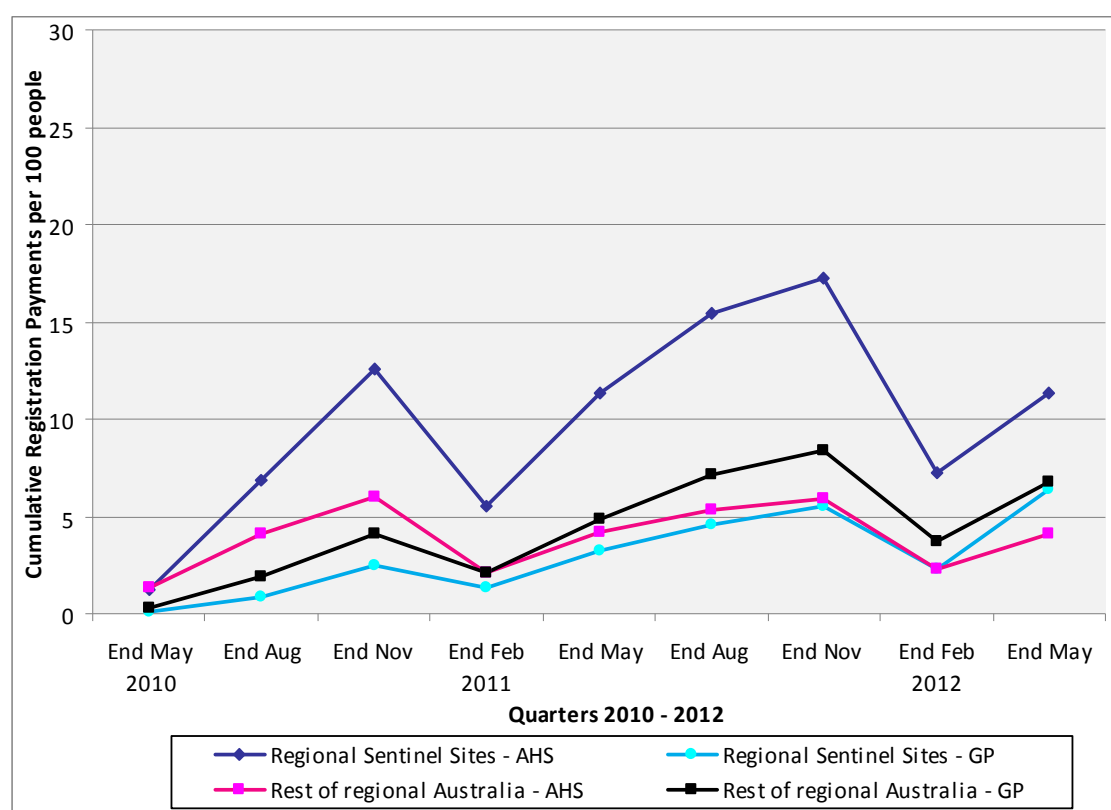


Figure 7.11: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for regional Sentinel Sites and the rest of regional Australia by sector, and quarter, March 2010 - May 2012

For Health Services in regional locations, an average of around 35-45% of registrations in the six months from December 2011 to May 2012 were re-registrations. This was a little higher than that reported for urban locations. Unlike urban locations, regional locations indicated little difference between the sectors with respect to the average proportion of registrations that were re-registrations (Figure 7.12).

As outlined in more detail below, there was wide variation in patient registration, and in proportion of registrants who were re-registrants in the different regional Sentinel Sites.

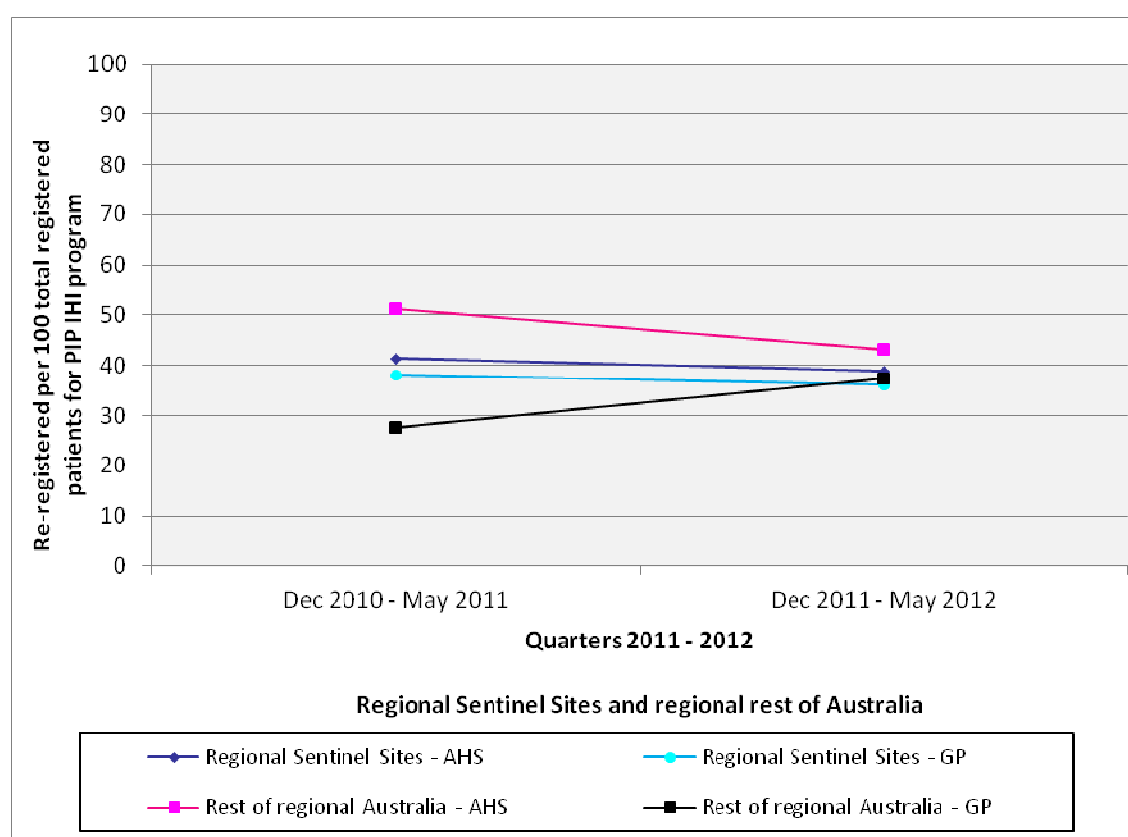


Figure 7.12: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012 by regional Sentinel Sites and the rest of regional Australia, by sector

Variation in registration and re-registrations between regional Sentinel Sites

Of the 12 regional Sentinel Sites, eight had higher levels of registration per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 than at the end of November 2010. This is consistent with the pattern for the rest of regional Australia, which showed about a 50% increase in registrations between November 2010 and November 2011.

There was a particularly marked increase in registrations in Dubbo between November 2010 and November 2011. Cairns and Swan Hill/Mildura had relatively high numbers of registrations in November 2010 and showed notable increases from November 2010 to November 2011.

In contrast, the number of registrations per 100 Aboriginal and Torres Strait Islander people at the end of May 2012 compared to the end of November 2010 in Bairnsdale and Grafton was half and less than half respectively. However registrations in Grafton continued to grow steadily throughout 2012 and by May 2012 were higher than for the rest of regional Australia.

Hobart and Gladstone showed persistently low numbers of registrations over both 2010 and 2011. Numbers of registrations per 100 people increased in Hobart in 2012, but still remained low in Gladstone (Figures 7.13-7.15).

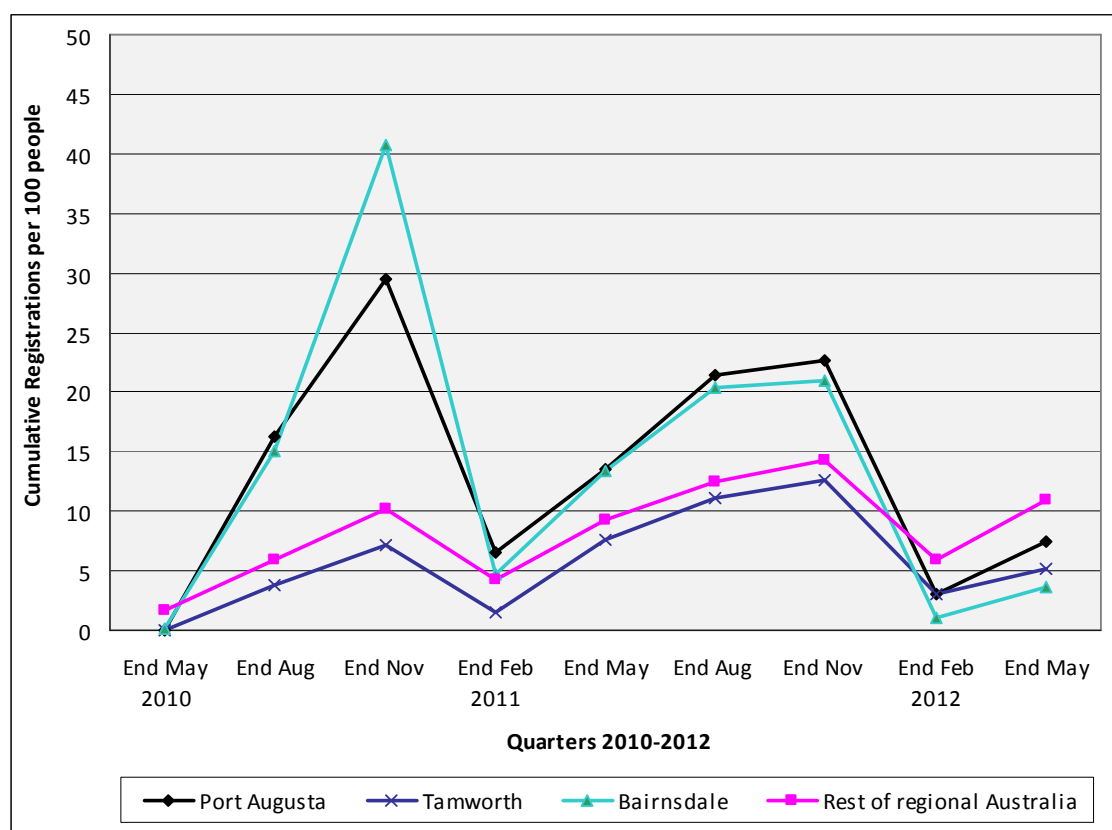


Figure 7.13: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for case study regional Sentinel Sites and the rest of regional Australia by quarter, March 2010 - May 2012

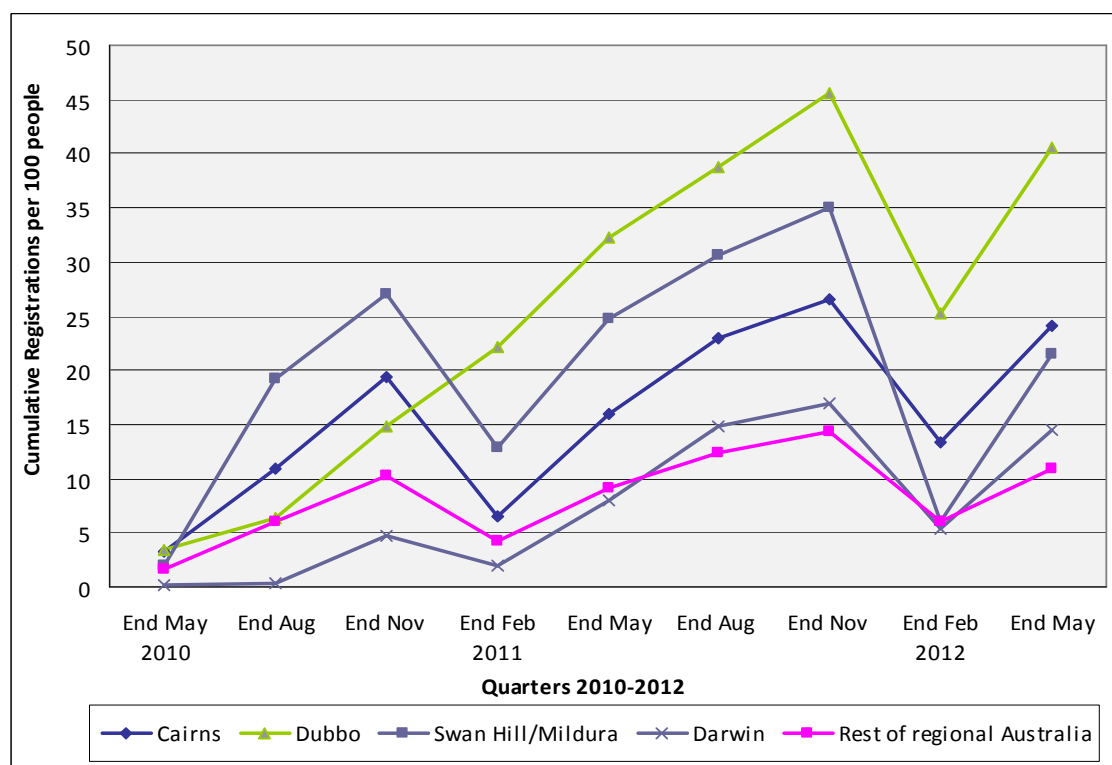


Figure 7.14: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for enhanced tracking regional Sentinel Sites and the rest of regional Australia, by quarter, March 2010 - May 2012

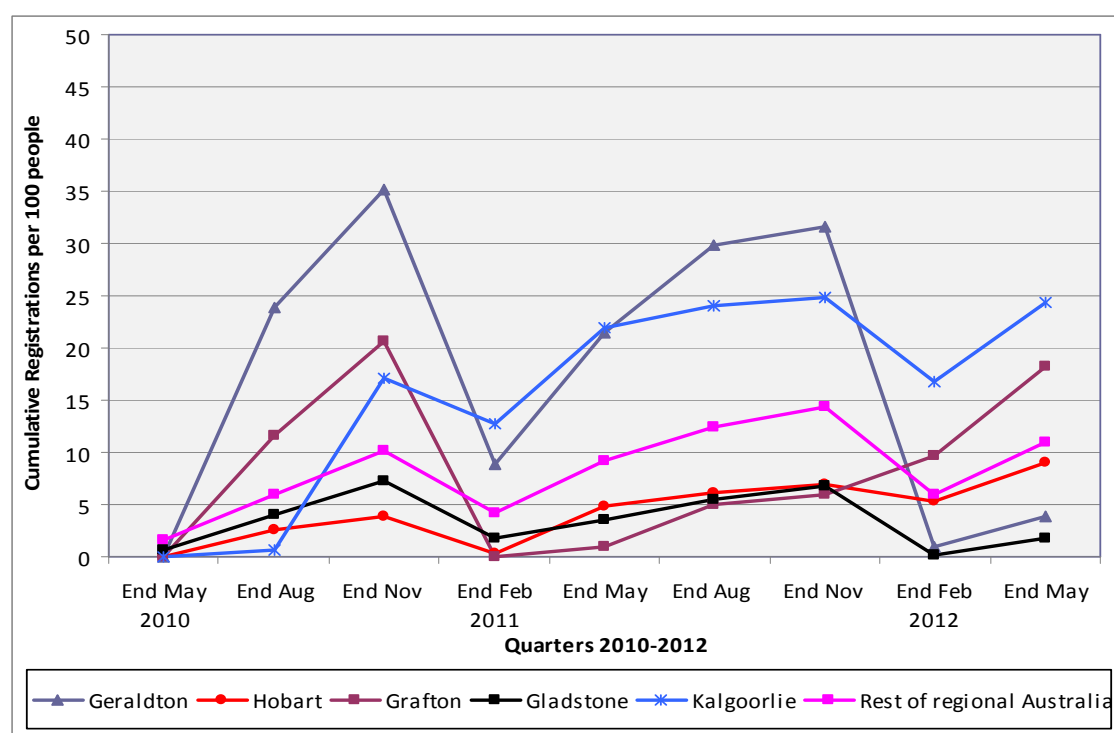


Figure 7.15: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for tracking regional Sentinel Sites and the rest of regional Australia by quarter, March 2010 - May 2012

There was wide variation between regional sites in the percentage of re-registrations in December 2011 - May 2012 compared to the corresponding period for the previous year, with Port Augusta, Tamworth, Grafton, Hobart and Geraldton showing notable declines in re-registration, and Darwin, Dubbo and Bairnsdale showing increases (Figures 7.16-7.18). There was no change in the level of re-registrations in the rest of regional Australia over this time period.

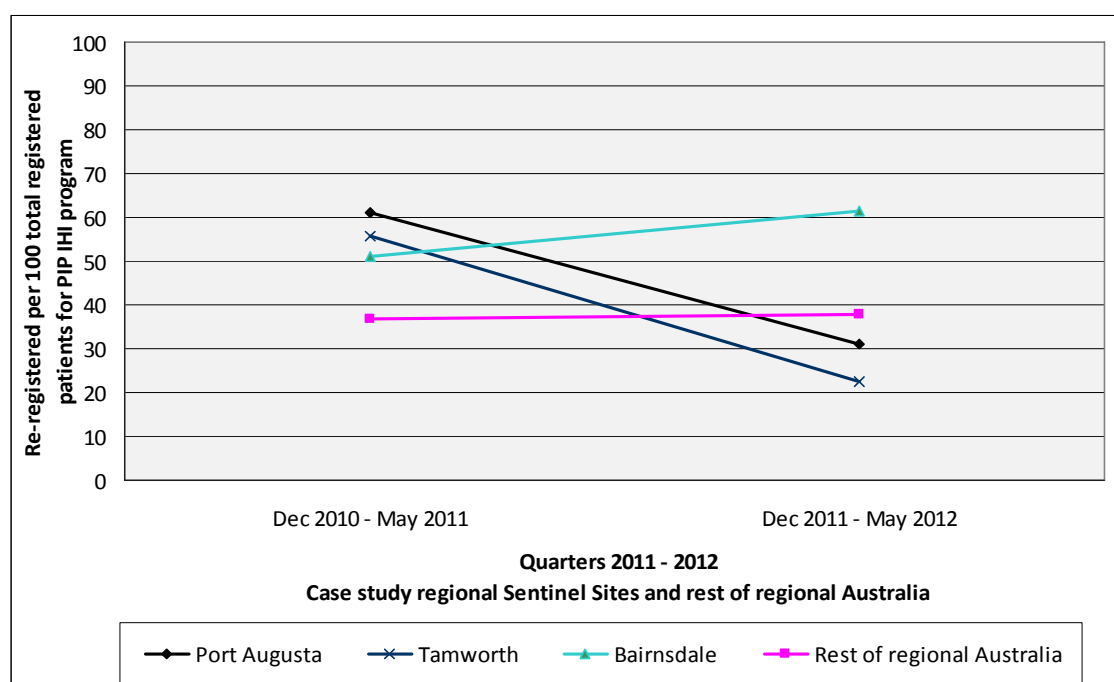


Figure 7.16: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012, by case study regional Sentinel Sites and rest of regional Australia

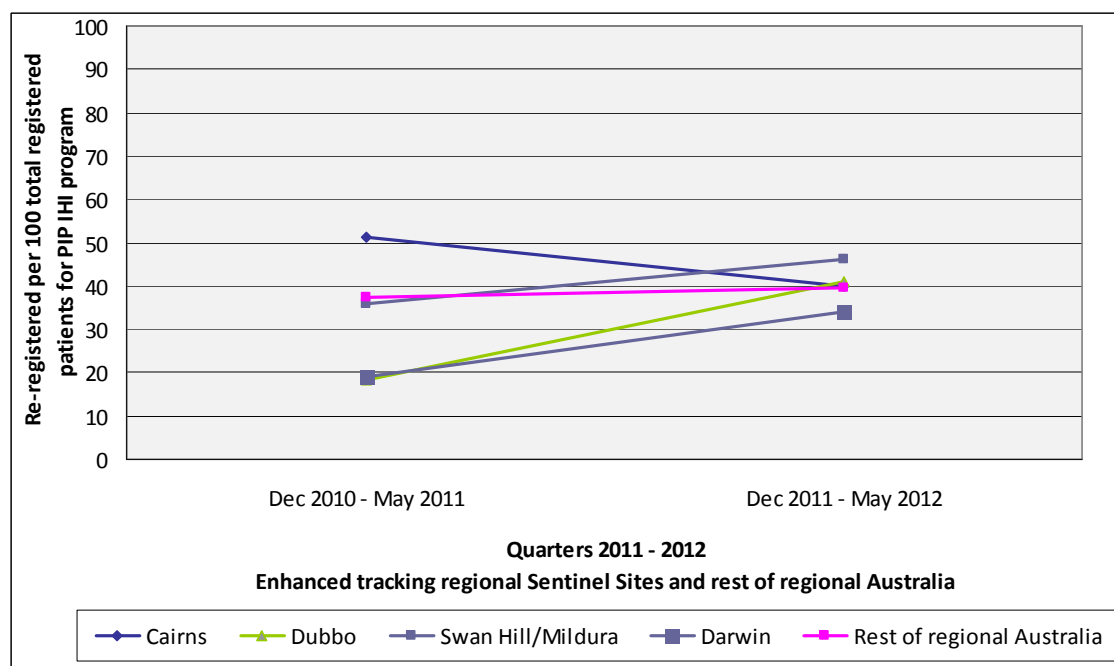


Figure 7.17: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012, by enhanced tracking regional Sentinel Sites and rest of regional Australia

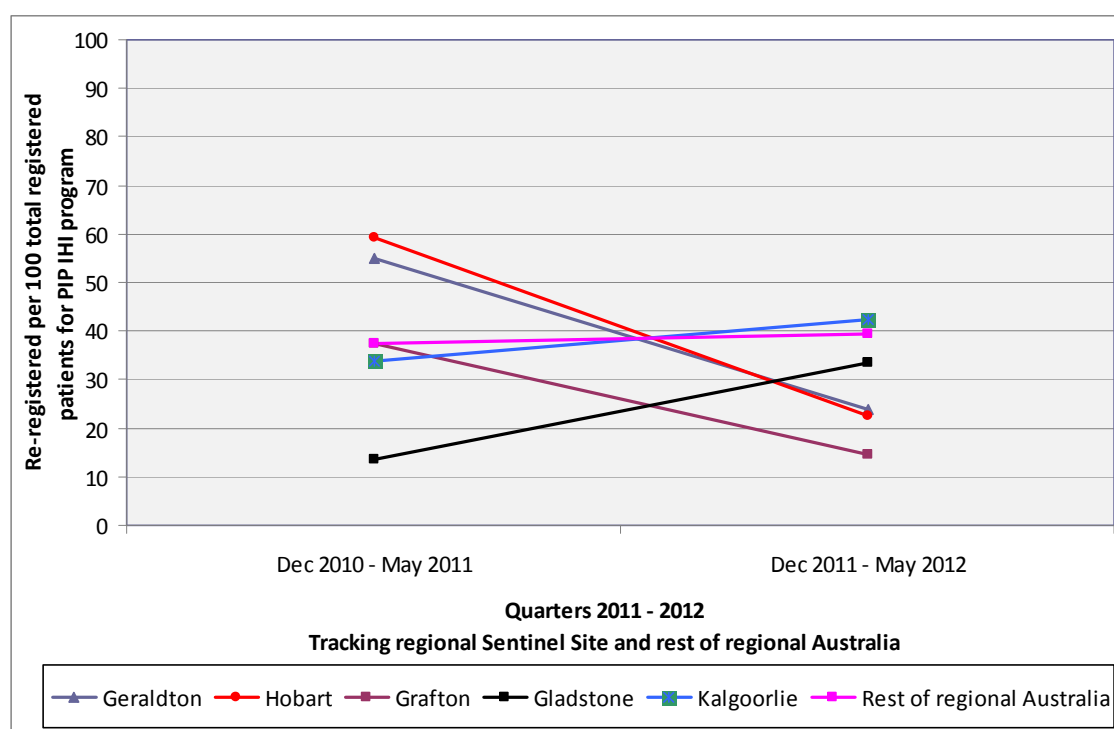


Figure 7.18: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012, by tracking regional Sentinel Sites and rest of regional Australia

Remote areas – illustrative patterns

Different patterns evident for different sectors in remote areas

Similar to urban and regional locations, remote locations recorded earlier involvement of the AHSs in patient registration, compared to General Practice, with registration of patients by AHSs approximately double that of General Practice in the rest of remote Australia at the end of November 2010 (Figure 7.19).

The number of registrations per 100 Aboriginal and Torres Strait Islander people in AHSs in the rest of remote Australia at the end of November 2011 exceeded the number of registrations at the end of November 2010 by more than 50%. There was a similar increase between the end of May 2011 and the end of May 2012. There was a smaller proportional increase over these two time periods for General Practices in the rest of remote Australia. In contrast, AHSs in Sentinel Sites showed no increase in registrations between the end of November 2010 and the end of November 2011, and showed a decline between the end of May 2011 and the end of May 2012. There were very few registrations in General Practices in remote Sentinel Sites throughout the period covered by the SSE (Figure 7.19).

It appears from these data that in contrast to urban and regional locations, in remote locations there has been a continuing increase in registrations in AHSs (and to a lesser extent in General Practice, recognising that there are relatively few General Practices in remote locations, especially in the remote Sentinel Sites) over the past two years, while registrations in AHSs in Sentinel Sites have declined in early 2012.

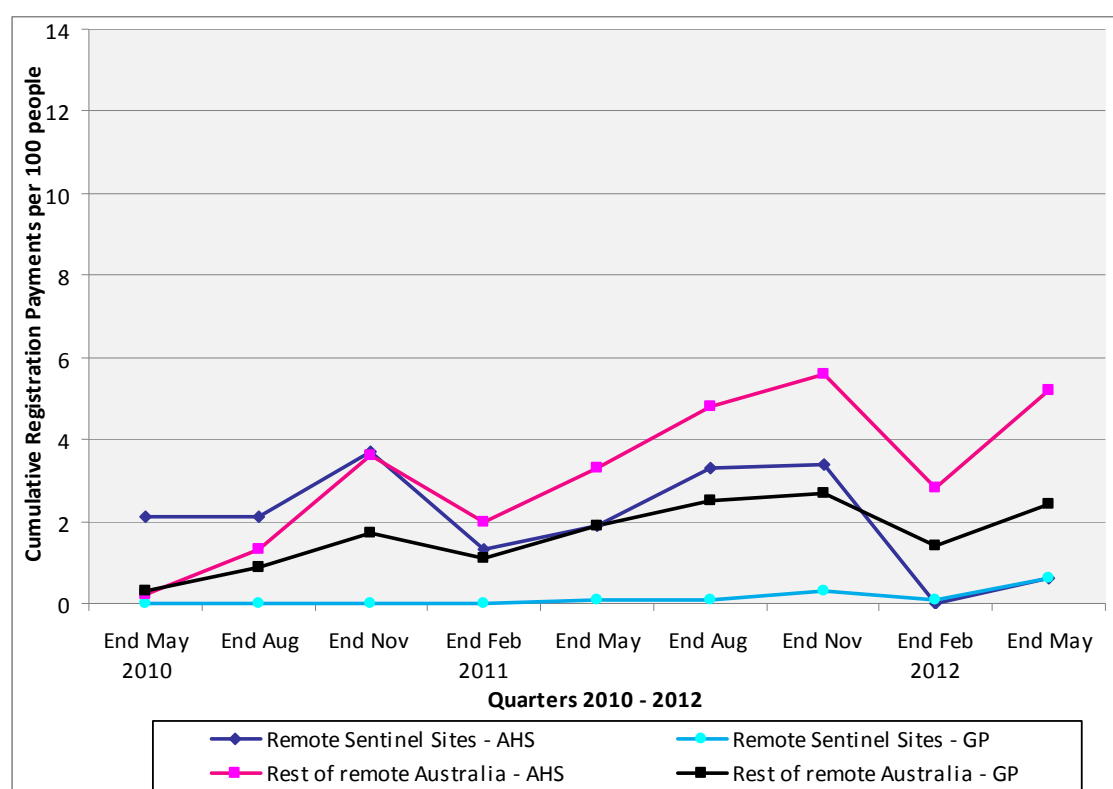


Figure 7.19: Patients registered (PIP Indigenous Health Incentive patient registration payment) per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia by sector by quarter March 2010 - May 2012

In AHSs in remote Sentinel Sites, the percentage of re-registrations between the end of December 2011 and the end of May 2012 were almost double that of the corresponding period of the previous year. While the data show that almost 30% of the registrations in General Practices in Sentinel Sites in the period from the end of December 2011 to the end of May 2012 were re-registrations, this is based on very few registrations by these General Practices. There was almost no change in the percentage of re-registrations in General Practices and AHSs in the rest of remote Australia, with around 35-40% of total registrations being re-registrations (Figure 7.20).

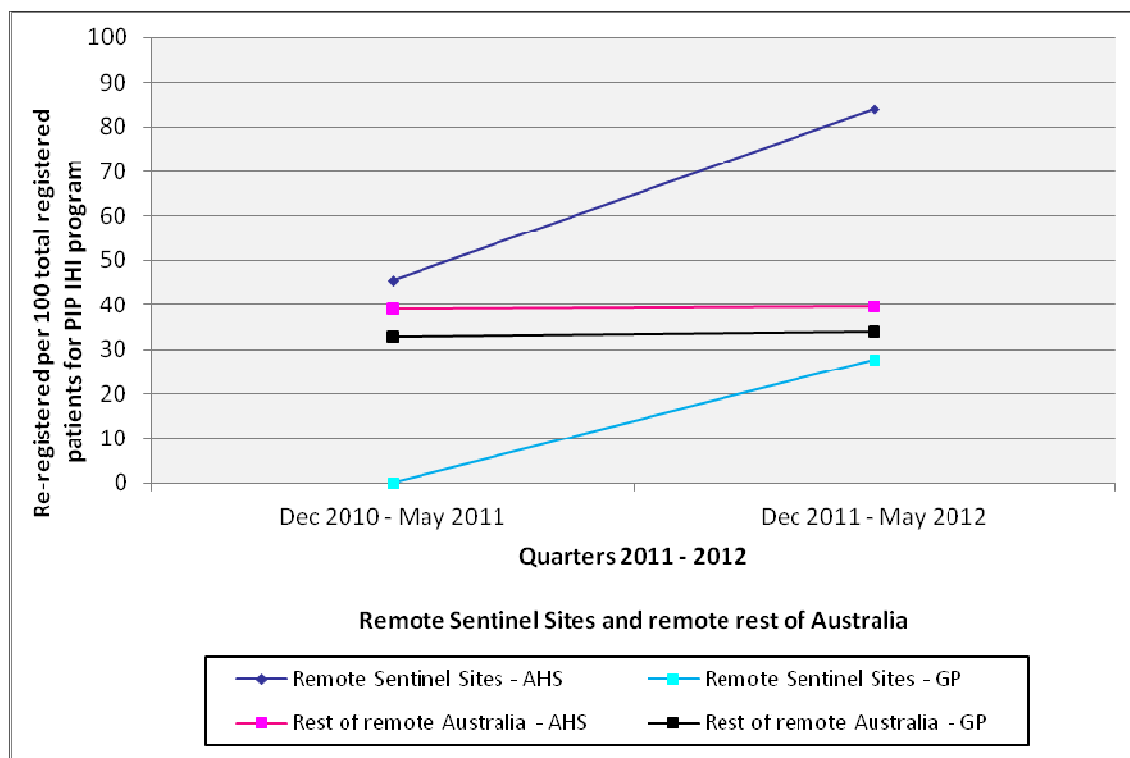


Figure 7.20: Percentage of PIP Indigenous Health Incentive registrants at the end of May 2012 who were also registered in the previous year, 2011 and 2012 by remote Sentinel Sites and the rest of remote Australia, by sector.

In remote locations, levels of registration were driven by a relatively small number of Health Services. Of the four remote Sentinel Sites, two (East Pilbara and Barkly) had higher levels of registration per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 than at the end of November 2010. East Pilbara continued to register patients, with substantially higher numbers registered at the end of May 2012 compared to the end of May 2011, while Barkly did not conduct any registrations between the end of November 2011 and the end of May 2012. Derby appears to have conducted a relatively large number of registrations per 100 Aboriginal and Torres Strait Islander people in early 2010, somewhat fewer in early 2011, and none between the end of November 2011 and the end of May 2012. Katherine West conducted no registrations over the period covered by the SSE (Figure 7.21).

Trends in re-registrations are not reported for remote locations because the small number of registrations made estimates unreliable, but it is clear that for three of the four remote Sentinel Sites there have been no registrations or re-registrations between the end of November 2011 and the end of May 2012.

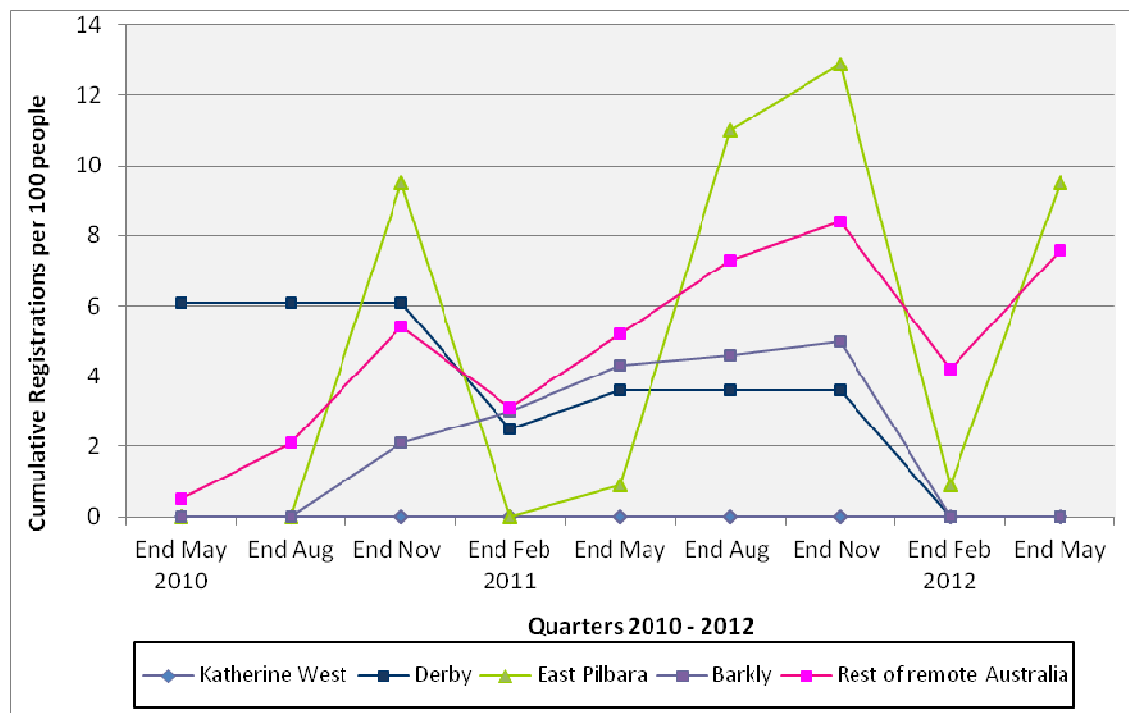


Figure 7.21: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for remote Sentinel Sites and the rest of remote Australia by quarter, March 2010 - May 2012

7.3.5. TIER 1 AND TIER 2 OUTCOMES PAYMENTS

KEY POINTS

- Tier 1 payments were triggered for about 10% of registered patients in 2011.
- Tier 2 payments were triggered for around 75% of registered patients in 2011. Tier 2 payments were almost invariably triggered for patients whose care also triggered Tier 1 payments.
- Given that patients registered for the PIP Indigenous Health Incentive are expected to have a diagnosed chronic disease (as per the guidelines on eligibility), it is important to note that neither Tier 1 nor Tier 2 payments were triggered for around 30% of patients. This indicates a substantial proportion of patients registered for the PIP Indigenous Health Incentive are not regularly attending any Health Service registered for the PIP Indigenous Health Incentive.
- The percentage of patients for whom Tier 1 payments have been made increased between 2010 and 2011, although numbers remain small.
- Health Services appeared to have a clear understanding of what is required to receive tiered payments, but understanding and awareness of how the payment requirements and monetary incentives could translate to improved care for patients was inconsistent across services.
- Factors influencing the ability of Health Services to trigger the outcomes payments included function and use of disease registers and system support for follow-up; workforce capacity issues; and workforce preferences and priorities. These factors were most pertinent to triggering of Tier 1 payments, since Tier 2 payments do not require services to change practice.

Tier 1 and Tier 2 outcomes payments for PIP registered patients overall

This section presents levels and trends in Tier 1 and Tier 2 outcomes payments triggered by Medicare billing for patients registered with the PIP Indigenous Health Incentive. These data provide an indication of Medicare services provided to patients registered with the PIP Indigenous Health Incentive.

Across both sectors in 2011, Tier 2 payments were triggered for around 70% of registered patients, and Tier 1 payments were triggered for around 10%. Tier 1 payments were almost invariably triggered for patients whose care also triggered Tier 2 payments. The percentage of patients for whom Tier 1 payments were made increased two- to three-fold between 2010 and 2011. (Figure 7.22 and Appendix H, Tables H4 and H5).

Given that patients registered for the PIP Indigenous Health Incentive are expected to have a diagnosed chronic disease (as per the guidelines on eligibility), it is important to note that neither Tier 1 nor Tier 2 payments were triggered for around 30% of patients (Figure 7.22 and Appendix H, Tables H4 and H5). This indicates a substantial proportion of patients registered for the PIP Indigenous Health Incentive are not regularly attending any Health Service registered for the PIP Indigenous Health Incentive. Figure 7.22 also shows that, in general, the percentage of PIP registered patients for whom no payments were made was higher in the AHS sector than in the General Practice sector.

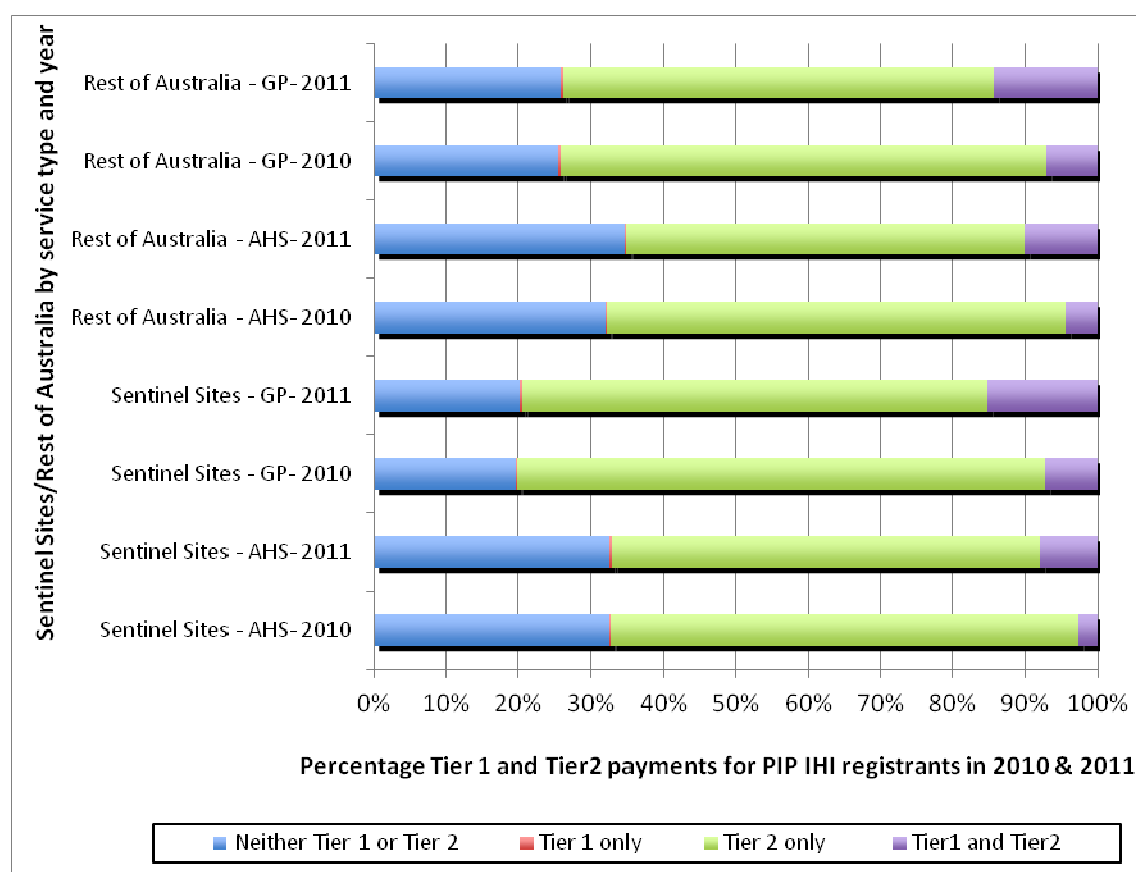


Figure 7.22: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive for Sentinel Sites and the rest of Australia, by sector and year 2010-2011

Tier 1 outcomes payments per population

Figure 7.23 shows the number of Tier 1 outcome payments for services provided for Sentinel Sites and the rest of Australia from June 2010 to May 2012 per 100 Aboriginal and Torres Strait Islander people aged ≥15 years. Tier 1 payments are made in the quarter following the completion of the required

services, that is, to practices that have both developed and reviewed a GPMP or TCA within the calendar year. The figure presents the three quarter rolling averages for Tier 1 payments (that is, the data shown for each quarter are the averages of the data over three quarters, including the quarters before and after). The rolling average smoothens out quarter-to-quarter variation to provide a clearer picture of longer term trends.

The data indicate that Tier 1 payments were made for less than one in 100 Aboriginal and Torres Strait Islander people over the period of evaluation.

The rolling average of Tier 1 payments in each quarter shows that by the September - November 2011 quarter, rates had increased three-fold or more in General Practice and AHSs in Sentinel Sites and General Practice in the rest of Australia compared to September - November 2010. The level of increase was slightly lower in AHSs in the rest of Australia but the absolute differences were relatively small. The slight decline in the rolling average in the quarters from December 2011 - May 2012 partly reflects seasonal variation in service provision and the fact that Tier 1 payments are only made once in each year for care delivered during the course of the year (it should be noted that estimates for the quarter March - May 2012 assumed that rates would be the same in subsequent quarters, and will be underestimates of the real situation if there is an increasing trend beyond the period for which data were available for the SSE).

There was a significant correlation between the number of ICDP workers at the end of June 2011 and the number of PIP Tier 1 payments made per 100 Aboriginal and Torres Strait Islander people in December 2011 - May 2012 ($\rho=0.46^*$, $p=0.03$) (Appendix I, Figure I2). This analysis provides supportive evidence that the ICDP workers had an influence on uptake of Tier 1 payments once they had been in the role for six months or more. This relationship was not observed in earlier reports.

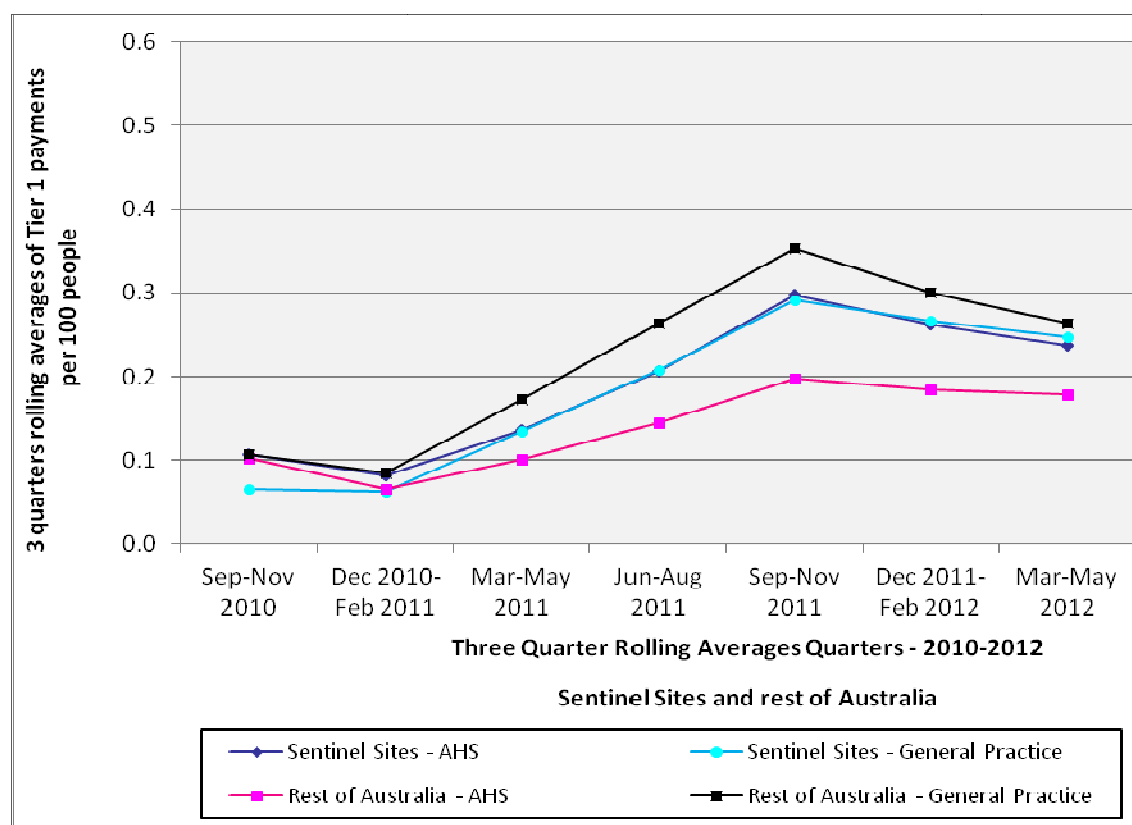


Figure 7.23: Three quarter rolling averages for Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islanders aged ≥ 15 years for Sentinel Sites and the rest of Australia by sector, 2010-2012

The precision of comparisons between Sentinel Sites and the rest of Australia is limited by the possibility that people may register at one Health Service (in or outside a Sentinel Site) and that the Tier 1 payment may be made to another service that is different with respect to location in or outside a Sentinel Site. The extent to which such changes are made is likely to be too small to have a marked effect on the comparisons made in this analysis.

Tier 2 outcomes payments per population

In 2010 the number of Tier 2 payments made per 100 people for the AHS sector combined with the General Practice sector in both Sentinel Sites was close to 10 – i.e. Tier 2 payments were made for about 10% of the Aboriginal and Torres Strait Islander population. In the rest of Australia the corresponding figure was about 8%. In 2011 Tier 2 payments were made for about 9% of the Aboriginal and Torres Strait Islander population. Thus between 2010 and 2011 there was a slight decline in the proportion of the population for whom Tier 2 payments were made in Sentinel Sites and a slight increase in the rest of Australia. The trends by sector are shown in Figure 7.24.

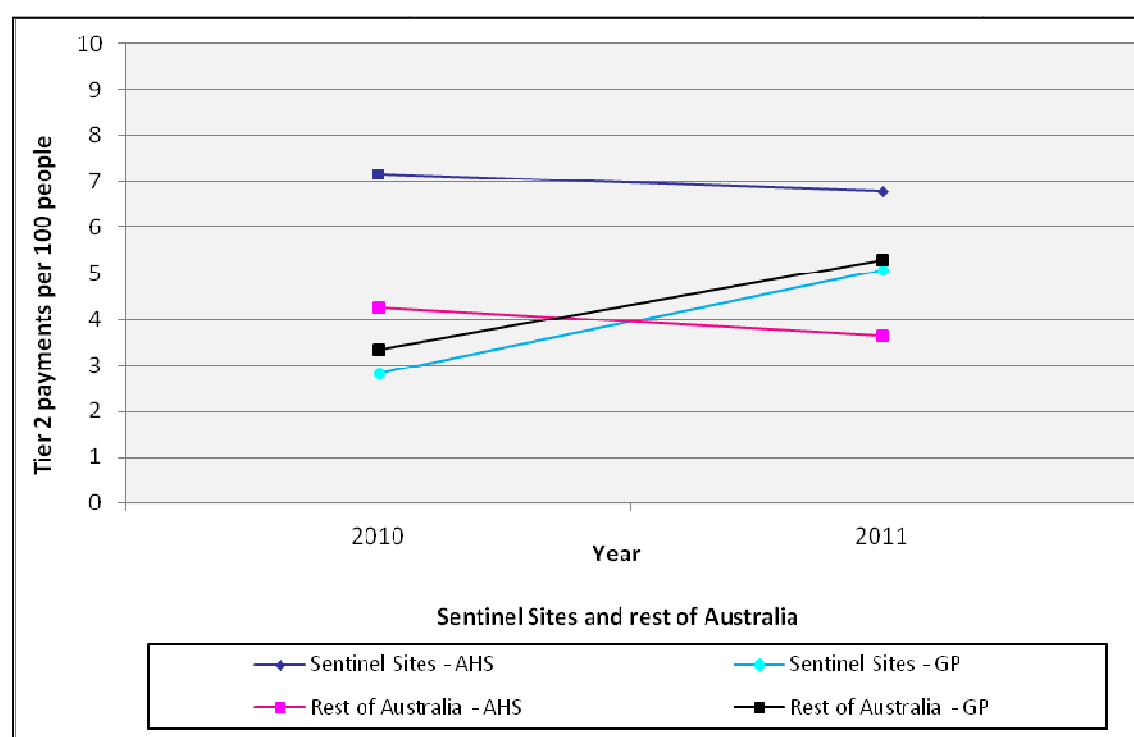


Figure 7.24: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for Sentinel Sites and the rest of Australia by sectors and year, 2010–2011

The precision of comparisons between Sentinel Sites and the rest of Australia is limited by the possibility that people may register at one service (in or outside a Sentinel Site) and that the Tier 2 payment may be made to another service that is different with respect to location in or outside a Sentinel Site. The extent to which such changes are made is likely to be too small to have a marked effect on the comparisons made in this analysis.

Factors influencing Tier 1 and Tier 2 payments

A number of factors appeared to contribute to the extent to which Tier 1 and Tier 2 payments were triggered in the Sentinel Sites. These included factors related to awareness and understanding of requirements and potential benefits of the payments; factors related to function and use of disease registers and system support for follow-up; workforce capacity issues; and workforce preferences and priorities. Each of these groups of factors is discussed in more detail below.

Appendix I presents an analysis of the relationship between different service use variables (for example Tier 1 and follow-up items) and contextual variables (for example pre-existing uptake of related MBS items and the number of ICDP workers in the site). There are a number of limitations with the analysis, and these are detailed in Appendix I. The key findings from the analysis are:

- Uptake of follow-up services by an allied health professional showed statistically significant associations with number of Tier 1 payments and with the number of people receiving medications through the PBS Co-payment measure, and showed borderline statistically significant associations with the number of Tier 2 payments and with the number of PIP Indigenous Health Incentive registrations. These associations are consistent with expectations that patients who are more likely to receive care through the MBS item for follow-up allied health services are also more likely to be registered for the PIP Indigenous Health Incentive, to receive the type of care associated with Tier 1 and Tier 2 payments, and to access the benefits available through the PBS Co-payment measure. The associations indicate that in sites where more patients are accessing MBS items for follow-up services for allied health professionals, more patients are using primary care providers who are registering patients for the PIP Indigenous Health Incentive and providing other ICDP-related services.
- Uptake of follow-up services by a nurse or registered AHW was associated only with the number of people receiving medications through the PBS Co-payment measure, and there was no association between uptake of follow-up services by nurse or registered AHW and follow-up services by an allied health professional. The lack of association between follow-up services by a nurse or registered AHW and registrations for the PIP Indigenous Health Incentive and Tier 1 or Tier 2 payments suggests these items are being used in sites where some services have a specific interest in such follow-up care, and relatively limited interest or capacity to make use of other ICDP-related benefits through the MBS.
- The number of Tier 1 payments was not significantly associated with the number of Tier 2 payments or with the number of people receiving medications through the PBS Co-payment measure. The lack of association between these variables is not surprising, as Tier 1 payments reflect a particular approach to care and to billing for MBS items, while Tier 2 payments and access to the PBS Co-payment measure are simply reflective of relatively frequent use of services and medications.
- The number of Tier 2 payments was statistically significantly associated with the number of people receiving medications through the PBS Co-payment measure. This is as expected, with sites where patients are registered for the PIP Indigenous Health Incentive and who are accessing primary health care services more frequently for chronic illness care (reflected in Tier 2 payments) also more likely to have more patients accessing medications regularly through the PBS Co-payment measure.

Awareness and understanding of requirements and potential benefits

Awareness raising initiatives from DGPs and DoHA have generally focused on signing up patients or Health Services for the PIP Indigenous Health Incentive with relatively limited focus on what is required to trigger the tiered payments and how to re-orientate systems to support this.

‘Through the last six months we are still focusing on registrations. Around November we re-register – a lot of effort is involved for very little outcome – there are no clinical outcomes for re-registration.’ (AHS, GP)

In some cases, there was a lack of understanding about how the outcomes payments could be triggered. The quote below illustrates that there was still some confusion about requirements, even among staff of a peak body with a key role in informing members about the incentive.

'When lots of Tier 2 payments are being received, they should be doing something ... maybe triggering it from something that's happening in the Tier 1.' (NACCHO affiliate)

It was also noted that awareness and knowledge of the incentive and requirements needed to permeate throughout the organisation. As highlighted below, it is not enough for just one person in the team to have knowledge about the incentive.

This may reflect the time taken to get the sort of engagement of Health Service teams required to achieve practice change.

'I feel I know a little bit about registration/re-registration and the tiered payment but others don't, because we need to sit down and discuss it and that has not happened yet and requires support to get this happening across the team.' (General Practice, GP)

Awareness around optimal billing practices was noted as influencing ability of Health Services to access the tiered payments. Some Health Services, particularly AHSs, had employed people whose specific role was to optimise Medicare revenue. These positions sometimes assisted in ensuring correct billing, but in many cases did not have the authority or influence to change the way care was conducted or planned. There were some reports of difficulties in communication between GPs and reception staff in respect of which items to bill for, further constraining ability to trigger Tier 1 and Tier 2 payments.

Particularly in relation to Tier 1 payments, it was necessary for the whole team to be committed to the process: this was highlighted by some interviewees as challenging to arrange, impacting on the Health Service's ability to receive the payments for work completed.

'My biggest problem is getting the TCA done because we send things off to the specialists to say are you willing to be involved with this patient's team care and I do not hear back from them. I tried to print off the sheet and ask them please sign if you would like to be part of this arrangement. I think I have got only two faxes back this year. It's a lot of work on my behalf and I need to chase up the specialists. It's really hard to do the TCA which then becomes an issue because it does not trigger the tier payments.' (AHS, GP)

Interviewees noted the importance of staff being computer literate, and being able to see for themselves the financial rewards of meeting the Tier 1 and Tier 2 requirements (and potential for generating funds that could be used to benefit patient care) – this was seen to be a motivator for participation in meeting incentive payment requirements. Relevant to this factor, some challenges were identified in relation to corporate practices or multi site services, as the funding from Medicare or PIP often goes back to a central location and the local Health Service is unable to disaggregate data and reflect on its own care processes and systems. Over the evaluation period there was increasing awareness of this issue and a number of multi-site services were making changes to enable access to location- or service-specific data.

In general across the evaluation cycles, there was an increasing percentage of interviewees who partly or strongly agreed with the statement *'Health Services have a clear understanding of what is required to receive the tiered PIP Indigenous Health Incentive payments'* – by the final evaluation cycle, 77% (53/69) of interviewees agreed with this statement. There were some differences evident in responses to this statement between interviewees from different sectors, with relatively little change in awareness between the third and fifth evaluation cycle in the AHS sector, and a marked increase in awareness in the General Practice sector (Figure 7.25). This increase in awareness in the General Practice sector corresponds with the relatively greater increases in Tier 1 and Tier 2 payments over time in the General Practice sector. The generally high levels of awareness about the requirements of the incentive by the fourth and fifth evaluation cycles indicate that levels of awareness are probably not a significant

ongoing barrier to uptake of tiered payments, and that limited uptake is due to other factors. As indicated by the qualitative comments, gaps in understanding may relate more to the scale of potential benefits for some services; lack of capacity and understanding of how to re-orientate local systems to access these payments, and; how to link tiered payments to better care for patients, thereby contributing to ‘closing the gap’.

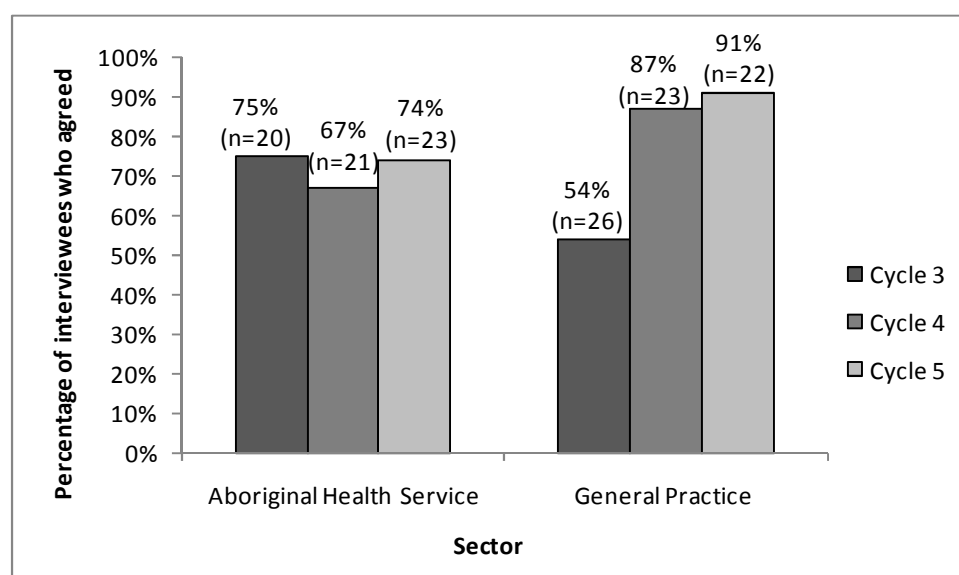


Figure 7.25: Clinicians’ and practice managers’ responses to the statement: ‘Health Services have a clear understanding of what is required to receive tiered payments’ (% who strongly or partly agreed), by sector and report period

Functioning of disease registers and system support for follow-up

Inefficient or non-functioning chronic disease registers and lack of effective systems for recall and follow-up of patients have been previously identified in literature as barriers to the use of GPMPs and TCAs in rural Australia. These barriers were also identified in the SSE as important factors influencing the low uptake of Tier 1 payments.

Specifically in the Sentinel Sites, interviewees noted the ‘bottleneck’ around completion of the GPMPs and TCAs through the review process (required to trigger the Tier 1 payment). In some cases a review could not be done due to lack of co-operation from team members, or was incorrectly billed (payment is not triggered when review is billed as a regular consultation).

‘We do review care plans but we are terrible at billing for them. Getting patients in ... when not unwell for a GPMP review is too hard. We do the check up as part of the consult when they come in for other things but don’t bill for a review, just a regular consult.’ (AHS, GP)

Of concern was the development of Excel spreadsheets to manage patient registration for PIP Indigenous Health Incentive, separate to the main clinical information systems such parallel systems may have had short-term gains, but did not advance systematic development and use of follow-up and recall systems in the longer-term.

In describing difficulties following up patients, Health Service staff identified the inadequacies of their recall and reminder systems, the difficulties experienced in contacting patients for purposes of recall, and in getting patients to attend a follow-up appointment. Some Health Services were linking with OWS to assist with following up patients. It was difficult to ascertain from available data whether or not this strategy was effective. Some of the ways in which Health Services improved or failed to improve their

recall and reminder systems during participation in the PIP Indigenous Health Incentive are outlined in Section 7.3.8.

Some Health Services in the Sentinel Sites reported considering, or commencing to use incentives for patients to attend follow-up appointments.

‘One of our problems is getting follow-up services provided by a practice nurse done, as it is hard to get patients to come back. Even if we send letters out they don’t always come back, but we are working with the Division on this. One of my other problems, because I also do the chronic disease care plans, is trying to find time to get everybody in for a review as well. For follow-up appointments it’s often 4-5 months before patients can be seen ... we do have some good proactive patients who do come back and see their GP on a regular basis.’ (General Practice, nurse)

‘Doing the follow-up is always a challenge in how do you actually recall or get them back. There has been a bit of work done to follow-up - that is, utilise the outreach workers or giving incentives.’ (AHS, CEO)

Workforce capacity

It was commonly reported that GPs or nursing staff do not have time to do the work required to claim payment for the Medicare items, and a focus on meeting the demands of acute care was highlighted as detracting from ability to fulfil requirements for triggering the Tier 1 and to a lesser extent Tier 2 payments.

‘We are low on staff - it is difficult to recall people. We have five GPs and one nurse, 3000 patients and at the moment I am acting practice manager also.’ (AHS, registered nurse)

‘We have 15 minute consults, I can run one hour late.’ (General Practice, GP)

Some Health Services reported that they had quarantined staff time that enabled them to access the Tier 1 and Tier 2 payments. For example, two of the Sentinel Sites that showed higher than average Tier 1 payments (Dubbo and Darwin) included AHSs that had specifically dedicated nursing and GP time for completion of GPMPs and TCAs, and health assessments. Both sites had existing Healthy for Life funding that focused on increasing health assessments and GPMP/TCAs. The strategy of dedicated time seemed more successful where there were large numbers of Aboriginal and Torres Strait Islander patients, or where Aboriginal and Torres Strait Islander patients appeared to attend Health Services more regularly. Some General Practices reported that they had commenced specialised Aboriginal health clinics focused on adult health assessments and care planning, but some of these had been subsequently discontinued due to poor patient attendance.

Lack of staffing capacity also impacted on establishing and maintaining chronic disease lists and recalls, as outlined above. Some interviewees noted that setting up these systems required an initial investment of time, which they felt unable to prioritise over other needs. The type of capacity required included capacity to use information systems effectively.

Workforce preferences and priorities

Some GPs did not see the value in doing GPMPs and TCAs and asked for evidence that these would improve clinical outcomes. At times it was suggested that the younger generation of GPs were more willing to work with these MBS items. Access to dental care benefits (that become available if the patient has a care plan) was identified by interviewees as an incentive to use these tools. During the final evaluation cycle interviewees expressed concern about possible changes to the dental benefits available to patients with chronic disease.

The individual working style of many GPs was identified as a barrier to use of care planning tools - several interviewees noted that GPs did not like having nursing or AHW staff doing the preliminary work and felt they needed to complete every aspect themselves, restricting what could be achieved. It was also reported that locum GPs were less willing to undertake care planning as they would not personally be able to follow-up, and believed follow-up systems would not support the processes they started.

There was some evidence in the Sentinel Sites of leadership and management directives changing practice in relation to use of care planning tools, and changing GP practices that enabled them to see the value of GPMPs and TCAs. These developments came about through networking with other GPs/Medical Officers or 'leader practices' that have been using the care plans and had positive experiences.

'At present the service is working through my involvement in the GPMPs but I think they are a useful tool to manage a patient's condition appropriately.' (AHS, nurse)

'It has dramatically improved our rate of GPMPs and TCAs which is good for the patient. One of GPs told me that they did not previously see much value [for the patient] in doing the GPMPs but since they have been doing more they have changed their position.' (AHS, GP)

'The relative investment in the ICDP of training of existing staff is apparent. Health professionals do not necessarily have the skills required in chronic disease management and the ability to structure care in a Health Service to allow for this to occur.' (DGP, program manager)

It was suggested by some interviewees that the process is 'evolutionary' in some respects and that the focus on health assessments that has been occurring in services will, in due course, turn towards further care planning.

'I am not sure though, that it is [PIP Indigenous Health Incentive] driving us to provide care any differently. It's an evolutionary process at these clinics, getting the health assessments done, then the GPMP and TCAs which will then result in the follow-ups. It's a lot of work and requires a team effort [to change care practices].' (AHS, GP)

The following section presents data that illustrate the wide variation in triggering of Tier 1 and Tier 2 payments between geographic locations, sectors and different Sentinel Sites. This variation suggests that outcomes payments are not yet well embedded as an incentive for better quality care. Reasons for variation and options for system strengthening are outlined in the following sections of this chapter.

7.3.6. VARIATION IN OUTCOMES PAYMENTS BY GEOGRAPHIC LOCATION AND IN SPECIFIC SENTINEL SITES

KEY POINTS

- Wide variation existed between sites in the proportion of PIP registered patients for whom neither Tier 1 nor Tier 2 payments were made (from less than 10% in some sites to almost 50% in others).
- The number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people was in general higher in regional and remote locations than in urban locations (although the number in remote Sentinel Sites was lower than for Sentinel Sites in other locations and for the rest of Australia).
- The number of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people was in general higher in regional and urban locations than in remote locations.
- There was wide variation in trends in Tier 1 payments, with particularly marked increases in a few of the Sentinel Sites. The apparent general increase in Tier 1 payments was driven by increases in a limited number of sites, with some sites showing little or no increase over the evaluation period.

Urban areas – illustrative patterns

In urban locations the percentage of PIP Indigenous Health Incentive registrants for whom no Tier 1 or Tier 2 payments were made was around 20% in General Practice in urban Sentinel Sites and 25% in General Practice in the rest of urban Australia. In General Practice there was very little change in percentage of PIP Indigenous Health Incentive registrants for whom no Tier 1 or Tier 2 payments were made in 2011 compared to 2010. No Tier 1 or Tier 2 payments were made for around a third of PIP Indigenous Health Incentive registrants attending AHSs in urban Sentinel Sites and the rest of urban Australia in 2010 - this percentage increased slightly in both urban Sentinel Sites and the rest of urban Australia in 2011. The major change in urban locations between 2010 and 2011 was an increase in the proportion of PIP Indigenous Health Incentive registrants for whom both Tier 1 and Tier 2 payments were made, and a decrease in the proportion for whom only a Tier 2 payment was made (Figure 7.26).

The relative increase in the proportion of PIP Indigenous Health Incentive registrants was made was greatest in AHSs in the rest of urban Australia, although the level remained relatively low in 2011 compared to AHSs and General Practices in urban Sentinel Sites and General Practices in the rest of urban Australia. General Practices in urban Sentinel Sites and in the rest of urban Australia tended to have a higher proportion of PIP Indigenous Health Incentive registrants for whom both a Tier 1 and a Tier 2 payment was made in 2011 than AHSs in Sentinel Sites and in the rest or urban Australia.

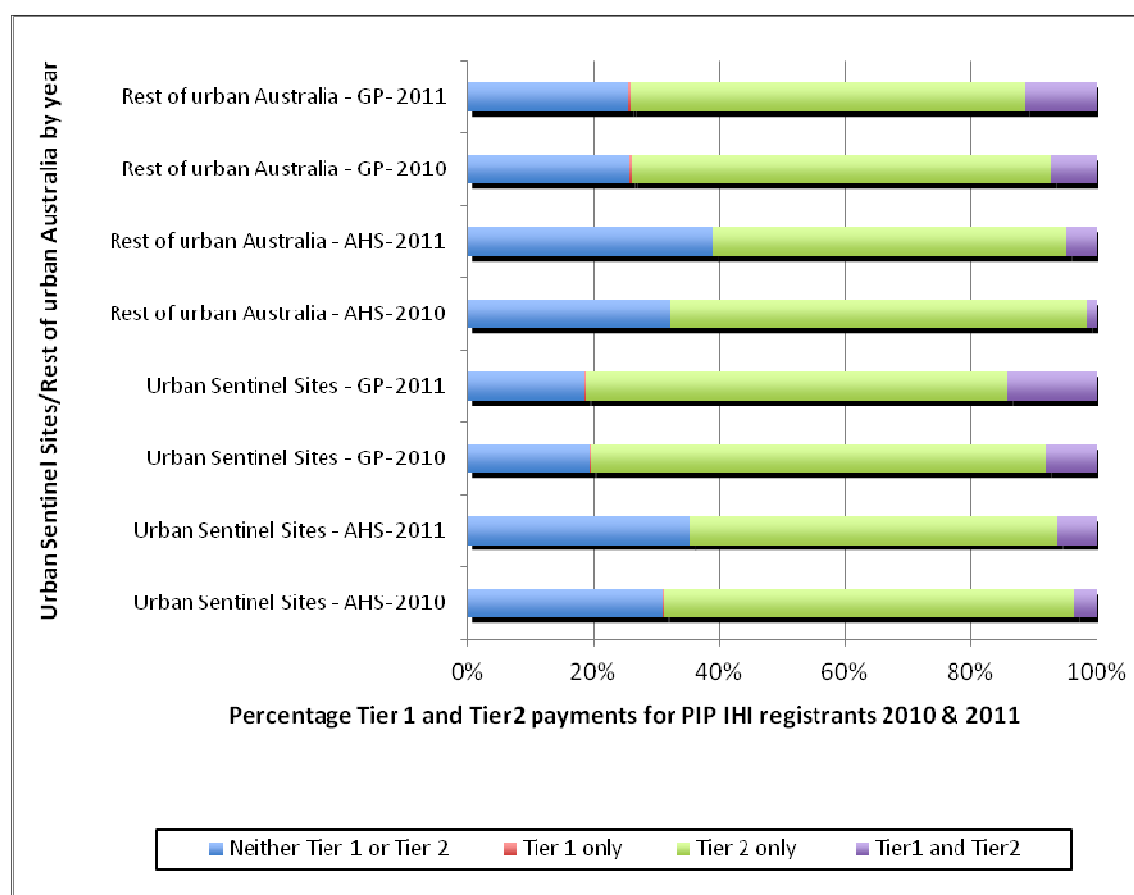


Figure 7.26: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive for urban Sentinel Sites and the rest of urban Australia, by sector and year 2010-2011

There were steadily increasing trends in Tier 1 payments between the December 2010 – February 2011 quarter and the September – November 2011 quarter. Over this period the number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people was notably higher in General Practice than in AHS – both in urban Sentinel Sites and in the rest of urban Australia. This increasing trend has continued over subsequent quarters in AHSs in urban Sentinel Sites but has levelled off or declined in General Practice in urban Sentinel Sites and in the rest of urban Australia, and in AHSs in the rest of urban Australia (Figure 7.27).

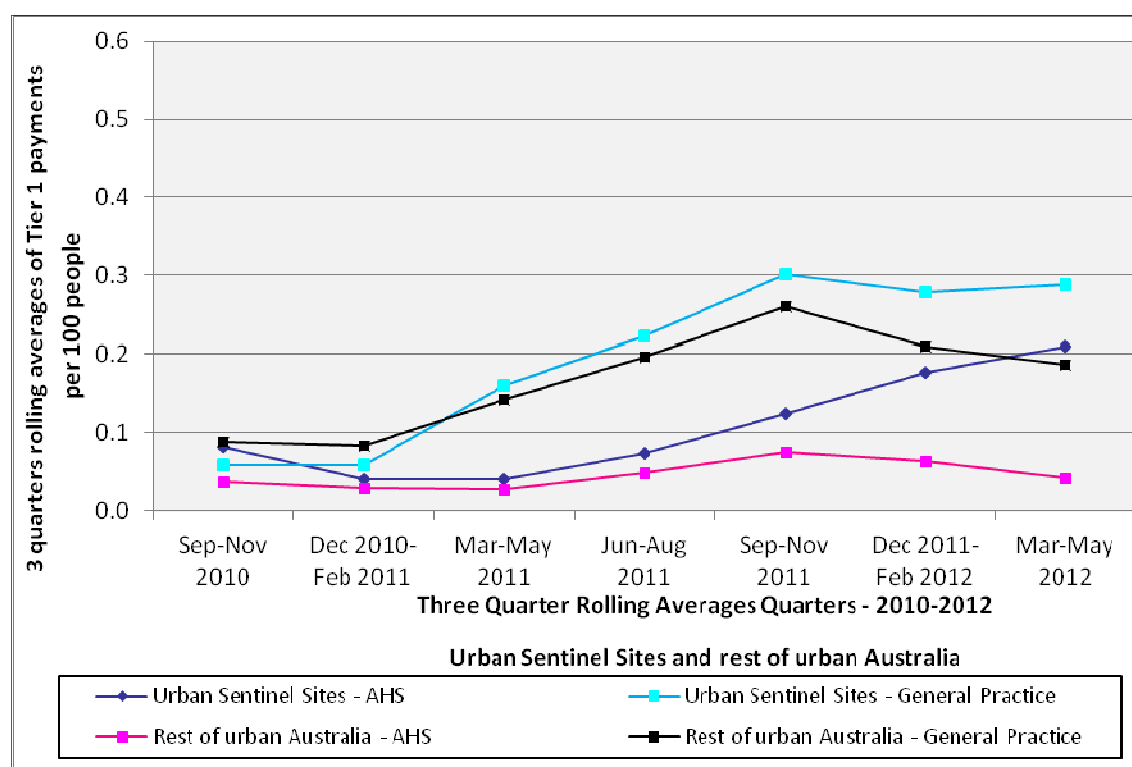


Figure 7.27: Three quarter rolling averages for Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by sector, 2010-2012

Figure 7.28 shows that the Sentinel Sites of Logan/Woodridge, Brisbane South, Dandenong, and North Lakes/Caboolture had lower percentages of PIP Indigenous Health Incentive registrants from whom no Tier 1 or Tier 2 payments were made than the rest of urban Australia in 2010 and 2011. In Logan/Woodridge, Brisbane South and Newcastle there were increases between 2010 and 2011 in the percentage of registrants for whom no payments were made. In Campbelltown site there was a large decrease in the percentage of PIP Indigenous Health Incentive registrants from whom no Tier 1 or Tier 2 payments were made between 2010 and 2011. A smaller decrease was also apparent in the Elizabeth site. An increase in the percentage of Tier 1 payments between 2010 and 2011 were apparent in Canberra, Campbelltown, Dandenong, North Lakes/Caboolture, Newcastle and the rest of urban Australia.

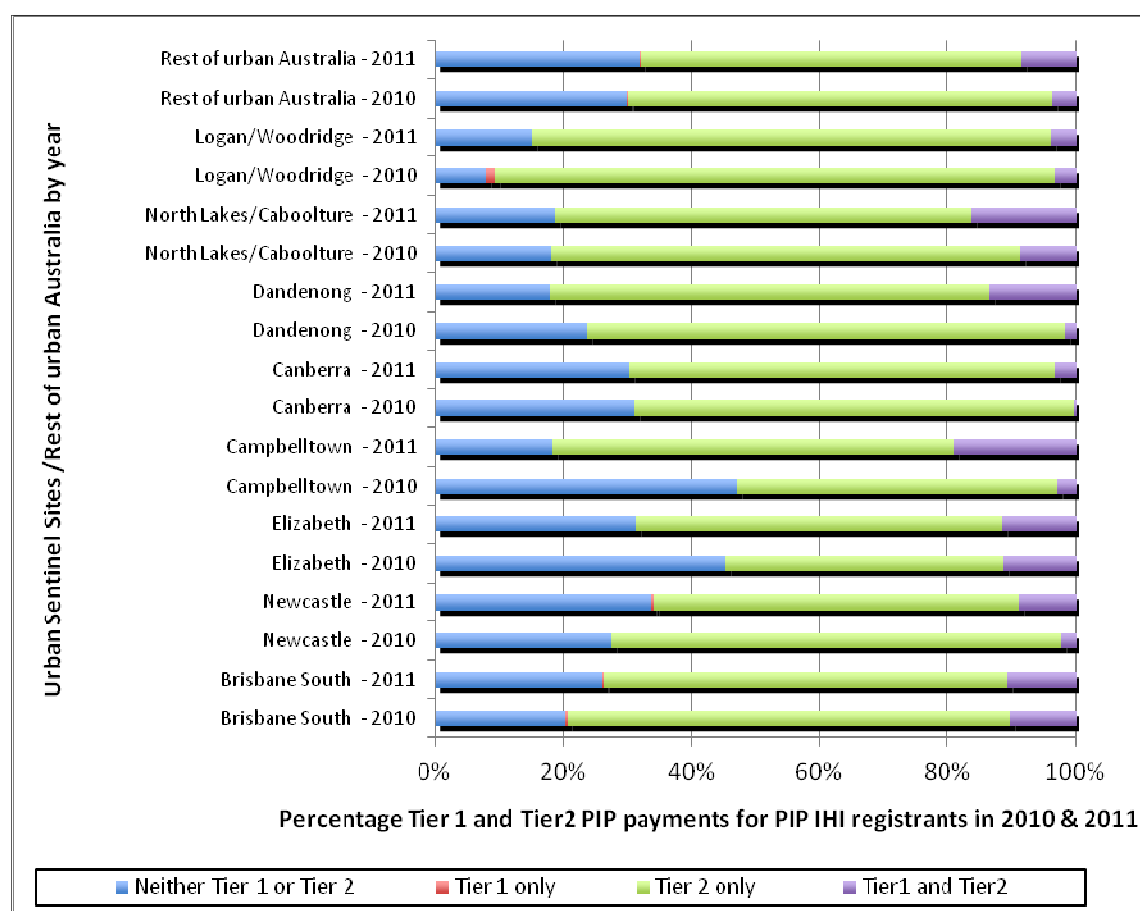


Figure 7.28: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive for urban Sentinel Sites and the urban rest of Australia, by year 2010-2011

Population coverage of Tier 1 payments in urban areas

There was a wide variation in Tier 1 payments proportional to population across the urban Sentinel Sites – for example, in the period March - May 2012, there was an 18-fold variation in the numbers of Tier 1 payments per 100 population between the sites with the highest and those with the lowest number of Tier 1 payments.

Figures presented below compare the rolling averages of Tier 1 payments in the periods from September - November 2010 to March - May 2012. Trends in Tier 1 payments varied with urban, regional and remote locations (Appendix H, Table H6 and H7).

Almost all urban Sentinel Sites, and the rest of urban Australia, showed at least some increase in the number of Tier 1 payments per 100 people from September - November 2010 to March - May 2012. Most urban Sentinel Sites had higher numbers of Tier 1 payments per 100 people than the rest of urban Australia by the March - May 2012 quarter. The exceptions were Dandenong and Canberra, in which numbers of Tier 1 payments per 100 people remained low. Campbelltown, Elizabeth, Logan/Woodridge and North Lakes/Caboolture all showed strong growth to the end of the September - November 2011 quarter. The number of Tier 1 payments per 100 people continued to increase in North Lakes/Caboolture but levelled off or declined in the other Sentinel Sites (Figure 7.29).

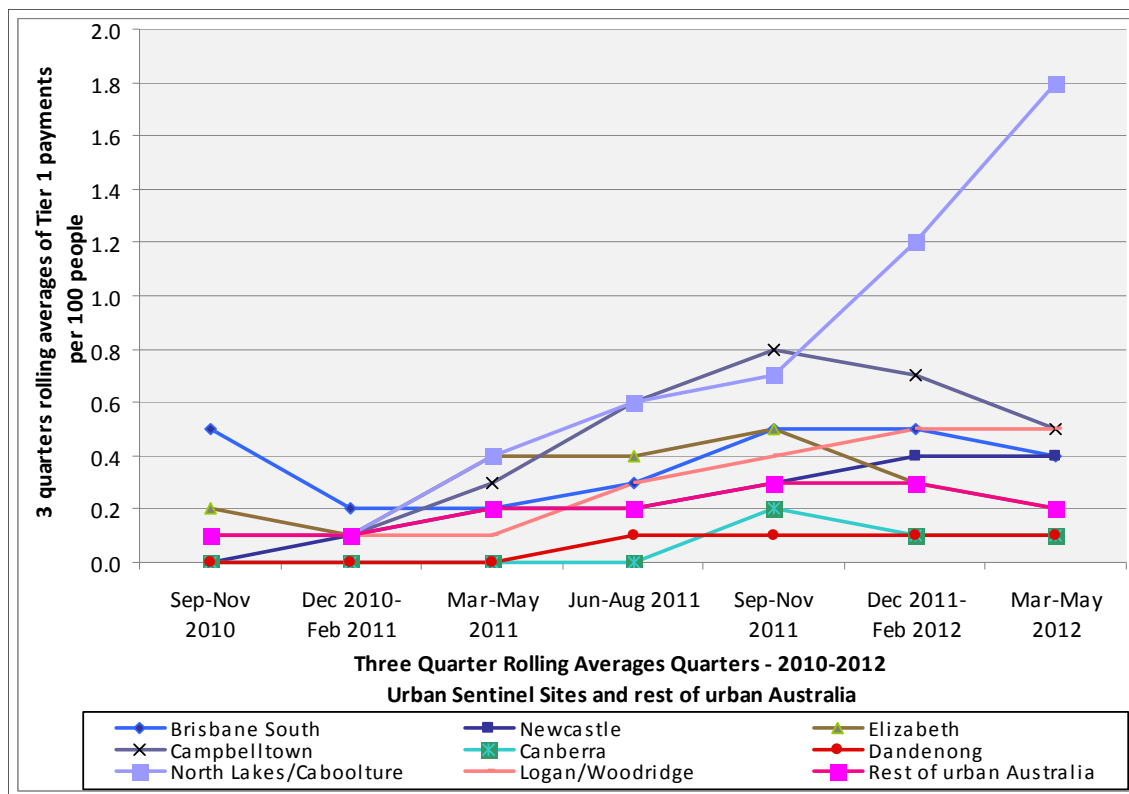


Figure 7.29: Three quarter rolling averages for Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years, for urban Sentinel Sites and the rest of urban Australia, 2010-2012

Population coverage of Tier 2 payments in urban areas

In 2011 the number of Tier 2 payments in urban Sentinel Sites was about 10 per 100 Aboriginal and Torres Strait Islander people, and about 8 per 100 in the rest of urban Australia – i.e. Tier 2 payments were made for about 10% and 8% of the population respectively in these locations. In General Practices in urban Sentinel Sites and in the rest of urban Australia the numbers of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people increased from 2010 to 2011, while the numbers decreased over the same period in AHS in urban Sentinel Sites and in the rest of urban Australia. AHSs in both urban Sentinel Sites and the rest of urban Australia had higher levels of Tier 2 payments per 100 people than General Practice in 2010 but the reverse was true in 2011 (Figure 7.30).

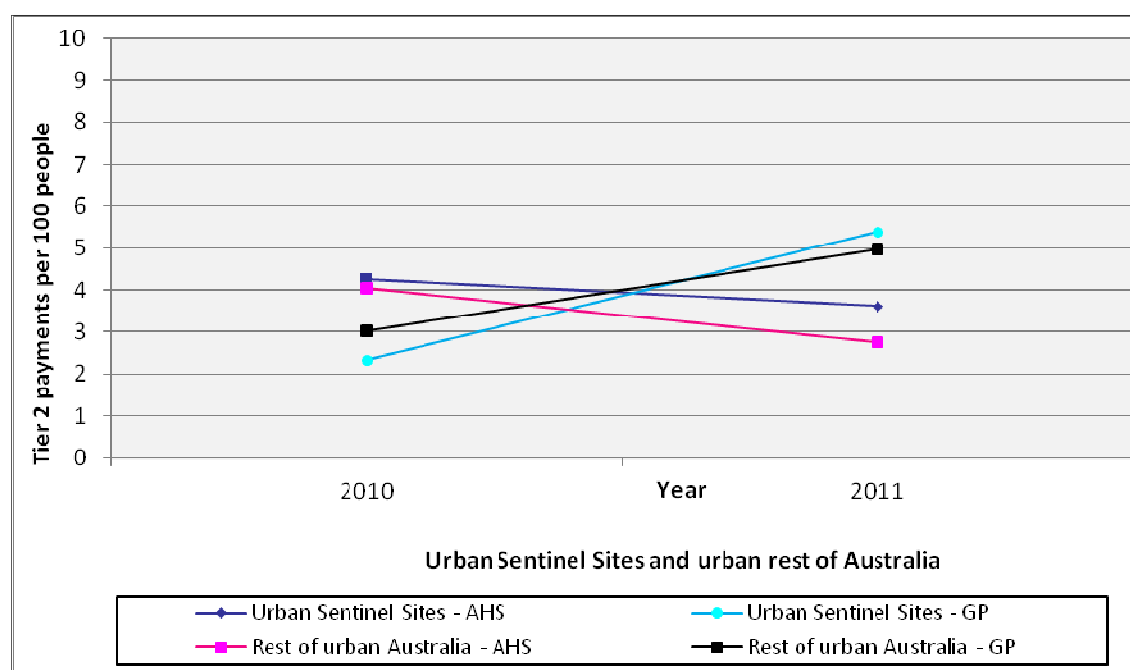


Figure 7.30: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by sectors and year, 2010–2011

In urban Sentinel Sites and the rest of urban Australia Tier 2 payments increased or were stable in all sites between 2010 and 2011 (Figure 7.31). In 2011, Brisbane South, Campbelltown, Elizabeth, Logan/Woodridge, Canberra and North Lakes/Caboolture had higher levels of Tier 2 payments than the rest of urban Australia. In the case of Campbelltown, Elizabeth and North Lakes/Caboolture this was due to increases between 2010 and 2011.

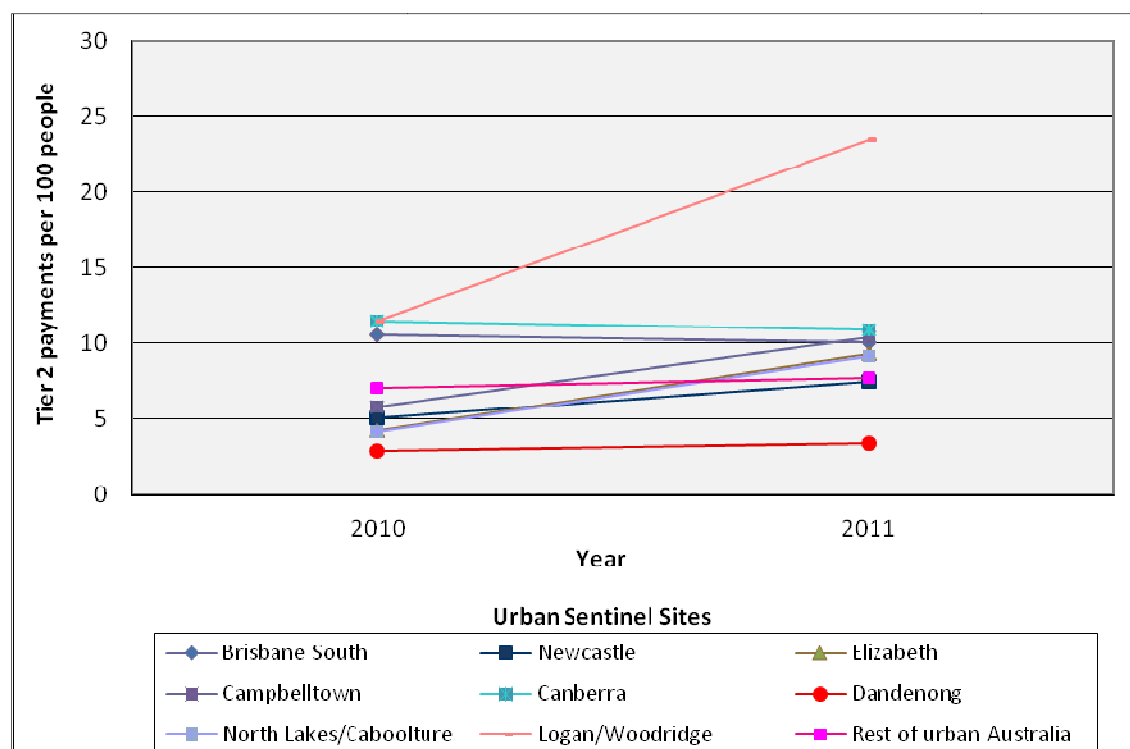


Figure 7.31: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by Sentinel Sites and year, 2010–2011

Regional areas – illustrative patterns

The percentages of PIP Indigenous Health Incentive registrants for whom no Tier 1 or Tier 2 payments were made in different sectors showed similar patterns overall to those described for urban locations. There was very little change in the percentage of PIP Indigenous Health Incentive registrants for whom no Tier 1 or Tier 2 payments were made in 2010 compared to 2011 in General Practice in regional Sentinel Sites and the rest of regional Australia. There was a small decrease in the percentage of PIP Indigenous Health Incentive registrants for whom no Tier 1 or Tier 2 payments were made in AHSs in regional Sentinel Sites and a small increase in the rest of regional Australia from 2010 to 2011.

In General Practice in regional Sentinel Sites and AHSs and General Practice in the rest of regional Australia Tier 1 payments were around two and half times greater in 2011 than 2010. In AHSs in regional Sentinel Sites Tier 1 payments were around four and half times greater in 2011 compared to 2010, but still remained relatively low (Figure 7.32).

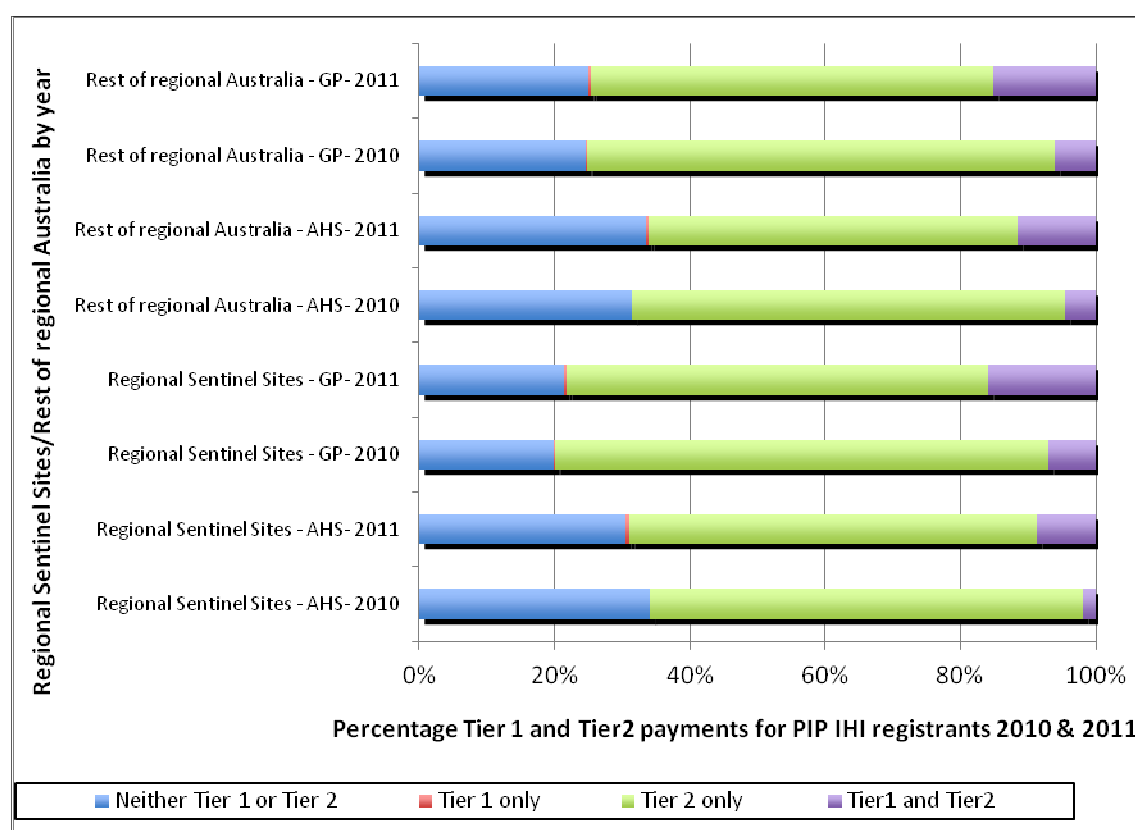


Figure 7.32: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive for regional Sentinel Sites and the rest of regional Australia, by Sector and year 2010-2011

All regional Sentinel Sites and the rest of regional Australia showed increases in the percentage of PIP Indigenous Health Incentive registrants for whom both Tier 1 and Tier 2 payments were made, except Bairnsdale, where no Tier 1 or Tier 2 payments were made. Darwin stands out as the regional site with the highest percentage of Tier 1 payments, and also has a relatively low percentage of registrants for whom neither Tier 1 nor Tier 2 payments were made (although this has increased between 2010 and 2011). Hobart, Grafton and Cairns also stand out as regional sites with a relatively low proportion of registrants for whom no Tier 1 or Tier 2 payments were made, with decreases in these proportions between 2010 and 2011 (Figures 7.33-7.35).

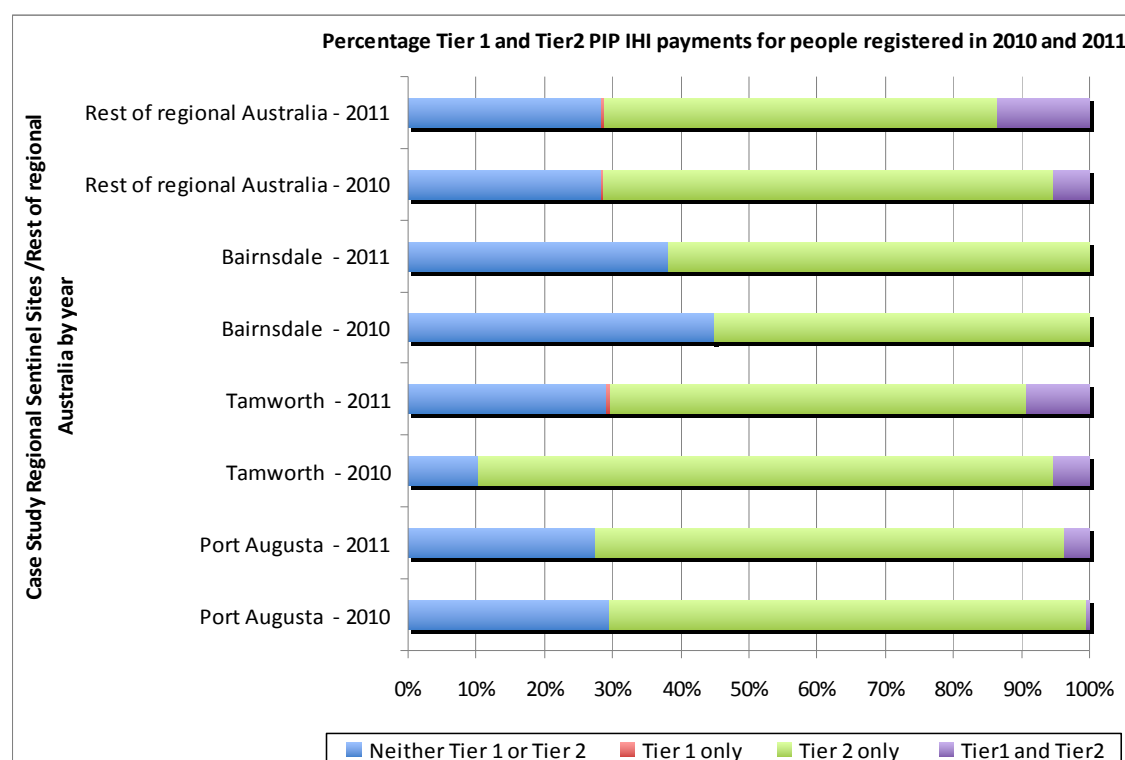


Figure 7.33: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 and 2011 for case study regional Sentinel Sites and the rest of regional Australia

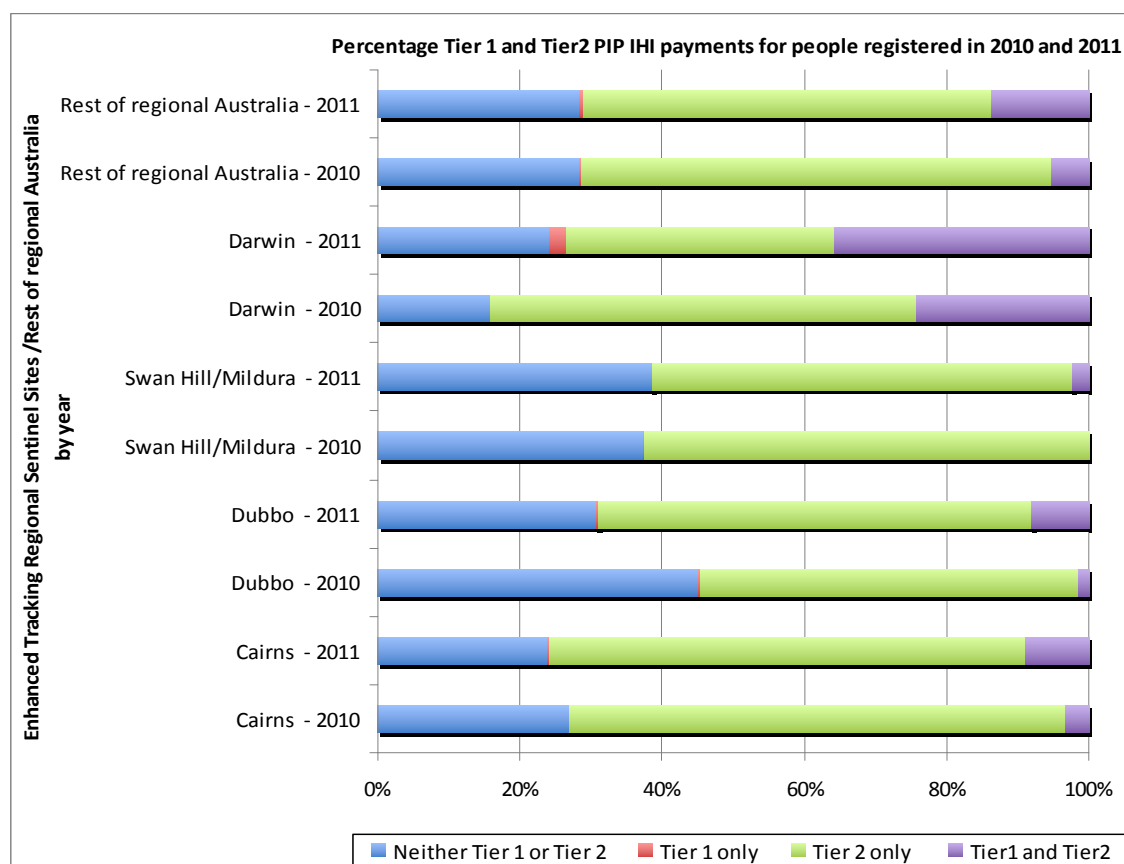


Figure 7.34: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 and 2011 for enhanced tracking regional Sentinel Sites and the rest of regional Australia

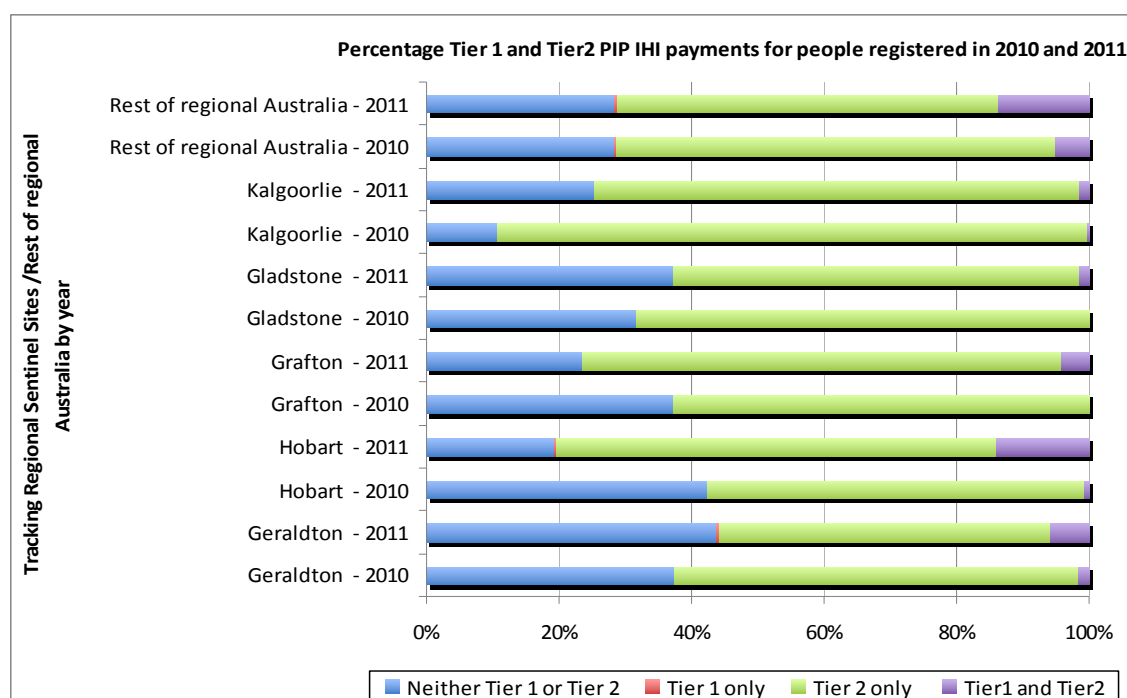


Figure 7.35: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 and 2011 for tracking regional Sentinel Sites and the rest of regional Australia

Population coverage of Tier 1 payments in regional areas

In both sectors in regional areas there was an approximately two-fold increase in Tier 1 payments per 100 Aboriginal and Torres Strait Islander people between the March – May 2011 and the March – May 2012 quarters. This was true for both regional Sentinel Sites and the rest of regional Australia. Throughout the evaluation period the number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people was higher among AHSs than General Practice in Sentinel Sites but the opposite was true in the rest of regional Australia (Figure 7.36).

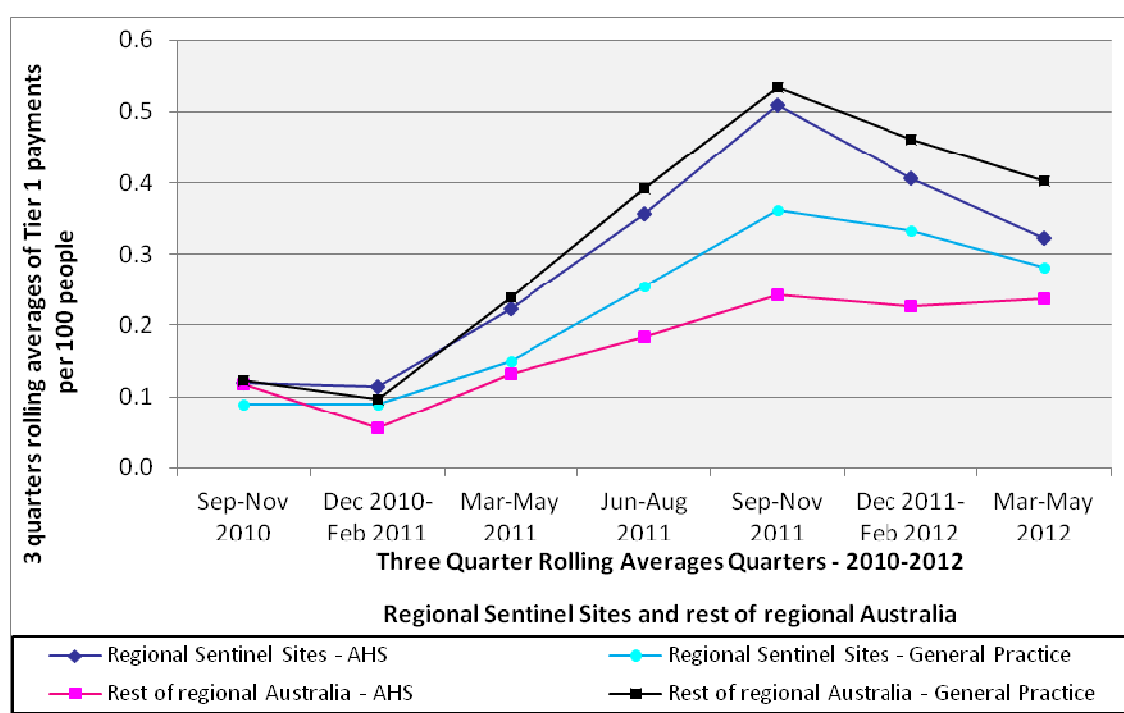


Figure 7.36: Three quarter rolling averages for Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people for regional Sentinel Sites and the rest of regional Australia, by sector, 2010-2012

Similar to that reported for urban Sentinel Sites, there was wide variation in the numbers of Tier 1 payments per 100 people between different sites (Figures 7.37-7.39). Almost all regional Sentinel Sites and the rest of regional Australia showed increases in the number of Tier 1 payments per 100 people from September - November 2010 to March - May 2012. Bairnsdale received no Tier 1 payments over the period of the evaluation. Darwin and Dubbo stood out as having relatively high numbers of Tier 1 payments per 100 people over most of the evaluation period. In Cairns the pattern of Tier 1 payments per 100 people was similar to that for the rest of regional Australia. Other regional Sentinel Sites had lower numbers of Tier 1 payments than the rest of regional Australia over most of the period of the evaluation.

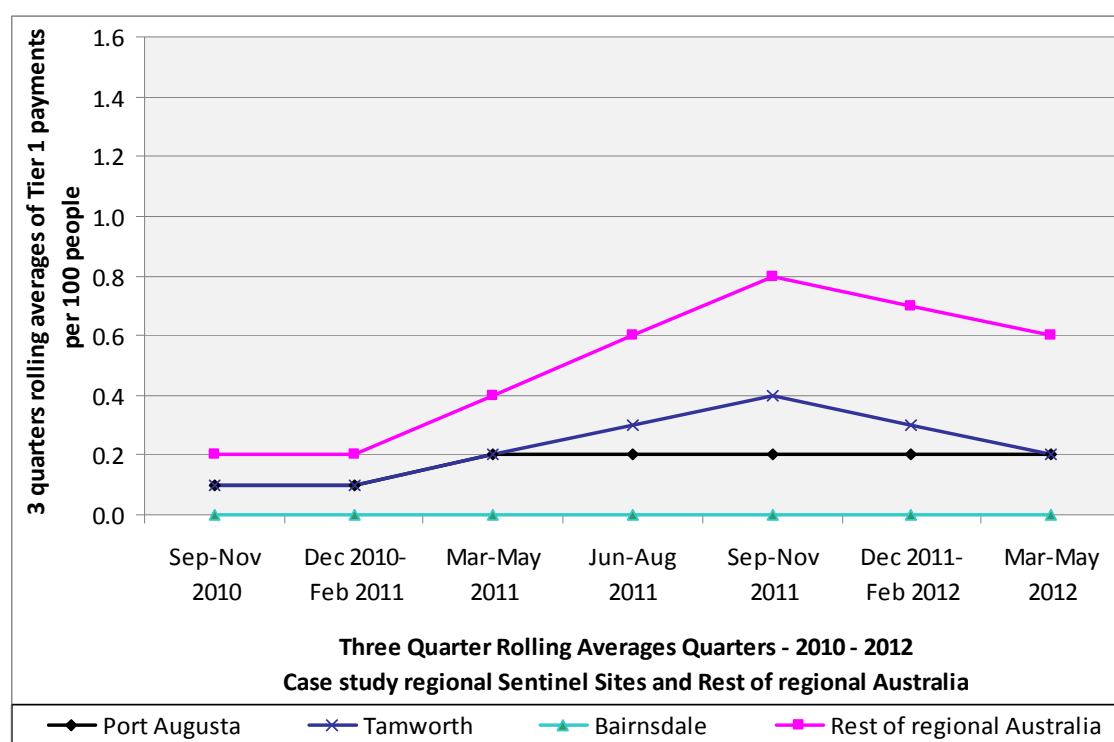


Figure 7.37: Three quarter rolling averages of Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for case study regional Sentinel Sites and the rest of regional Australia, 2010-2012

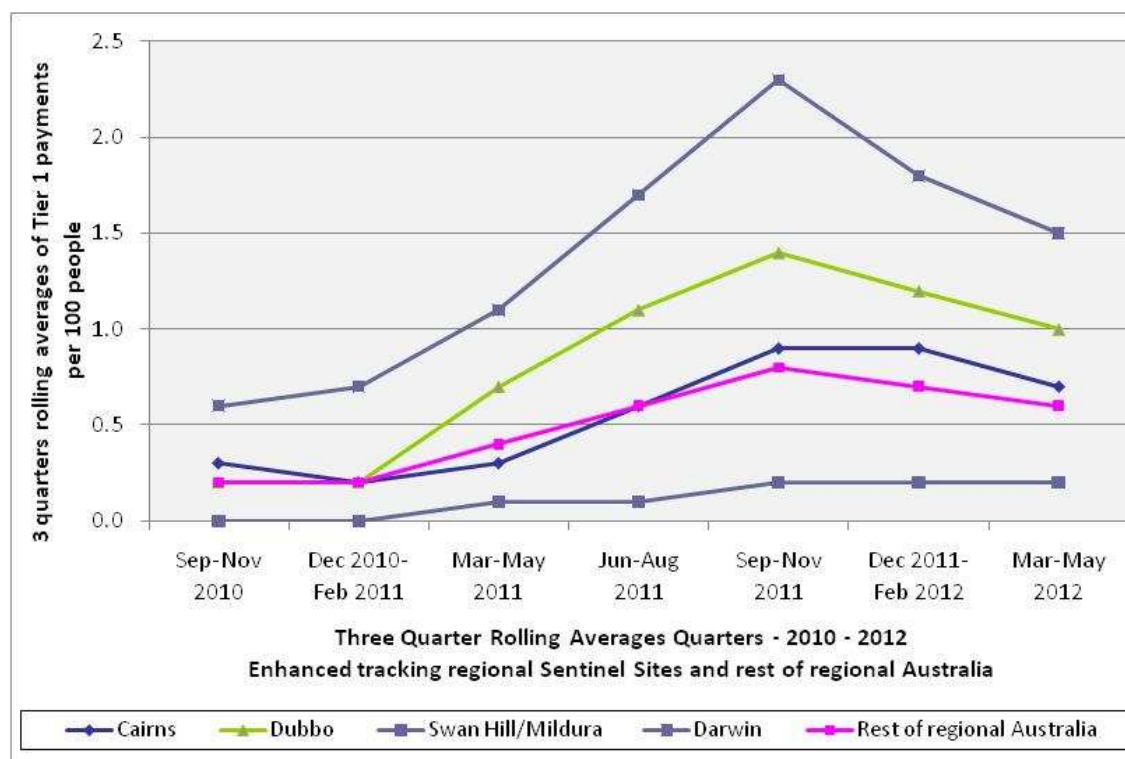


Figure 7.38: Three quarter rolling averages of Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for enhanced tracking regional Sentinel Sites and the rest of regional Australia, 2010-2012

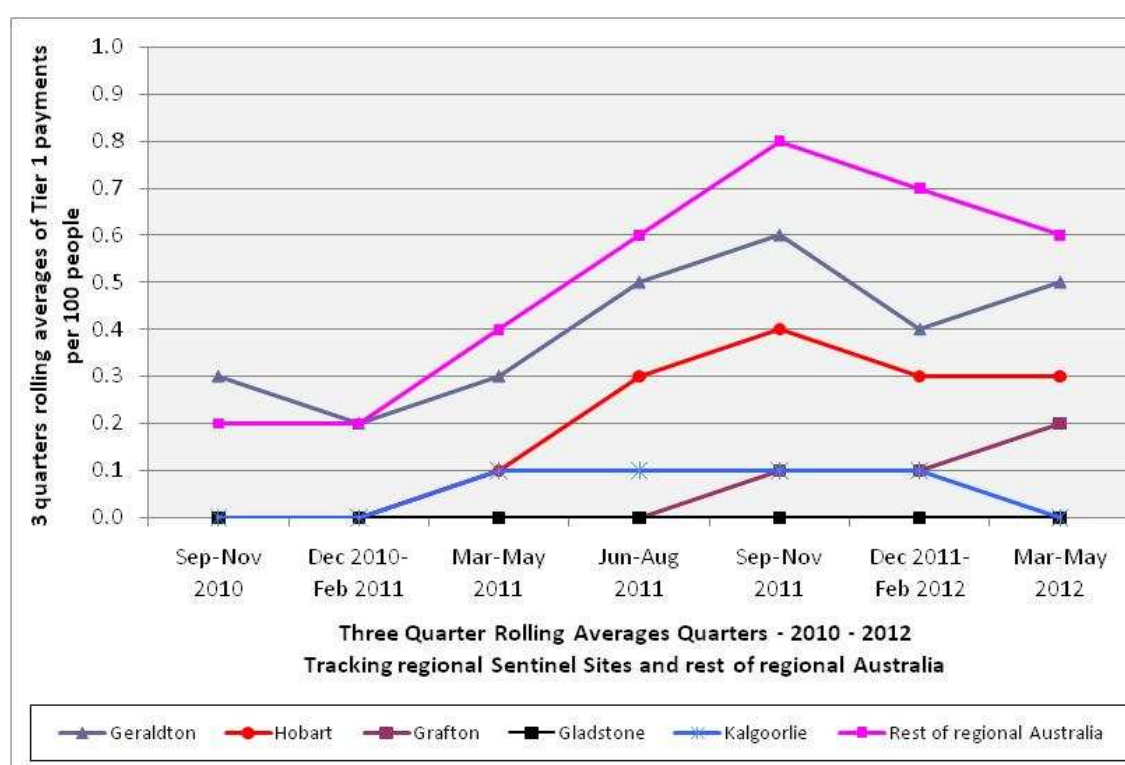


Figure 7.39: Three quarter rolling averages of Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for tracking regional Sentinel Sites and the rest of regional Australia, 2010-2012

Population coverage of Tier 2 payments in regional areas

In regional Sentinel Sites and the rest of regional Australia the numbers of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people was about 17 and 12 respectively in 2011, with increases of between 15% and 20% between 2010 and 2011. Thus the population coverage in regional areas has generally been higher than in urban areas.

The numbers of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people in AHSs were much higher than any other group and remained stable between 2010 and 2011. The numbers of Tier 2 payments in General Practice in regional Sentinel Sites increased by about 50% in 2011 compared to 2010. For AHSs in the rest of regional Australia the number of Tier 2 payments per 100 people declined from about five in 2010 to about four in 2011 (about 20% decrease). The levels in these AHSs were higher than in General Practice in 2010, but the reverse was true in 2011. The number of Tier 2 payments per 100 people in General Practice in Sentinel Sites and in the rest of regional Australia were around four to five in 2010, increasing to between six and eight in 2011 (50-60% increase) (Figure 7.40).

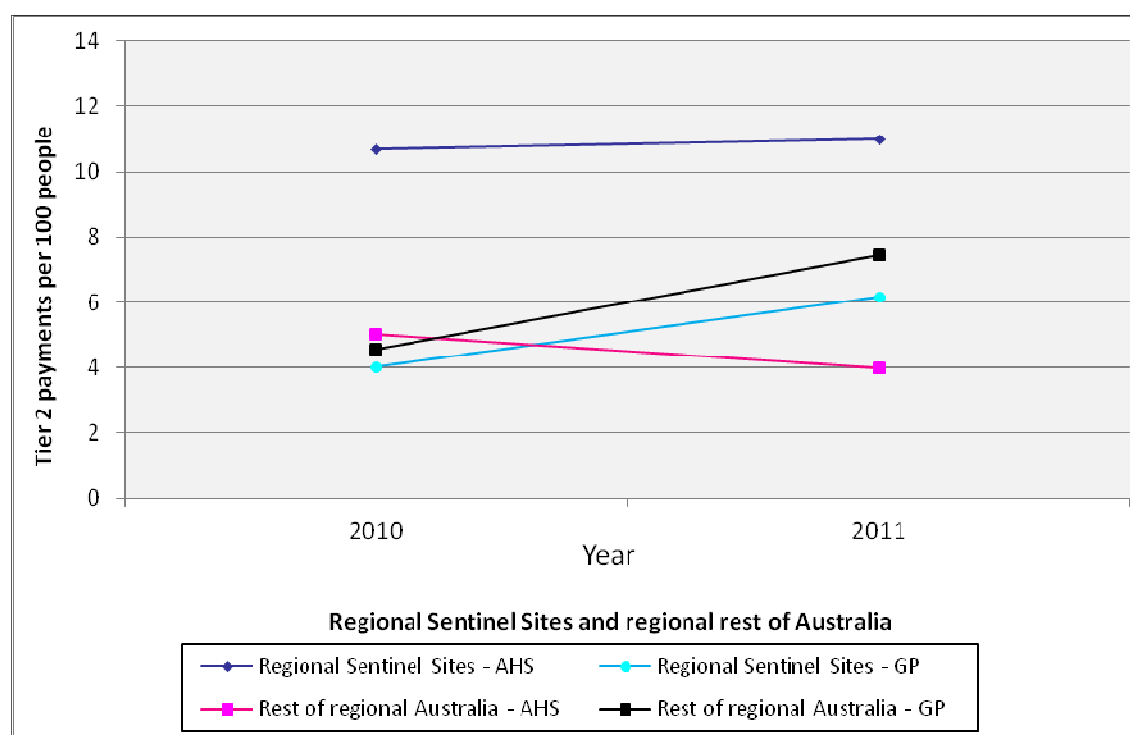


Figure 7.40: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for regional Sentinel Sites and the rest of regional Australia by sectors and year, 2010–2011

The number of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people increased between 2010 and 2011 in Cairns, Dubbo, Darwin, Hobart and Tamworth, decreased in Bairnsdale, Geraldton, Gladstone, Port Augusta and Swan Hill/Mildura and remained stable in Kalgoorlie. Some of the decreases occurred in sites that had greater numbers of Tier 2 payments than the rest of regional Australia in both 2010 and 2011. These sites included Bairnsdale, Geraldton, Port Augusta and Swan Hill/Mildura. Dubbo also had higher numbers of Tier 2 payments per 100 people than the rest of regional Australia in 2010 and 2011 and Darwin had higher numbers of Tier 2 payments in 2011 (Figures 7.41–7.43).

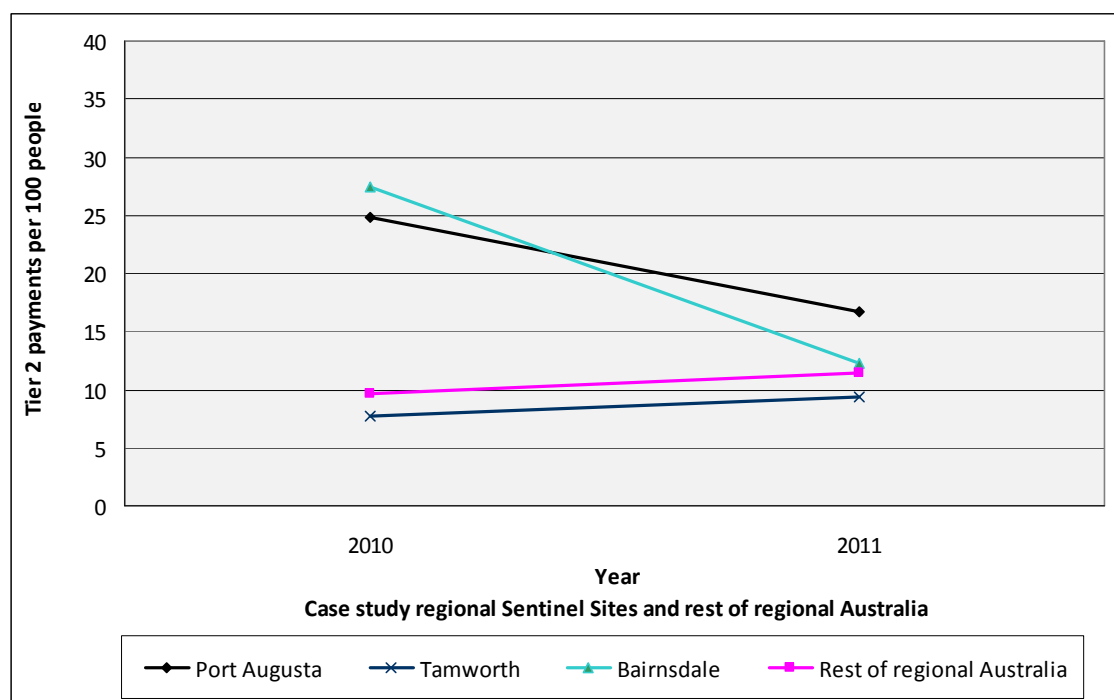


Figure 7.41: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for case study regional Sentinel Sites and the rest of regional Australia by Sentinel Sites and year, 2010–2011

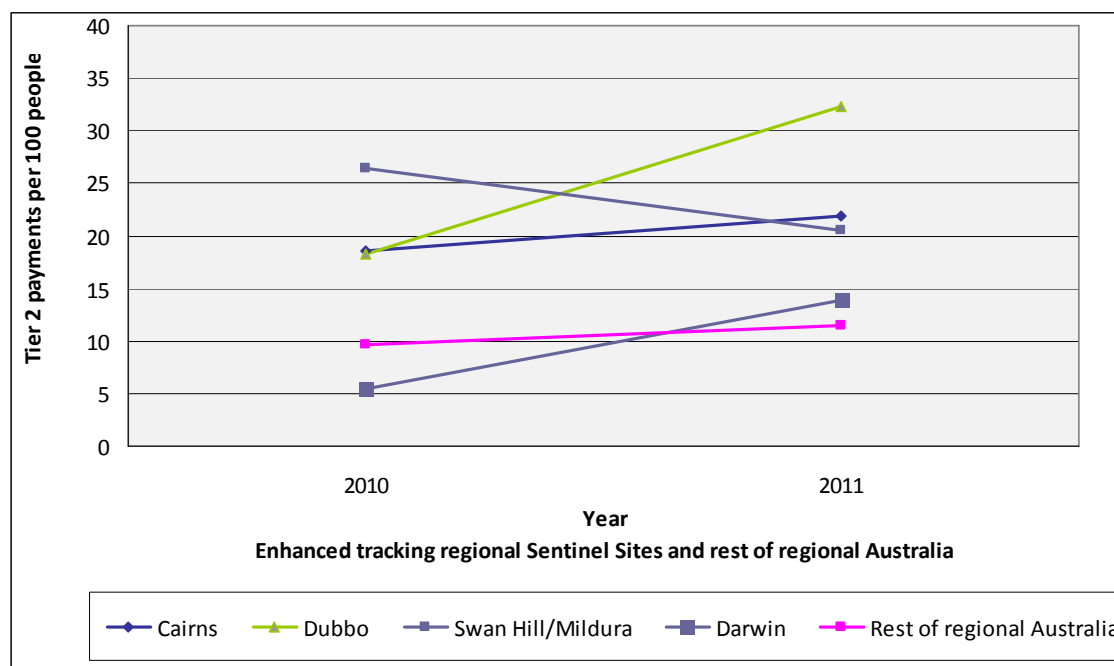


Figure 7.42: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for enhanced tracking regional Sentinel Sites and the rest of regional Australia by Sentinel Sites and year, 2010–2011

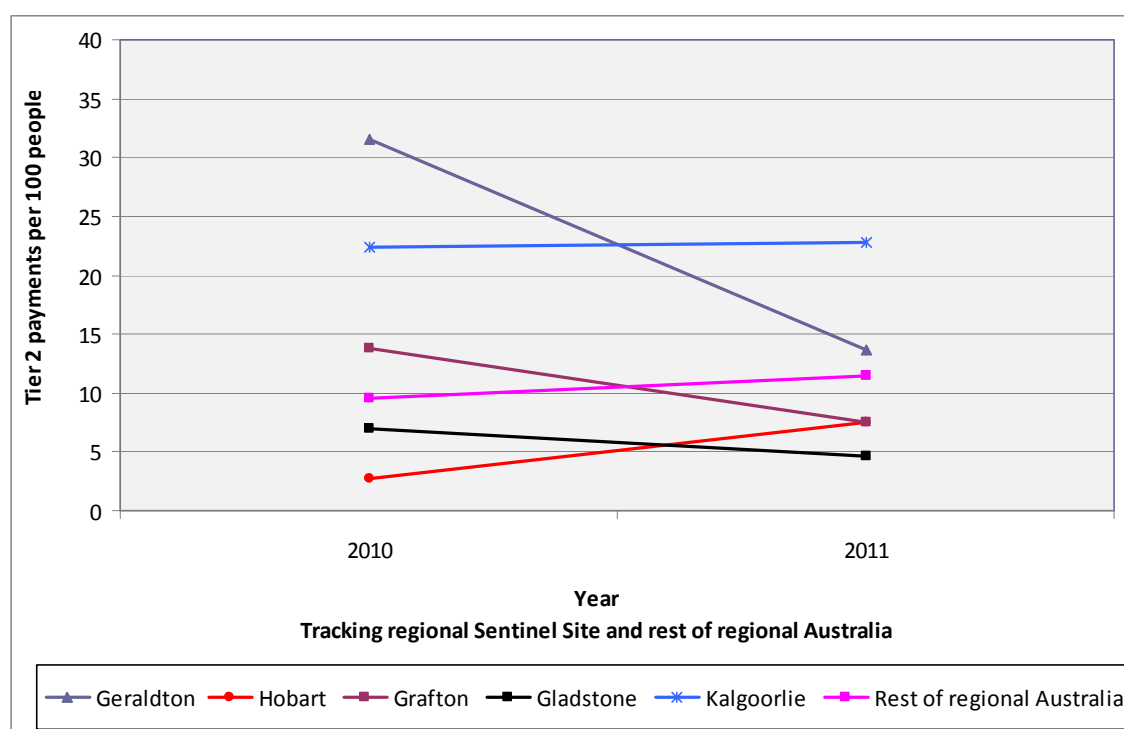


Figure 7.43: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for tracking regional Sentinel Sites and the rest of regional Australia by Sentinel Sites and year 2010–2011

Remote areas – illustrative patterns

The trends in payments for PIP Indigenous Health Incentive registrants' payments were similar in the rest of remote Australia to regional and urban locations but very different in remote Sentinel Sites. This difference is associated with low numbers of PIP Indigenous Health Incentive registrants in remote Sentinel Sites.

No Tier 1 or Tier 2 payments were made to AHSs in the rest of remote Australia for about a third of PIP Indigenous Health Incentive registrants in these locations, with little change between 2010 and 2011. The comparative figure for General Practice in the rest of remote Australia was slightly lower, also with little change between 2010 and 2011.

In General Practice and AHSs in the rest of remote Australia payments there was an increase in Tier 1 payments between 2010 and 2011 of about 50%, with the level being around 15% in General Practice and slightly less in Sentinel Sites.

In remote Sentinel Sites the percentage of patients for whom no Tier 1 or Tier 2 payments were made increased from 2010 to 2011 in both AHSs and General Practice. These data are influenced by the low numbers of General Practices in the remote Sentinel Sites. The percentage of Tier 1 payments made to AHSs in remote Sentinel Sites was very similar for 2010 and 2011. There were no Tier 1 payments recorded in General Practice in Sentinel Sites in either year (Figure 7.44).

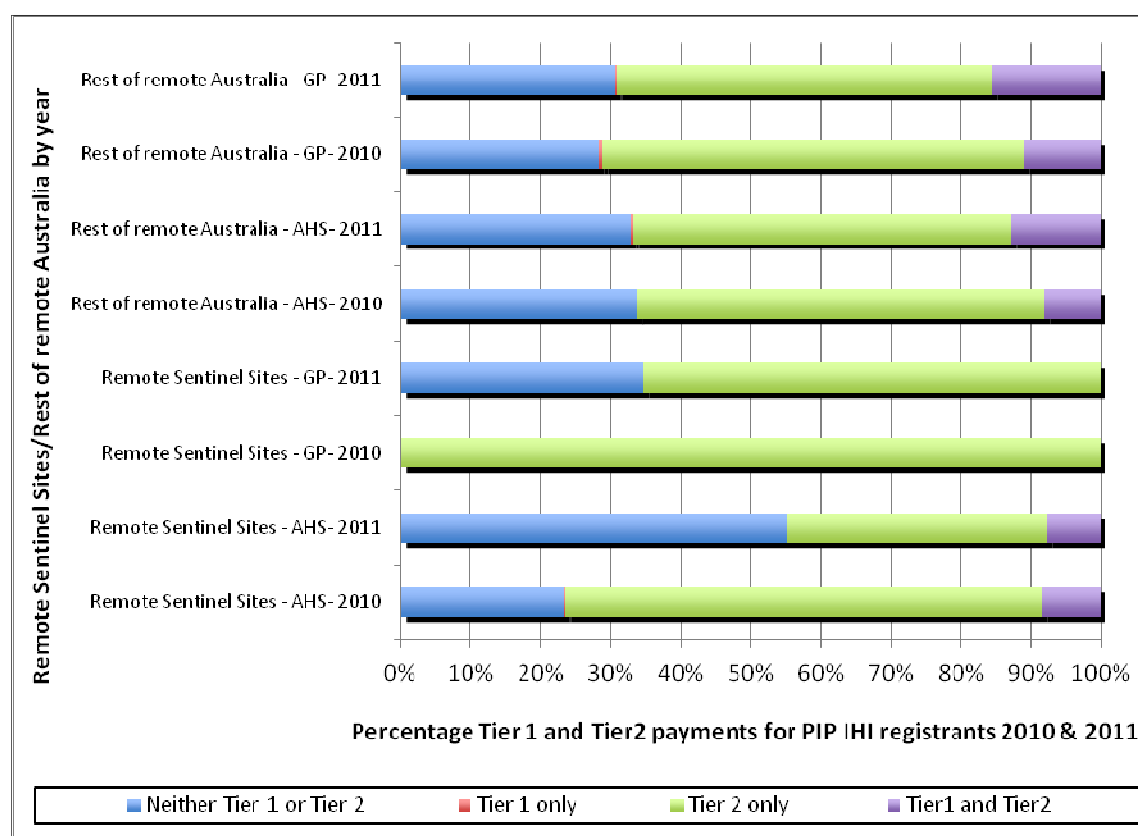


Figure 7.44 Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive for remote Sentinel Sites and the rest of remote Australia, by sector and year 2010-2011

There was also significant variation in Tier 1 and Tier 2 payments between remote Sentinel Sites (Figure 7.45). In Katherine West there were no Tier 1 or Tier 2 payments as there were no people registered for the PIP Indigenous Health Incentive. In the other three remote sites the percentage of PIP Indigenous Health Incentive registrants for whom no payment was received increased between 2010 and 2011. For Barkly and Derby the increase was substantial, from about 15% to about 90% in Barkly, and from less than 30% to over 65% in Derby. In East Pilbara the increase was less, from slightly less than 20% to almost 25%.

In Barkly and Derby there were also decreases in the proportion of registrants for whom Tier 1 payments were made, from about 10% to less than 5% in Derby, and from about 20% to zero in Barkly. In East Pilbara there was an increase in Tier 1 payments, from zero in 2010 to almost 15% in 2011.

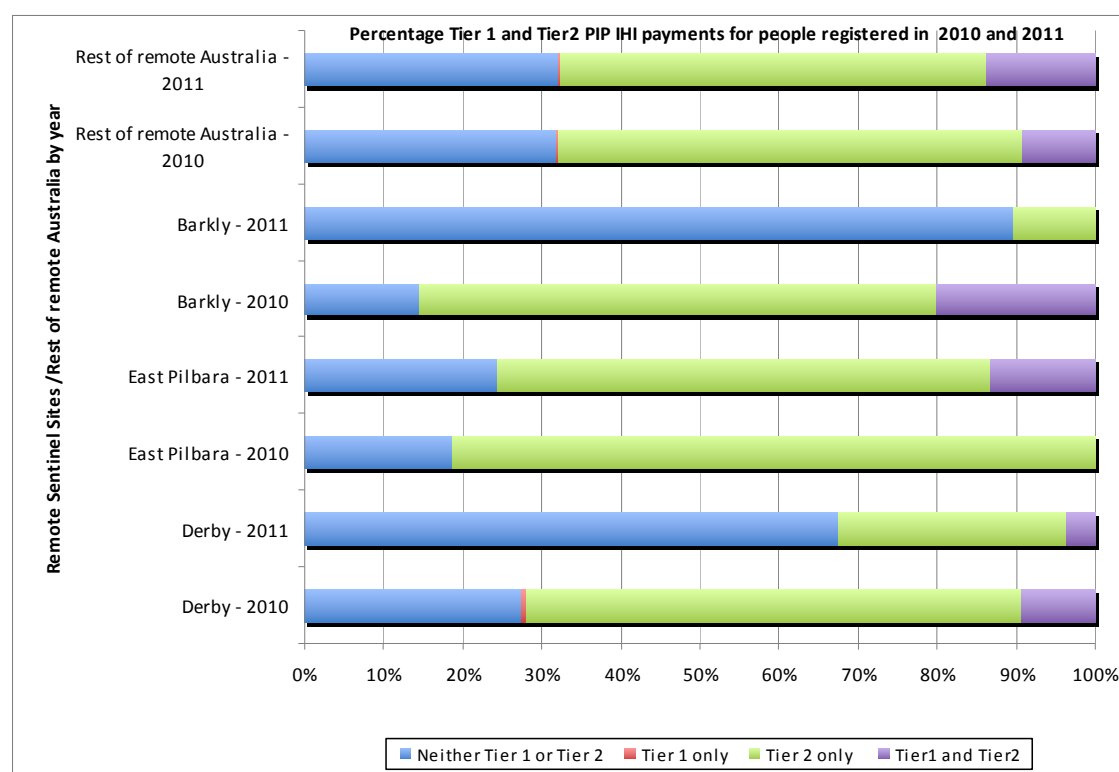


Figure 7.45: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 for remote Sentinel Sites and the rest of remote Australia

Population coverage of Tier 1 payments in remote areas

The proportion of the Aboriginal and Torres Strait Islander population for whom Tier 1 payments were made was less than 1% in the rest of remote Australia. For all four remote Sentinel Sites the proportion was less than for the rest of remote Australia.

There was a general increasing trend in Tier 1 payments per 100 Aboriginal and Torres Strait Islander people in AHSs and General Practices in the rest of Australia, with the level of payments being higher in AHSs than in General Practices. There were no Tier 1 payments in General Practice in remote Sentinel Sites, and a decreasing trend in Tier 1 payments in AHSs in remote Sentinel Sites (Figure 7.46).

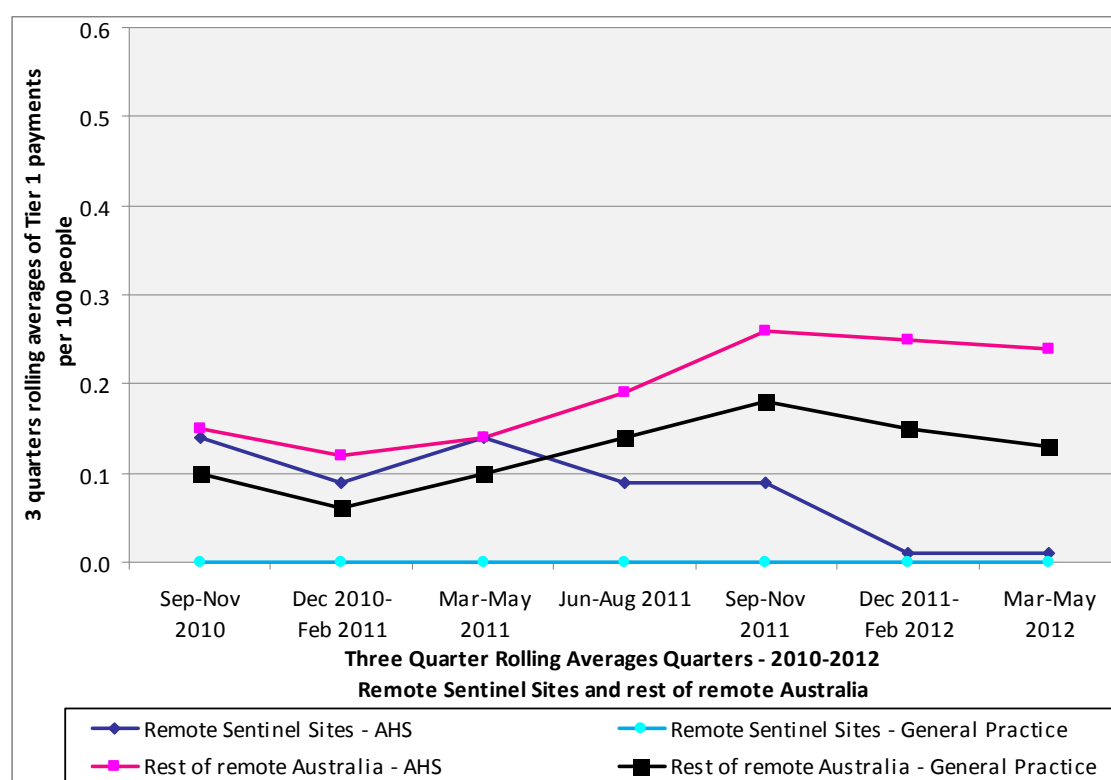


Figure 7.46: Three quarter rolling averages for Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia, by sector, 2010-2012

In the December 2011 - February 2012 period numbers of Tier 1 payments per 100 people were lower in all remote Sentinel Sites than numbers in the rest of remote Australia (Figure 7.47). The number of payments triggered in Derby declined over the evaluation period – this corresponded to a decline in the number of patients registered since the end of 2011. In East Pilbara, there was a marked increase in Tier 1 payments triggered during 2011, but numbers declined in 2012.

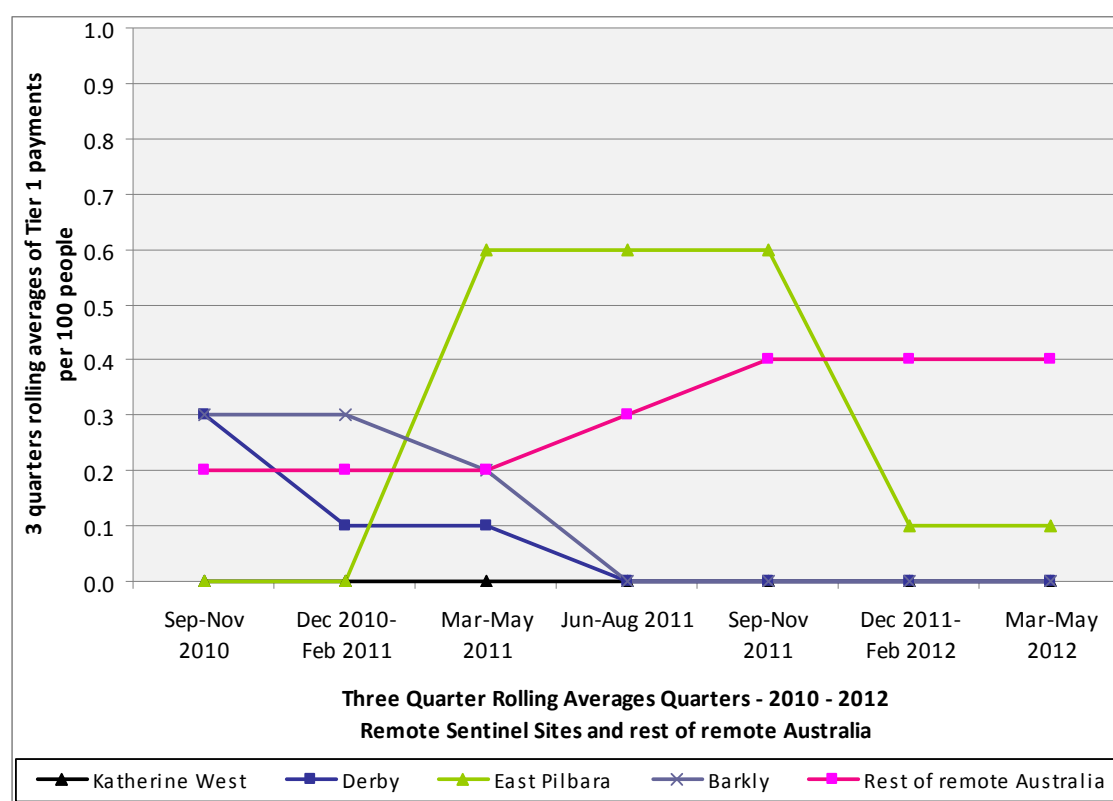


Figure 7.47: Three quarter rolling averages of Tier 1 payments (PIP Indigenous Health Incentive) per 100 Aboriginal and Torres Strait Islander people aged ≥ 15 years for remote Sentinel Sites and the rest of remote Australia, 2010-2012

Population coverage of Tier 2 payments in remote areas

In remote Sentinel Sites and the rest of remote Australia the number of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people in 2011 was very similar (about four). This was a decline from almost six in the rest of remote Australia and a small increase for AHSs in remote Sentinel Sites. Thus the population coverage for Tier 2 payments in remote areas has generally been substantially lower in remote locations than in urban and regional locations.

In remote locations Tier 2 payments per 100 Aboriginal and Torres Strait Islander people in 2011 compared to 2010 increased by between 20% and 30% in General Practice and AHSs in the rest of remote Australia, and decreased by more than 50% in AHSs in remote Sentinel Sites. Tier 2 payments per 100 Aboriginal and Torres Strait Islander people were too low to reflect meaningful trends over 2010 and 2011 (Figure 7.48).

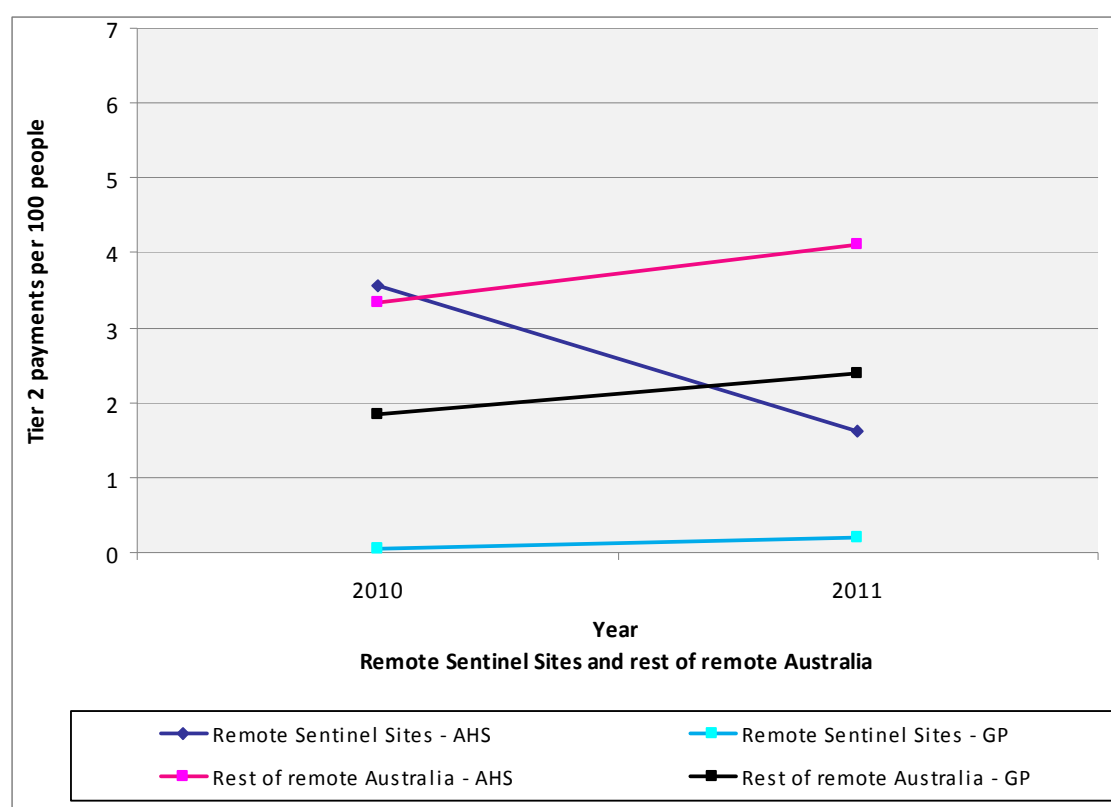


Figure 7.48: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia by sectors and year, 2010-2011

The number of Tier 2 payments triggered per 100 Aboriginal and Torres Strait Islander people varied between the four remote Sentinel Sites. There were very few Tier 2 payments triggered in Barkly and Derby during 2011, with payments declining markedly in these two sites since 2010. As reported for Tier 1 payments, and for patient registrations, no Tier 2 payments were triggered in Katherine West.

Tier 2 payments in the East Pilbara increased between 2010 and 2011 and remained higher than payments in the rest of remote Australia. East Pilbara was the only one of the four remote Sentinel Sites where levels of Tier 2 payments per 100 people were higher than in the rest of remote Australia in 2011 (Figure 7.49).

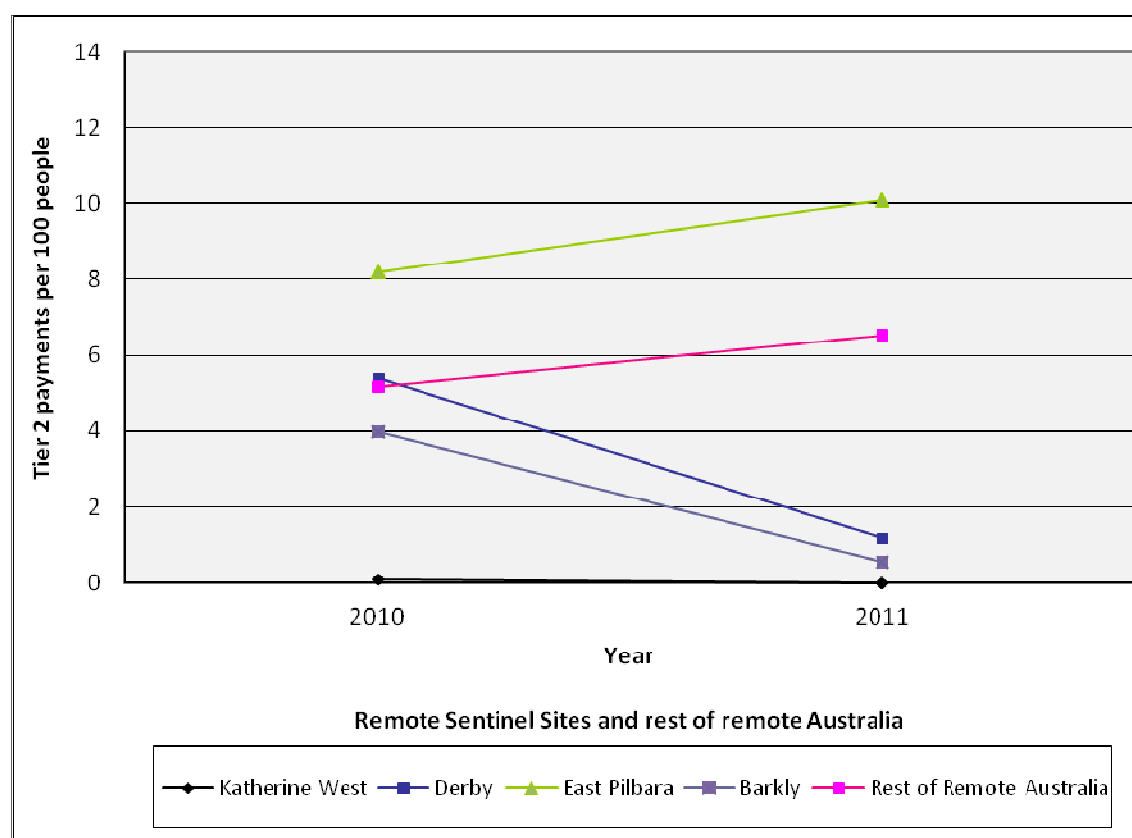


Figure 7.49: Tier 2 payments per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia by Sentinel Sites and year, 2010–2011

7.3.7. CULTURAL AWARENESS TRAINING

KEY POINTS

- Access and uptake of cultural awareness training increased over the evaluation period, with a range of training available by the final evaluation cycle.
- Training accessed included online and face-to-face training, and encompassed a range of content and depth, from basic awareness raising, to training that was more challenging. Most training was focused on individual/clinical cultural awareness.
- In general, the cultural awareness requirement of the PIP Indigenous Health Incentive has been successful at local level, with evidence of General Practices becoming more orientated to the needs of Aboriginal and Torres Strait Islander patients.
- Gaps in types of training included training in organisational cultural competence, specific training tailored to the needs of overseas trained doctors, and training for reception staff.
- Staff turnover necessitated on-going availability of cultural awareness training.
- A number of positive changes were reported to have been implemented in response to cultural awareness training and appreciated by community members. These included:
 - making physical spaces more welcoming and inclusive of Aboriginal and Torres Strait Islander patients;
 - changed approaches in asking about Aboriginal and Torres Strait Islander status;
 - changed terminology in speaking about Aboriginal and Torres Strait Islander people, and
 - increased sensitivity to cultural responsibilities.

This section describes what has been learnt from the Sentinel Sites in relation to the implementation and effectiveness of the cultural awareness training requirement of the PIP Indigenous Health Incentive. As indicated in Section 7.1.1 the requirement to undergo cultural awareness training applies only to select Health Service staff in General Practice participating in the PIP Indigenous Health Incentive, not to staff in the AHS sector – therefore data provided below derive from interviews in the General Practice sector unless otherwise indicated.

Access and availability of training

As outlined in Section 7.2, over the period of the evaluation there has been progress in development and availability of cultural awareness training at a national level. This increased availability of training was evident in the Sentinel Sites – for example, in early evaluation cycles, interviewees expressed frustration at being unable to access required training, and in later evaluation cycles, interviewees indicated that they had been able to access training. By the final evaluation cycle, some 68% (15/22) of practice managers and clinicians agreed with the statement '*Organising access to the required cultural awareness training has been easy*' compared to 31% (8/26) in the fourth evaluation cycle.

Type of training accessed and gaps

A wide range of cultural awareness training was accessed by Health Service staff in the Sentinel Sites – this included the training developed by RACGP, online training, and training developed through DGPs, with the support of IHPOs and OWs.

In earlier evaluation cycles, the requirement to undergo cultural awareness training was identified as a disincentive to participate in the PIP Indigenous Health Incentive by some Health Services; the reason for this was not that staff did not want to undertake training, but that the duration and time commitment required were unclear. Early uncertainty about requirements also made some participating Health Services circumspect about training they would invest time in – in some cases, training was undertaken and it was later ascertained that it did not satisfy PIP Indigenous Health Incentive requirements, as illustrated by the following quote:

'[We] accessed one [course] developed by the DGP but then we found out it was not the right one that would cover the PIP Indigenous Health Incentive requirements. There was such confusion at the start around this. [We are] aware of the online training being offered by RACGP now, but have not undertaken it as yet. I know I need to do it, but ... I have heard it takes some time and [I'm] just struggling to find the time to do it. I know it is important ... and will try and do ASAP.' (General Practice, GP)

By the fourth and fifth evaluation cycles, issues of eligibility and accessibility of training generally seemed to be resolved. Several DGPs had conducted cultural awareness training days in Sentinel Sites that had been well attended by Health Service staff. In general, Health Service staff who had attended training were satisfied. In some cases, staff attended more than one type of cultural awareness training and found the face-to-face training more valuable than the online training.

'Some of the staff members have attended the cultural awareness training. They both did the RACGP online training and the cultural awareness organised by the Medicare Local a couple of months ago. The Medicare Local's one was very good, in fact better than the online one. The online one was too much reading but in the face-to-face one ... actually having someone there from the Aboriginal community and talking about their own stuff was useful. The training gave the practice an understanding of how many Aboriginal patients they have got in their record. The practice manager is aware that there is a big Aboriginal population in Logan area, but also there is a big multicultural population so made them aware of the differences - and [we] also realised that not all the Aboriginal population access the Aboriginal Health Service.' (General Practice, practice manager)

This quotation also suggests the interviewee valued the population health perspective highlighted in the Medicare Local's training – it appeared this emphasis enabled participants to identify the potential relevance of the PIP Indigenous Health Incentive and cultural awareness training to their own health service.

In general, the face-to-face cultural awareness training accessed in Sentinel Sites seemed to focus primarily on clinical/individual cultural awareness including for example, how to ask about Aboriginal identity, and how to make the Health Service environment more culturally respectful and welcoming for Aboriginal and Torres Strait Islander patients.

Gaps identified were the need to ensure that reception staff received training, as they were the first point of contact with patients, and the need for ongoing access to training, given high staff turnover in some Health Services. There were also questions raised about whether the needs of overseas trained doctors in relation to achieving greater cultural competency were being adequately addressed by the

available training. This was identified as an important issue, since overseas trained doctors commonly provide services in remote and regional locations, or locations with large numbers of Aboriginal and Torres Islander patients, and may face particular challenges in delivering culturally competent care – informants noted that some overseas trained doctors have a lack of English communication skills or may have difficulty appreciating the health inequities in Australia.

Effects of cultural awareness training

Participation in cultural awareness training was important in effecting change in General Practice approach to Aboriginal and Torres Strait Islander care. In general, interviewees from Health Services identified changes in the area of making physical spaces more welcoming; increasing identification of Aboriginal and Torres Strait Islander patients; changing terminology and the way people talk; and greater appreciation of cultural responsibilities (such as those arising from connection to family and land) and how this may impact on attendance at appointments.

Welcoming physical space

One fairly frequently reported change instituted by some Health Services in response to cultural awareness training was to make their physical environment more welcoming and inclusive. The surprisingly simple strategy of including Aboriginal art works and magazines in the reception area was noted to be effective in helping people feel more confident to identify as Aboriginal or Torres Strait Islander and, as illustrated by the following quotations, was appreciated by community members.

'Yes changes [have been] made, we get Aboriginal magazines in the waiting room and subscriptions, on Australia day we fly an Aboriginal flag too so they feel more part of the organisation. I was expecting flack when asking 'do you identify' and we didn't [get it].' (General Practice, nurse)

A number of community focus group members noted a change in some General Practices, with the waiting rooms having flags on desks and Aboriginal art works displayed on walls.

'There is now Aboriginal art in a lot of the General Practices ... not just western art.' (Community focus group)

'I've been going there for 20 years and they've only just put up Koori poster.' (Community focus group)

Changed approach to asking about Aboriginal and Torres Strait Islander Status

A number of interviewees reported that, subsequent to the cultural awareness training, they no longer made assumptions about patients' Aboriginal and Torres Strait Islander status based on appearance, and were more confident in asking patients directly whether or not they were Aboriginal and Torres Strait Islander.

'The practice is aware that they have got many Indigenous patients now. Patients are very ok to say they are Indigenous, they are happy about it. Even [when] they look so white they are happy to identify.' (General Practice, GP)

Whilst improved identification was generally perceived to be a positive change – and was reflected in greater numbers of Aboriginal and Torres Strait Islander patients recorded in clinical information systems (Appendix E), some interviewees felt that the cultural awareness training that they attended had over-emphasised issues of identification, to the exclusion of other important issues. These interviewees believed that the training should have taken a broader approach – in particular they

wanted more information on how to access social and other services available to Aboriginal patients. This may reflect the diverse range of training available and undertaken by staff.

Changing terminology and appreciation of cultural responsibilities

Several interviewees noted that the cultural awareness training had changed the way that Health Service staff spoke about Aboriginal and Torres Strait Islander patients. Along with this, interviewees expressed greater appreciation of connection to family and land, and how this may impact on patients' ability to keep appointments, thus changing the service provider's response to 'no shows' to one of greater acceptance.

'The practice staff now are more aware. There have been changes with the terminology that they use at the practice with the Indigenous patients and approach to the patients – it's now done in a more culturally sensitive way.' (General Practice, GP)

'The cultural awareness trainings were valuable – it reminds you to do things differently. It's good to keep going to this kind of awareness sessions.' (General Practice, GP)

'Cultural awareness was good ..., [it promoted] better understanding of culture, it made everyone more aware and accepting that clients might not turn up.' (General Practice, nurse)

Interviewees often stressed the importance of including reception staff in cultural awareness training because of the vital role they play as the first contact for patients with the Health Service.

Overall, changes to practice in response to cultural awareness training appeared to be fairly widespread by the final evaluation cycle – for example, 59% (13/22) of clinicians and practice managers in General Practice agreed that the cultural awareness training resulted in a change to their practice compared to 19% (8/26) in the previous reporting period. This probably reflects greater access to training, and improvements in the available training.

7.3.8. STATE OF SYSTEM DEVELOPMENT FOR IDENTIFICATION, FOLLOW-UP AND RECALL OF ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS WITH CHRONIC DISEASE

KEY POINTS

- Health Services participating in the PIP Indigenous Health Incentive in general lack good systems to support the intent of the measure and, with a few exceptions, funding derived from the incentive has not been used to develop better systems for identification, follow-up and recall.
- System support at a regional and meso-level was an important influence on ability of Health Services to participate in the ICDP in some locations.
- Delivery system redesign, including allocation of time to chronic disease; better use of nurses and AHWs for some aspects of care; and AHW or nurse employment have been successfully used in some of the Sentinel Sites, both to support identification, recall and follow-up, and in response to financial incentives available through the measure.
- Clinical information systems in general were not found to be supportive of the requirements of the PIP Indigenous Health Incentive. There is wide variability between services in the functional state of clinical information systems and in the ability of Health Service staff to use these systems to enhance quality of care at the service or population level.
- Lack of system or staff capacity to record Aboriginal status, PIP registration status, and clinical information at both individual and population-level were noted as hindering implementation of the measure. In some cases parallel systems were being set up to address perceived inadequacies in existing systems.
- There was no evidence from the SSE that income generated through the PIP Indigenous Health Incentive was being used to increase skills in use of available clinical information systems or to modify systems to support information needs for improving chronic illness care at a population level, including an orientation to equity.
- Health providers were more motivated to participate in the measure where they could see direct clinical benefit accruing to patients (e.g. through employment of AHWs and new service development); some providers were reportedly motivated through financial incentives. Many Health Service interviewees were unaware of how PIP Indigenous Health Incentive income was being used in their Health Service.

One of the conditions of Health Service participation in the PIP Indigenous Health Incentive is that Health Services institute systems for recall and follow-up of Aboriginal and Torres Strait Islander patients with chronic disease. This section presents information available through the SSE on the state of system development in relation to recall and follow-up of Aboriginal and Torres Strait Islander patients, and some of the ways in which Health Services used or failed to use the resources available through the incentive to strengthen these systems. This is important because it illustrates how the state of development health care systems is constraining quality of chronic illness care, and specifically the extent to which the PIP Indigenous Health Incentive can achieve the intended outcomes, and also because these findings may suggest options for enhancing the effectiveness of this measure.

Since identification of Aboriginality was a pre-condition for patients to participate in the PIP Indigenous Health Incentive, this is also briefly discussed in relation to the implementation of the measure.

The state of system development is described using concepts described in the Chronic Care Model (CCM) (delivery system design; decision support; clinical information systems, self-management support and community resources and policies)^{109,110} and the Innovative Care for Chronic Conditions framework.¹¹¹ These concepts are relevant to the local health systems in the Sentinel Sites at the micro level, whether health service providers are informed and motivated, and at the meso-level, the extent to which there was organisation and coordination and support of local Health Services in achieving effective recall and follow-up.

Delivery system design

Delivery system design in this context refers to how well the Health Service is organised to enable better provision of care to Aboriginal and Torres Strait Islander people with chronic disease. Aspects of delivery system design may include clinic team functioning, clinic team leadership, appointment systems that ensure follow-up and facilitate seeing multiple providers in a single visit, customising follow-up to meet patient needs, an ability to plan scheduled clinic visits and multi-specialty coordination with continuity of care. The need for enhanced delivery system design, and the understanding that delivery system redesign cannot be assumed, even with financial resources available through the PIP Indigenous Health incentive, was noted by some interviewees, as shown in the quote below.

'The money from the PIP IHI has been very helpful which was much needed but in itself it does not change the way the clinicians practice.' (AHS, GP)

Some interviewees in Sentinel Sites indicated that delivery system design needed to start at the point of identification (and presumably recording) of Aboriginal and Torres Strait Islander status, and that care would flow from there. The quotation below suggested that the financial benefit available to Health Services through the PIP Indigenous Health Incentive had acted as a catalyst for the health service to be more systematic in identification of Aboriginal identity, and in their approach to care for Aboriginal and Torres Strait Islander patients.

'The identification process is better now at the practice because we want to access PIP Indigenous Health Incentive. We now tend to ask more of the Aboriginality questions. Next thing we ask if they have got any existing chronic conditions. If they come for just about flu we tend to ask for more health issues, family history, relationships etc. From then it is easy to identify the patients with chronic disease. The patients are now more aware that they need to have a blood test every six months/twelve months.' (General Practice, GP)

Several Health Services in the Sentinel Sites had developed different ways of clinic team functioning to ensure that chronic disease care was not overwhelmed by acute care needs and to reduce reliance on GPs, who were not always available. Many aspects of chronic illness care were understood as being appropriately undertaken by members of the health care team other than the GP. For example, an

¹⁰⁹ Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. 'Wagner Evidence On The Chronic Care Model In The New Millennium' *Health Affairs*, 28, no.1 (2009): 75-85.

¹¹⁰ E.H. Wagner, B.T. Austin, and M. Von Korff, 'Organising Care for Patients with Chronic Illness,' *Milbank Quarterly* 74, no.4 (1996): 511-544.

¹¹¹ World Health Organisation, *Innovative Care for Chronic Conditions: Building Blocks* [website] <<http://www.who.int/chp/knowledge/publications/icccreport/en/>> (accessed 13 January 2013).

urban AHS in an area of workforce shortage had a dedicated chronic disease nurse and a chronic disease GP. Another approach, used in a regional AHS, is outlined in the Vignette below. Both of these systems had been put in place prior to the ICDP, but were supportive of the ICDP and, as shown below, enabled better uptake of PIP Indigenous Health Incentive tiered payments for this AHS.

Vignette – developing and reviewing GP Management Plans and Team Care Arrangements.

A regional AHS uses a systematic approach to developing and reviewing GPMPs and TCAs for patients with chronic diseases. A non clinical staff member is employed to go through files on the clinical information system to identify those who are due for assessment or follow-up for chronic disease management. The Chronic Disease AHW then reviews the relevant patient files to review notes, ensure appropriate documentation is in place and determine the processes to be followed - for example, a health assessment, GPMP and a TCA. The AHW prepares instructions for the GP. Patients and others who need to be involved in consultations are contacted and a one hour appointment is made so that necessary processes can be completed in one booking if possible.

This procedure ensures consultation time is efficiently used for best patient care. In 2011 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people in this site were the highest of any regional Sentinel Site and higher than the rest of regional Australia.

In several other Sentinel Sites, dedicated Aboriginal health clinics within General Practices have been set up. In some of these cases, the clinics were primarily set up for nursing staff to complete or partially complete adult health assessments, and also to conduct care planning. Some interviewees noted that the money generated through the PIP Indigenous Health Incentive had been used to employ nurses or AHWs, whose time was less easily covered by Medicare billing.

One General Practice that was already delivering care through established systems using GPMPs and TCAs (prior to PIP Indigenous Health Incentive) indicated that they were using funding to top up the salary of a nurse to focus on Aboriginal and Torres Strait Islander patients within the practice.

‘We specifically focused over the last six to eight months with the practice’s Indigenous patients, especially for patients with a chronic disease, for example, Diabetes Clinics targeting the Indigenous patients. More of a focus and sort of putting in place the GP Management Plan and Team Care Arrangement and making sure that we do the Health Assessments - also a system for assessing Allied Professional Health helped. This process has taken a fair bit of nurses’ time where the PIP-IHI incentive money has been used.’ (General Practice, GP)

The evidence of success of these and other local models of delivery system redesign to support care for Aboriginal and Torres Strait Islander patients with chronic disease is not well developed – what is apparent is that some models are likely to be fit for purpose, and others not. There may have been cases in which systems were set up, not to improve care, but to take advantage of the income generated through the incentives – with little impact on care delivery. Whilst flexible funding, such as available through the PIP Indigenous Health incentive, may be useful to some Health Services in developing innovative delivery system redesign, some Health Services lack the capacity and resources to design and implement local system change, and require access to support to enhance systems in a way that will achieve benefit for Aboriginal and Torres Strait Islander patients.

Clinical information systems

Clinical information systems to support effective recall and follow-up of Aboriginal and Torres Strait Islander patients with chronic disease refer to information systems that provide timely, useful information about individual patients and populations – for example, to enable generation of disease lists and recall and reminders.

As identified in the sections above, poorly functioning clinical information systems and lack of staff capacity to use information systems effectively were identified as barriers to greater uptake of the Tier 1 and Tier 2 payments (see also Appendix E). Some interviewees in Health Services indicated that there is no place on clinical information systems to clearly mark if patients are PIP Indigenous Health Incentive registered. As outlined earlier, this led to duplication of effort in finding out whether or not patients were registered, or duplicate registrations being submitted. Recall and reminder systems were reported to be not functional – in many cases this was compounded by staff not knowing how to use existing clinical information systems effectively. Health Services were often unable to generate disease lists for Aboriginal and Torres Strait Islander patients and other patients easily. There were also issues identified with information systems not being well embedded or shared across the health service, so that reception staff for example may not be billing against the Aboriginal and Torres Strait Islander-specific Medicare items that ensure the patient is able to access the Medicare benefit to which he/she is entitled.

There were no examples in the Sentinel Sites of Health Services using money generated through the PIP Indigenous Health Incentive to improve information systems to support care for Aboriginal and Torres Strait Islander patients. As outlined earlier, there were examples of parallel systems being set up, such as Excel spreadsheets, to track care for PIP Indigenous Health Incentive registered patients, and these were generally not integrated with existing systems. One would have expected that over time there would be an improvement in chronic disease registers on clinical information systems due to the PIP Indigenous Health Incentive. The data from both AHSs and General Practice shows minimal evidence that this is occurring (see Appendix E).

The development of alternative and stand alone systems to manage PIP registrations has the potential to detract further from the effective functioning of existing information systems by diverting effort and resources that could be spent on enhancing the existing system, and by further complicating the organisation and coordination of clinical information.

Interviewees noted that there were a range of different plans, tools and associated templates to support health assessments, GPMPs, TCAs and reviews. The forms and templates for these were generally not well integrated with each other or with the existing information systems, with resulting confusion and inefficiencies in the use of the information systems, including in the use of the information systems to support implementation of key aspects of the ICDP.

'If I have a chronic disease I need to sign up for the PIP Indigenous Health Incentive, then I have a health assessment, medication reviews, GPMP, TCA and reviews every three months. Just make it all one template. For a patient at the moment they are possibly meant to have four blood pressures done for all these separate plans. So this means we do four BPs in one consult as we try and do all plans at once.' (Feedback from enhanced tracking site)

There were examples in some sites of efforts to develop more integrated approaches, including specifically to support implementation of ICDP related activities.

Organisational influence, Health Service providers informed and motivated

Participation in the PIP Indigenous Health Incentive, and using income generated to improve recall and follow-up, requires that health service providers are motivated to do so. There were numerous examples from the Sentinel Sites where leadership and organisational commitment to provide high quality chronic illness care for Aboriginal and Torres Strait Islander people through appropriate resourcing, training and support was having an important influence on the extent to which implementation of the PIP Indigenous Health Incentive was likely to achieve the intended outcomes.

In some Health Services, there was evidence of good motivation and support for the PIP Indigenous Health Incentive. Where this occurred, there was a perception that money generated had been used to improve care, and an understanding that this was the intent of the incentive. In the Vignette below, a Health Service had used the income generated through the PIP Indigenous Health Incentive to employ an AHW whose roles included patient recall and follow-up.

Vignette – employing an AHW within a General Practice

A regional practice illustrates how PIP Indigenous Health Incentive funding is being used to offer additional and complimentary services to Aboriginal and Torres Strait Islander patients.

35% of patients registered with this General Practice in a regional city are Aboriginal or Torres Strait Islander. The practice is using PIP funds to employ a full-time Aboriginal Health Worker (AHW) to work with the seven doctors and two practice nurses.

Employment of a registered AHW with a provider number has enabled the practice to allocate up to an hour for complex adult health assessments, and to utilise social networks to better involve family members in discussions when required. The patient recall and reminder system is now more robust. The practice has experienced an increase in new Aboriginal or Torres Strait Islander patient registrations, which it believes to be due to the work of the AHW. These changes were recorded just one month after recruitment of the AHW. Plans for this practice include the establishment of a diabetes clinic, more AHW autonomy and better marketing of the additional and complementary services offered as a result of this role. While the manager considers the practice 'extremely fortunate', the AHW feels valued and respected. *'I enjoy it here because I have a lot of input into this practice for my people and we are trying to close that gap ...'*

However in many Health Services in the Sentinel Sites, there was a perception that the incentive rewarded paperwork, and had no benefit to clinical outcomes – this was regarded as a disincentive for participation by some providers. Other providers felt they could 'use the money' and therefore would participate, but with no real expectation of improved care for their patients. At the same time, during the evaluation period there was an increasing emphasis in many Health Services on practice manager roles, responsible for optimising Medicare revenue (not necessarily with a view to improving care).

Some interviewees in the latter evaluation cycles expressed the view that registration payments should be replaced by payments for care delivered and services should not be benefiting financially from simply signing up patients without delivering care. Clinicians raised concerns about using GPMPs and TCAs as indicators of quality of care.

'This is more of an administrative thing rather than clinical outcomes.' (AHS, GP)

'The paperwork for GPMP and TCA stops me doing it. There is a bit of pressure to do the TCA from time to time as it allows access for a patient to allied health services – access drives this for me to do it rather than perceiving it to be adding a layer of quality of care. Income is a driver for some GPs to do the GPMPs and TCAs but from my perspective again it doesn't do anything that adds to the quality of care.' (AHS, GP)

Conversely, some GPs who had previously been not supportive of these plans indicated that owing to pressure or directives from clinical leaders or management they had started to use care plans, and found that they were useful.

In other cases, particularly in small General Practices, the financial aspect of the PIP Indigenous Health Incentive was regarded as providing motivation for improved care.

'The financial side of the package is good, especially for a small medical centre such as ours. It encourages our GPs to follow-up with a health assessment and/or GP management plan.' (General Practice, GP)

The implication from the above quotation was that for some of the Health Services, there were direct financial benefits accruing to individuals through the incentive payments – and that this was a motivator for delivery of some services that had not previously been delivered. For other Health Services, there may have been salary-top ups or additional staff or administrative support able to be provided through income generated.

'In August we got \$20 000 from PIP IHI registrations this went into our general fund 'operational' for wages.' (AHS, GP)

'PIP funding is being used on pharmacy. It also just covers administrative tasks to get the sign-up done.' (Feedback from enhanced tracking site)

Some interviewees felt that some of the behaviours incentivised (such as the use of care plans) would have increased in AHSs in the absence of the PIP Indigenous Health incentive.

'The clinic manager has been pushing the use of care plans. GPMPs and TCAs would have continued to increase without PIP as AHSs often have their eye on the income to be generated.' (AHS, GP)

A further factor that appeared to influence health service provider motivation was a perception that the measure design was inequitable. Some interviewees raised concerns about being unable to register patients with a chronic disease who were under 15 years of age, whilst others found the issue of determining eligibility on the basis of Aboriginal and Torres Strait Islander status a tricky issue to navigate.

'Confusion on the requirements is caused with PBS and PIP IHI. If you have got a ten year old with asthma therefore suffering from the chronic disease they are not eligible for the PIP, they will have to wait another five years to be eligible. I don't really understand the thinking around the age criteria. It does not make sense at all.' (AHS, CEO)

'The proof for people whether Indigenous or non-Indigenous is a bit of a complicated issue. Sometimes a patient would come and say that they are Indigenous and we have to take the word of the patient ... I do not know if there are any other ways to confirm this or better way to find it out. It's not like the driver's licence or Medicare card, it's written there. In the practice it's

not too [much] of an issue when they say they know a few of the Elders that we know. We think then probably it is ok to record them as Indigenous. In the software we make sure to tick the boxes if Indigenous.’ (General Practice, GP)

‘Some of the patients are white and they come and say I am Aboriginal - that makes it difficult to find out.’ (General Practice, GP)

The concerns about identification are relevant to the PIP Indigenous Health Incentive and the PBS Co-payment measure. These issues reflect the ongoing need for cultural awareness training and for Health Service staff to develop skills in enquiring about Indigenous status. This issue of identification has emerged as an important cross cutting theme that has implications across the whole of the ICDP (Chapter 17).

There were examples of regional organisations supporting Health Services in developing systems for recall and follow-up. Notably, the IUIH has a model of support for Health Services in the SE Queensland region to change service delivery models to maximise revenue and to re-orientate patient flow to allow for the Health Services to have dedicated staffing time for health assessments and care planning.

‘It’s all about developing a business minded model of care that maximises the Medicare opportunities. The Institute is looking at how we can assist services to develop their business model – this may sometimes involve bringing a whole team in to up-skill the staff and develop systems. It’s about looking at what the right mix of staff is for a particular service.’ (AHS, GP)

It was felt there was a relative lack of support through the ICDP to re-orientate local Health Service systems to provide high quality chronic illness care tailored to the needs of Aboriginal and Torres Strait Islander patients. Some interviewees noted that until this was addressed more systematically, Health Services would be responding to incentives in a piecemeal way rather than re-orientating their systems to support appropriate care. At least one interviewee noted that more direct support for Quality Improvement approaches may be useful.

Community linkages, resources and Informed and activated patients

There was evidence in some sites that the work of the OWs (and to some extent the HLWs), and that processes related to conduct of health assessments (and to a lesser extent the PIP registration process) was being used to raise awareness and increase motivation among community members to become more actively engaged in prevention and management of chronic diseases, including self-initiated regular and timely use of primary health care services. There was also evidence that self-management support efforts were being developed in some sites (see Chapter 9). However, there were no particular comments from community focus group participants that suggested PIP Indigenous Health Incentive registered patients were more likely to understand needs for recall and follow-up.

In the final evaluation cycle some individuals noted that they had received a care plan and /or a adult health assessment, also that they had received recalls and/or a reminder when a check up or procedure was due.

‘Here at [name of Health Service] they do a health care plan, they will say we will send you a letter because your check-up is due. Reminders generally come as a text message, a letter and a phone call.’ (Community focus group)

7.3.9. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the PIP Indigenous Health Incentive required incentive design to be functional at site level and aligned with improvements in care for Aboriginal and Torres Strait Islander people with or at risk of chronic conditions.
- At site level, a support team or champion of the ICDP working across Health Services supported understanding and uptake of the measure and the broader ICDP package.
- At Health Service level, incentivised care needed to be aligned with professional perspectives. Health professionals were more motivated to participate when they could see direct patient benefit from the income generated through the incentive.
- Effective functioning of the incentive within services required team support and co-operation between team members, and health professionals' understanding of the intent of the measure and potential benefit to patients.
- Implementation of the incentive needed to be workable and practical for the participating Health Services, which was positively influenced by:
 - motivation to change systems to make the measure work, including allocation of time and resources to delivery of high quality chronic illness care. The size of the Aboriginal and Torres Strait Islander patient population relative to the total patient list was an important influence in this respect
 - ability to identify Aboriginal and Torres Strait Islander patients in Health Services, and to record and retrieve Aboriginal status across clinical information systems
 - shared understanding with patients regarding what care was required and why.
- Constraints to workability and practicality in services included:
 - limitations in clinical information systems and capacity of Health Service staff to use the available systems
 - difficulties ascertaining whether or not a patient was registered for the PIP Indigenous Health Incentive elsewhere
 - lack of awareness of the measure by individual health care providers.
- Clinicians' recognition of the clinical value of knowing Aboriginal status and its relevance to care delivery, and orientation of Health Services to chronic conditions, were enabling factors.
- Historical commitment and interest by Health Services in Aboriginal and Torres Strait Islander health issues was an enabler to participation in the incentive and realising its intent.
- Effective functioning of the PIP Indigenous Health Incentive required the establishment of complementary linkages with other ICDP funded activities. Linkages were formal (e.g. between patient registration and the care coordination program) and informal (e.g. between Health Services and the ICDP workforce who provided education about implementing the measure).
- The linkage to the PBS Co-payment measure appeared to attract PIP Indigenous Health Incentive registrants, and motivate Health Services to participate in the incentive.

Effective implementation of this measure would result in General Practices and AHSs accessing PIP Indigenous Health Incentive funding and re-orienting their systems to provide best practice care to Aboriginal and Torres Strait patients with chronic conditions. As is evident through the analysis presented above, progress with implementation of the PIP Indigenous Health Incentive has varied substantially between different Sentinel Sites. It is clear from the evaluation that this variation in progress with implementation cannot be simply attributed to geographic location or any other specific characteristic of specific sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective implementation can be achieved and the influences that enable and constrain the operation of these mechanisms.

An overarching consideration is that for the measure to have a population impact at site level, the measure activities would need to reach a high proportion of Aboriginal and Torres Strait Islander people, with or at risk of developing, chronic disease, particularly those facing significant barriers to accessing appropriate high quality care, and therefore most likely to suffer the effects of chronic illness.

Our analysis has identified four broad mechanisms of change identified for effective implementation of the PIP Indigenous Health Incentive (Figure 7.50). Across all mechanisms a key enabler was the ability to effectively identify Aboriginal and Torres Strait Islander patients in Health Services and to record and retrieve Aboriginal or Torres Strait Islander status in an integrated way across clinical information systems. Other broad enabling factors applicable to a number of mechanisms, included clinicians recognising the clinical value of knowing Aboriginal status and its relevance to care delivery, and orientation of Health Services to chronic conditions, rather than just responding reactively to acute care needs. These and other constraints and enablers specific to each of the mechanisms are outlined below.

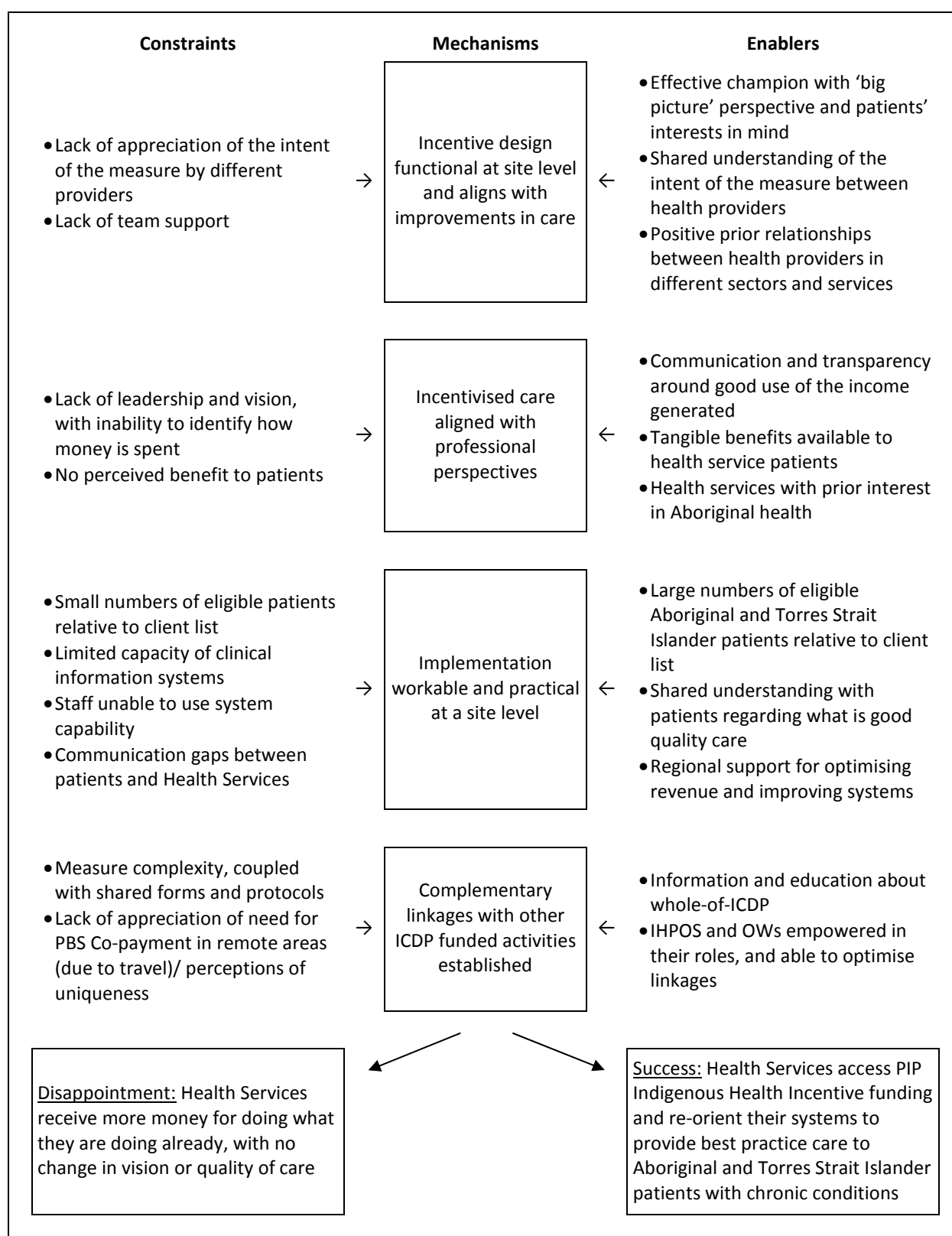


Figure 7.50: Enablers and constraints to effective implementation of the PIP Indigenous Health Incentive measure

Incentive design functional at site level and aligns with improvements in care for Aboriginal and Torres Strait Islander people with or at risk of chronic conditions

Although the PIP Indigenous Health Incentive has a standard core design, similar to the other measures, it worked differently in different contexts, and with different outcomes. Key factors that appeared to influence the effective functioning to contribute to improved care for Aboriginal and Torres Strait Islander people at site level are outlined below.

First, the presence of either a team, or an individual champion of the ICDP, who had the interests of patients clearly in mind and worked across a number of Health Services to promote uptake of the package as a whole enabled the incentive to be functional at a site level and aligned with service improvement. In some sites, the IHPO was this champion, along with the OW, and other members of an Aboriginal health team. For example, in one of the urban sites (a site with particularly high patient registration per population), IHPOs and OWs worked with communities to empower them to self-identify and request registration. The Health Service in the urban site in which this occurred had a long history of working with the community, which in turn, may have enabled the success of this proactive strategy. In other sites, other health professionals became involved. For example, in another site also with high PIP Indigenous Health Incentive registrations per population, where Aboriginal and Torres Strait Islander patients presented to the local pharmacy without PBS Co-payment measure annotated prescriptions, the pharmacist followed up with the relevant Health Service, promoting PIP Indigenous Health Incentive registrations and PBS Co-payment measure registration. The pharmacist also spread the word about the PIP Indigenous Health Incentive to other health professionals working in the area.

Linked to the enabler of effective champions with a ‘big picture’ or whole-of-site perspective, was the importance of team support and co-operation between team members. Health Service providers in some sites spoke about the lack of team support as a barrier to effective implementation, particularly in relation to meeting requirements to trigger Tier 1 payments. These interviewees identified challenges of lack of buy-in by specialists and allied health professionals, since their co-operation was needed in meeting the requirements of Tier 1 payments, and these team members did not in the view of the interviewees, see the benefit to patients, or understand the package as a whole. This resulted in lack of co-operation with implementation and limited effectiveness. Conversely, team support in a broad sense was noted as an enabler of success in some sites. In one example, a member of the SSE team conducting an evaluation visit at a regional site witnessed an event in which a health service provider being interviewed received a call about a regular patient of his from a neighbouring Health Service. The patient had presented at this neighbouring Health Service and requested registration with the PIP Indigenous Health Incentive there. The health service provider wanted to ensure that the patient registered with their regular provider and was able to call to confirm this – following the call, the patient was escorted to their regular service to facilitate appropriate registration. These team members demonstrated a shared understanding regarding the intent of the measure. In this instance, and others of co-operation at site level in relation to the incentive, underlying positive prior relationships between individuals was an additional enabling factor – in this regional site just described, the individuals had previously worked together in another Health Service.

Incentivised care aligns with professional perspectives

The way that the PIP Indigenous Health Incentive aligned (or failed to align) with how health professionals understood the needs of their patients, and their understanding of best practice care was identified as a key mechanism influencing the effectiveness with which Health Services took up the PIP Indigenous Health incentive at local level. This mechanism is consistent with prior research on pay for performance and incentive programs, which has consistently shown that financial incentives alone are

insufficient to drive improvements in care – and that they need to work through health provider motivation.

Similar to the situation for revenue generated through other incentive areas of the PIP program, there is considerable flexibility to Health Services with respect to how they used the additional income generated through the measure. How this money was used at a local level, or at least the communication and transparency around its use was a key contextual influence that either enabled or constrained effective implementation – as outlined below, this was particularly evident in relation to the ability of the measure to ‘work’ through its alignment with professional perspectives on care quality.

For example, in one Health Service, staff clearly identified direct patient benefit from the income generated through the PIP Indigenous Health Incentive (in this Health Service – described earlier - an AHW was employed with PIP Indigenous Health Incentive revenue). This transparency and pride in how the money was being spent appeared to enable the alignment of the incentive with professional perspectives. In this example, the AHW had direct responsibility for follow-up of patients with chronic disease – and the health service staff spoke positively about the improved recall and follow-up that had resulted. Conversely, where health professionals and other staff were unable to identify what the income generated through the measure had been used for, the alignment between professional perspectives of best practice care and the PIP Indigenous Health Incentive was constrained. In these constraining contexts, even if health professionals complied with administrative requirements of the incentive, they did so whilst questioning its value, and alluded to a possible compromise of quality through too much focus on business models and maximising revenue opportunities.

Identifying alignment of incentivised care with professional perspectives as a mechanism of change is also consistent with the frequent mention of benefits available to patients as drivers of compliance with administrative requirements of the measure. For example, some health professionals stated that their main reason for using TCAs and GPMPs was not to trigger the Tier 1 payment, but was so that their patients could have access to dental care and additional allied health care benefits available through use of these plans. Some (not all) health professionals regarded access to PBS Co-payment measure as the reason for registering patients with the PIP Indigenous Health Incentive, rather than the money accruing to the Health Service through registration. Conversely, where Health Services perceived little benefit for their patients, this was a barrier to implementation of the measure. For example in one of the remote sites where chronic medications were covered by the \$100 supply arrangements, and patients already had TCAs in place, several administrative hurdles appeared to have arisen that prevented patient registration for PIP Indigenous Health Incentive. In this context, despite the fairly considerable income that would have been generated if payments had been triggered for all eligible patients, there seemed little motivation by the Health Service to overcome these barriers, and by the end of the evaluation period there were still no patients registered and no payments recorded.

A final enabling context identified for this mechanism was that of a historical commitment and interest in Aboriginal health issues. Data presented earlier demonstrate that sites with high registration of patients proportional to population tended to have at least one local Health Service that already had a strong interest and commitment to Aboriginal and Torres Strait Islander health – and was often well regarded as a service provider by Aboriginal and Torres Strait Islander communities. This may have worked in two ways, as outlined below. First, whilst the presence of a well regarded and established service provider in the site boundaries may have artificially inflated PIP Indigenous Health Incentive patient registration rates (through influx of patients using the service from outside the site boundaries), this increased service use would have also made participation in the measure more financially beneficial for the Health Services. This in turn would enable them to further build on their facilities and

expand care and enhance accessibility and further build a good reputation. The SSE identified at least one instance where it seemed likely that this positive feedback loop was occurring. Second, established and well regarded providers with experience in Aboriginal health were also more likely to have a good sense of what would be needed to improve care quality - and to be able to align and communicate this to Health Service staff in relation to the incentive revenue. This also may have occurred in some of the Health Services in the Sentinel Sites.

Implementation is workable and practical at the Health Service level

For the incentive to be effectively implemented, implementation needed to be workable and practical for the participating Health Services.

The size of the Aboriginal and Torres Strait Islander patient population relative to the total patient list of a Health Service was an important factor influencing whether or not the PIP Indigenous Health Incentive was workable for Health Services. Where service provision was largely directed to Aboriginal and Torres Strait Islander patients, and where there was allocation of time and resources to providing high quality chronic illness care, there was more motivation and incentive to change systems, for example, billing systems, or identification systems in order to make the measure work. Conversely, if there were few Aboriginal and Torres Strait Islander patients, and the potential income stream was negligible in relation to other income, the impetus to adjust systems was less. Some Health Service providers in this situation reported that they had chosen not to participate as it was not worth their while to do so – they did not feel that they could justify changing routines in order to provide benefit to only few patients or to generate a small additional income.

One of the most important factors constraining the workability and practicality of the incentive was the limited support provided by clinical information systems – this may have been a result of limited capacity of the information systems to deliver what was required in support of the incentive, and in many cases, limited capacity of Health Service staff to use the available systems effectively.

Health Services across both sectors noted the difficulties that they faced in ascertaining whether or not a patient was registered for the PIP Indigenous Health Incentive elsewhere (and sometimes Health Services reported being unable to ascertain whether or not the patient had previously been registered within their own service). These difficulties constrained the workability of the measure at Health Service level. Underlying these difficulties may have been lack of understanding on the part of the patients regarding whether or not they had been registered, or communication gaps between patients and providers.

A shared understanding with patients regarding what care was required and why was also an important factor influencing workability. For example, where this was in place, in some Health Services, providers indicated that patient understanding had increased as a result of participation in the ICDP, and check ups and proactive care were more accepted by patients and attendance had increased. On the other hand, in other situations where there was limited shared understanding, some community focus group participants indicated that in some cases patients found that they were spending too much time at Health Services, without a clear purpose – these patients expressed dissatisfaction about being detained by long appointments, such as to complete an adult health assessment, when they had come for a particular reason – they wanted to use services when their personal health needs required it.

The role of regional support organisations (where these existed) was also noted as critical in enabling effective implementation of this measure, and the ICDP as a whole. Regional support was provided to Health Services through an ‘umbrella organisation’, whose perspective enabled greater optimisation of revenue, and use of the revenue to expand outreach and service delivery.

More general factors, such as lack of awareness of the measure by health care providers, relating to high staff turnover, high proportion of overseas trained doctors, or other providers who were not well oriented to the needs of Aboriginal and Torres Strait Islander patients, and mobility of patients which made it difficult for them to identify a regular provider with whom to register were identified as additional constraints to this mechanism.

Complementary linkages with other ICDP funded activities established

In the measure design, the PIP Indigenous Health Incentive was linked to several different aspects of the ICDP in different ways. For example, to access the PBS Co-payment measure, Health Services (but not individual patients) needed to be registered with the PIP Indigenous Health Incentive; to be referred to the care coordination program, individual patients needed to be PIP registered. Further, for referral to the care coordination program, patients needed a GPMP and a TCA (part of the requirement for Tier 1 payments for Health Services). Adult health assessments and associated follow-up items could contribute to the Medicare service items to trigger Tier 2 payments. There were also less formal linkages with other measures, for example whereby ICDP workforce provided education about the measure to Health Services to encourage optimal implementation, and to communities to encourage self-identification and consent. IHPOs were highly valued in several sites for their perspective in providing information and understanding about the ICDP as a whole. Establishment of complementary linkages with other aspects of the ICDP was a key mechanism for effective implementation. However this was not automatic, and occurred differently in different contexts.

It was widely reported that without the linkage to the PBS Co-payment measure, the PIP Indigenous Health Incentive would have been unable to attract registrants, or motivate Health Services sufficiently to participate. However, linkages with PBS Co-payment measure were not entirely straightforward and the overt linkages (for example through the shared registration form for the two measures) appeared to hinder understanding about differences in eligibility, and different administrative requirements (once off and annual respectively). This linkage was also less important in remote areas, where access to S100 supply arrangements made the PBS Co-payment measure less attractive – although it was still valued for its role in enabling access to pharmaceuticals for patients who required medication when travelling out of the S100 supply arrangement areas. The relevance of the PBS Co-payment measure was not always well understood by remote service providers, and some were confused about whether or not their patients could access medications through both S100 supply arrangements and use the PBS Co-payment measure where needed.

ICDP workers based in DGPs and in AHSs had a significant role in the Sentinel Sites in promoting awareness of the PIP Indigenous Health Incentive and related PBS Co-payment measure in the community (and also amongst GPs), and IHPOs reported significant roles in advocating for participation by pharmacists. IHPOs and OWs were also instrumental in developing cultural awareness training and providing opportunities for dialogue and face-to-face discussion of cultural awareness issues. Their empowerment in this role, and organisations that supported them to work effectively, were also key underlying factors – as outlined in Chapters 13 and 14.

7.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 7.4). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

7.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 7.4: Summary of key findings in relation to the program logic – PIP Indigenous Health Incentive measure

	Summary of key findings
Outputs for year 1 and beyond	
Eligible practices are aware of the PIP Indigenous Health Incentive and the level of care they are to provide.	Awareness and uptake of the measure by Health Services has been high. Requirements to register patients, to send staff to cultural awareness training and requirements to trigger outcomes payments are overall well understood.
Eligible practices register for the measure.	Registration may have met or exceeded expectation, apparently with all (or almost all) eligible AHSs registered and around 40% of General Practice in Sentinel Sites registered for the PIP Indigenous Health Incentive by the end of the evaluation period.
Registered practices attend cultural awareness training within twelve months.	Following some initial delays, access to and uptake of cultural awareness training is fairly well established. On-line and face-to-face training have been used and valued. Changes in practices as a result of the training have included making the physical environment more welcoming of Aboriginal and Torres Strait Islander patients; increasing sensitivity in terminology; greater appreciation of cultural responsibility and impact on attendance at Health Services; and greater confidence in identification practices. Remaining gaps include lack of clarity regarding adequacy of the training for meeting the needs of overseas trained doctors and meeting the needs of situations with high staff turnover. Greater attention may also need to be paid to increasing organisational and cultural competency, including support to Aboriginal and Torres Strait Islander health workforce and eliminating systemic barriers to access, such as patient understanding of care, language barriers and lack of trust. A strength of the program has been the requirement for cultural awareness training for General Practice, where even relatively small inputs have resulted in changes that seem likely to improve accessibility of General Practice to Aboriginal and Torres Strait Islander patients.

	Summary of key findings
Registered practices have measures in place to encourage the registration of eligible Indigenous people.	Registration processes have been successfully established in many in AHSs, and in a number of General Practices. There has been a declining trend in registrations over the course of the evaluation, largely due to substantial declines in AHSs in urban and regional locations. The decline in registrations in AHSs, and an increase in registrations by General Practices has resulted in an increase in the proportion of patients registered with General Practices. Some AHSs, particularly in remote locations, have had substantial difficulties in registering patients, largely due to resource constraints and difficulty in managing the administrative requirements. Approximately 60% of PIP registered General Practices had registered at least one patient by the end of 2011. The association between registration for the PIP Indigenous Health Incentive with registration for the PBS Co-payment measure has made an important contribution to the current levels of registration. There is a lack of shared understanding about what registration means, and what the responsibility of the Health Service is to the person who has been registered with them. Levels of re-registration for the PIP Indigenous Health Incentive are relatively low, being made more challenging because of difficulty in explaining the relevance or benefit of registration for the PIP Indigenous Health Incentive and lack of associated benefit of registration for the PBS Co-payment measure (which does not require annual re-registration).
Eligible people consent to participate	Consent has been obtained for many patients, but there is a general lack of understanding in communities about the purpose of patient registration (which was generally understood to be about access to the PBS Co-payment measure) and, as indicated above, there is a particular lack of understanding about the purpose of re-registration.
Expected early results for years 2 – 4	
Registered patients receive the target level of care.	Overall, levels of Tier 2 payments indicate that about 60% of registered patients have received at least five Medicare items from a single PIP Indigenous Health Incentive registered service provider within a calendar year. There has been a general increase in Tier 2 payments, largely driven by substantial increases in payments made to General Practices. There is no indication that the care items that are contributing to generation of Tier 2 payments are additional to what was received prior to the ICDP, or that the appropriateness or quality of care has been influenced in any way through the Tier 2 payments.
Practices offer care management plans and team care coordination as per the requirements of the incentive.	Use of care management plans and team care arrangements in a way that triggers Tier 1 payments has generally been very low, with some increase in numbers over the course of the evaluation, particularly in General Practices. Barriers to greater use of these items include the complexity of the requirements for delivery of care and billing in a way that generates the Tier 1 payment, deficiencies in the local health service systems (including allocation of dedicated resources for chronic illness care) that are required to support the delivery of care and billing in a way that generates the payment, the relative low monetary value of the Tier 1 payment in relation to the effort and systems development required for care delivery and billing for Tier 1 payments, and perceptions that the requirements for Tier 1 payments do not necessarily provide for better quality care than existing care arrangements in some services.

	Summary of key findings
Participating patients receive additional and complementary health services	There is little evidence that patients participating in the PIP Indigenous Health Incentive received additional and complementary health services. While some providers indicated that the potential to access additional services was a motivating factor for registering patients with the PIP Indigenous Health Incentive, there was little evidence that patients registered for the PIP Indigenous Health Incentive actually received additional or complementary services. As indicated above, few patients received care in a way that generated Tier 1 payments. The PIP Indigenous Health Incentive may have stimulated more interest and awareness, and possibly completion, of GPMPs, TCAs and review processes, the low levels of Tier 1 payments indicates the financial incentive as such has not had an important influence on the type of care provided to patients. To the extent that patients were benefiting from the ICDP related care coordination arrangements, it appears that they were registered for the PIP Indigenous Health Incentive because this was a requirement for access to care coordination, rather than registration for the incentive being the mechanism by which they came to receive the benefits of care coordination. Uptake of follow-up items for care by nurses or AHWs or allied health professionals was low, and there is little or no evidence that patients registered for the PIP Indigenous Health Incentive have received any benefits in relation to this type of follow-up care.
Expected medium term results for years 4+	
Registered practices are better equipped to provide an enhanced standard of care for Aboriginal and Torres Strait Islander people with a chronic disease.	The greatest benefit to participating Health Services so far from the measure appears to have been through the cultural awareness training, which has resulted in tangible changes in the way things are done in General Practice. Many services with large numbers of Aboriginal and Torres Strait Islander patients appear to need more direct assistance and resources to strengthen their systems for the purpose of providing high quality chronic illness care.

7.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the PIP Indigenous Health Incentive.

Awareness, sources of information and emerging communication issues

There were high levels of awareness of the PIP Indigenous Health Incentive evident in urban and regional sites, with lower but increasing awareness in remote sites.

- General Practice and the AHS sectors sourced information through formal channels of communication about the measure, word-of-mouth and networks, and valued opportunities for face-to-face communication and information sharing. High levels of staff turnover and varying stages of implementation by Health Services suggested a requirement for ongoing responsive communication about the measure. Ways in which the resources available through the measure could be used to enhance care for Aboriginal and Torres Strait Islander patients were generally not well understood or developed at local level.
- Community focus group members were in general poorly informed about the measure and its intent, and generally believed that registration with the incentive was necessary to access the PBS Co-payment measure.

Participation by Health Services and registration of patients

Registration of Health Services with the PIP Indigenous Health Incentive has been high. Sign-on payments by sector in the Sentinel Sites and the rest of Australia reflect the greater numbers of General Practices compared to AHSs and contrast with the relatively high number of patients registered with AHSs. Low numbers of (or lack of), Aboriginal and Torres Strait Islander patients or potential patients, coupled with uncertainty about the time required for cultural awareness training, appeared to be an important reason why many General Practices did not participate. Concerns were expressed about perceived administrative burden, particularly by small remote Health Services with limited internal capacity for administration, and limited access to regional support.

- The number of people registered for the incentive has increased over the evaluation period, with earlier patient participation through AHSs, and more recent increases driven mainly by General Practice. AHSs in Sentinel Sites achieved high registration overall. Most people registered for the PIP Indigenous Health Incentive are registered for the PBS Co-payment measure.
- A limited proportion of patients registered in one year have been re-registered in the following year (between 30% and 40% overall). Re-registrations have been relatively higher in the AHS sector, but have declined in the most recent period covered by the SSE, while those in General Practice have increased. This may be related to the earlier participation in the PIP Indigenous Health Incentive by the AHS sector.

There was wide variation in the number of registrations per 100 Aboriginal and Torres Strait Islander people between specific Sentinel Sites and across urban, regional and remote locations. Variations were due to a complex mix of local, regional and national influences, some of which varied over time.

Tier 1 and Tier 2 Outcomes payments

- The low percentage of patients for whom Tier 1 payments have been made increased between 2010 and 2011, when Tier 1 payments were triggered for about 10% of registered patients. The overall increase in Tier 1 payments appeared to be driven by marked increases in a few of the Sentinel Sites, with some sites showed little or no increase over the evaluation period. The number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people was higher in regional and remote locations than in urban locations (and lower in remote Sentinel Sites than in the rest of remote Australia).
- Tier 2 payments were triggered for a high proportion of patients. The number of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people was in general higher in regional and urban locations than in remote locations.
- Given that patients registered for the PIP Indigenous Health Incentive are expected to have a diagnosed chronic disease (as per the guidelines on eligibility), it is important to note that neither Tier 1 nor Tier 2 payments were triggered for around 30% of patients. This indicates a substantial proportion of patients registered for the PIP Indigenous Health Incentive are not regularly attending any Health Service registered for the PIP Indigenous Health Incentive.
- There was wide variation between sites in the proportion of PIP registered patients for whom neither Tier 1 nor Tier 2 payments are made (less than 10% to almost 50%).
- Unlike Tier 1 payments, Tier 2 payments have no specific requirements related to quality of care. Many providers questioned the appropriateness of the requirement for Tier 1 payments and how they could fit with established Health Service systems for providing high quality chronic illness care. Factors influencing the ability of Health Services to trigger the outcomes payments included

function and use of disease registers and system support for follow-up; workforce capacity issues; and workforce preferences and priorities.

Cultural awareness training

- Access and uptake of cultural awareness training increased over the evaluation period, with a range of training available by the final evaluation cycle that included online and face-to-face training, and encompassed a range of content and depth. Staff turnover necessitated on-going availability of training.
- The training requirement has generally been successful at local level, with evidence of General Practices becoming more orientated to Aboriginal and Torres Strait Islander patient needs. Gaps in types of training included training in organisational cultural competence, training tailored to the needs of overseas trained doctors, and training for reception staff.

State of system development for Identification, follow-up and recall of Aboriginal and Torres Strait Islander patients with chronic disease

The effective operation of the PIP Indigenous Health Incentive System measure requires Health Services to have effective systems for follow-up and recall of patients. Participating Health Services in general lacked good systems to support the requirements of the incentive and intent of the measure. Clinical information systems or staff lacked capacity to record Aboriginal status, PIP Indigenous Health Incentive registration status, and clinical information at both individual and population-level, hindering implementation. In some cases parallel systems were being set up to address perceived system inadequacies.

With a few exceptions, funding used through the measure has not been used to develop better systems for identification, follow-up and recall. Delivery system redesign has occurred in some services to support identification, recall and follow-up. System support at a regional and meso-level was an important influence on ability of Health Services to participate in the ICDP in some locations.

- There were no reports of income generated through the incentive payments being used to increase skills in use of available clinical information systems or to modify systems to support information needs for equity-oriented care, and no identified examples of decision support being optimally used to support identification, follow-up or recall of Aboriginal and Torres Strait Islander patients with chronic disease.
- Health providers were more motivated to participate where they could see direct clinical benefit accruing to patients. Some providers were reportedly motivated through the potential for financial benefit. Many Health Service interviewees were unaware of how PIP Indigenous Health Incentive income was being used in their Health Service.

7.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) There is a clear need to review the rationale for the PIP Indigenous Health Incentive, and the mechanisms through which it can achieve its intended outcomes. This will have important implications for ongoing communication about the measure.

- b) Whatever the future of the measure, it is clear that communication regarding this sort of measure needs to be tailored to the needs of different audiences in different locations and service settings; needs to be through multiple channels, specifically including face-to-face communication with people who have a strong overall understanding of the measure and with peers who are facing shared challenges in understanding the measure and finding solutions to effective implementation; and needs to be ongoing.
- c) The challenges faced by some services in registering for the PIP Indigenous Health Incentive and registering patients for the incentive; the relatively small proportion of General Practices that are providing care to significant numbers of Aboriginal and Torres Strait Islander people; the limited capability in many services to establish and use clinical information systems effectively to support high quality chronic illness care for their service populations; the small proportion of patients being re-registered in the year following initial registration; and the evidence of limited impact on quality of chronic illness care, indicates that resources available to support implementation of the PIP Indigenous Health Incentive could be more efficiently and effectively used by focusing on services with demonstrably significant numbers of Aboriginal and Torres Strait Islander patients, and a demonstrable interest in and commitment to enhancing their service systems for the purpose of providing high quality chronic illness care to the Aboriginal and Torres Strait Islander population in their region.

8. SUPPORTING PRIMARY CARE PROVIDERS TO COORDINATE CHRONIC DISEASE MANAGEMENT (*MEASURE B3 PART B*)

8.1. Description of measure

For the purposes of this measure, care coordination has been defined as working collaboratively with patients, General Practices and AHSs, and other service providers to assist in the management of coordinated care for patients with chronic disease. Consistent with the objectives of the ICDP, the Care Coordination and Supplementary Services (CCSS) program targets diabetes, cardiovascular disease, chronic respiratory disease, chronic renal (kidney) disease and cancer. The program intends to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through the following two components:¹¹²

- Care coordination provided by qualified healthcare workers (typically AHWs or specialist nurses) to Aboriginal and Torres Strait Islander patients with a chronic disease.¹¹³ Patients were to be referred by GPs in Health Services participating in the PIP Indigenous Health Incentive, referred with a care plan, such as a TCA or GPMP. In late 2011 the requirement that referring GPs needed to be from a Health Service participating in the PIP Indigenous Health Incentive was relaxed. Since this time fundholders could apply to DoHA for an exemption for areas in which limited access to Health Services participating in the PIP Indigenous Health Incentive was a barrier to referral.
- A flexible pool of funds ('Supplementary Services funding') that can be used to assist patients receiving care coordination under the CCSS program. The funds can be used to expedite access to medical specialist and allied health services that are in accordance with the patient's care plan but not available via a publicly funded provider in a clinically appropriate timeframe. The funds may also be used to assist with the cost of local transport to health care appointments.

It was anticipated that the CCSS program would enable an improved patient journey due to enhanced coordination across and within Health Services. This enhanced coordination is intended to remove or lessen barriers to meeting the goals of chronic disease care plans.¹¹⁴

Funds for the CCSS program were managed by SBOs, with an intention to transfer funding to Medicare Locals from 1 January 2013. SBOs (and later Medicare Locals) could subcontract to other organisations such as AHSs or other relevant organisations to provide the care coordination services. Implementation of the CCSS program was to be based on local needs assessments in each state/territory.¹¹⁵

DoHA guidelines allow for a variety of models of care coordination services. Different models may be combined and developed to meet the needs of a community and take into account any related services already operating. Examples of possible models suggested by DoHA in program guidelines included:

¹¹² DoHA, CCSS Guidelines April 2010 <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/\\$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf)> (accessed 9 August 2012).

¹¹³ DoHA, Support primary care providers with chronic disease management – factsheet <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/\\$file/DHA6136%20B3%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf)> (accessed 19 April 2012).

¹¹⁴ DoHA, Support primary care providers with chronic disease management – factsheet, op. cit.

¹¹⁵ DoHA, CCSS Guidelines April 2010, op cit.

- direct employment of a Care Coordinator by a host organisation
- sharing of a Care Coordinator position/care coordination role across General Practices
- contracting the services of an appropriately qualified clinician to provide care coordination
- ‘topping up’ the salary of an AHW or nurse in an AHS to increase the time spent on care coordination activities.

8.2. State of implementation – national context

The CCSS program commenced on 1 June 2010 with funding agreements in place with all eight SBOs, initially until June 2012. Care coordination services had commenced in all jurisdictions by the final quarter of 2011. Whilst it had been intended that the CCSS program would be implemented through a staged approach,¹¹⁶ implementation was still initially slower than anticipated. There were 22.1 FTE Care Coordinators employed by 30 June 2011, increasing to 64.3 FTE at 31 December 2011 and 87.2 FTE by 31 June 2012. The implementation of the CCSS program has increased steadily overall, and in all jurisdictions over the evaluation period.

At the time of the final evaluation cycle, information provided by DoHA indicated that the main achievements of the program at a national level included:

- Between 1 July 2011 and 30 June 2012, 6750 patients had been enrolled to the CCSS program nationally and 9319 Supplementary Services had been purchased. Two thirds of the Supplementary Service provision had occurred in three of the jurisdictions – Qld (33%), NSW (20%) and NT (15%).
- The number of GPs referring to Care Coordinator services increased substantially in all jurisdictions over the evaluation period. There were 2016 GPs who referred one or more patients to the CCSS program during 1 July 2011 - 30 June 2012. The number of patients referred per GP in the second half of 2011, ranged from 7 to 235 (mean 59) and for the first half of 2012, the number of patients referred per GP ranged from 21 to 464 (mean 193). There were notable increases in Qld and NSW.
- A wide range of relevant services were purchased using Supplementary Services funding. The most extensively purchased item overall was transport for health-related appointments. This was also the most commonly purchased item across host organisations with five of the eight SBOs reporting activity under this service item. The majority of the remaining purchases were for access to medical specialist and allied health care, with dental care, podiatry, exercise physiology, dietitian/nutrition, cardiology and ophthalmology listed by at least half of the SBOs as being in the top ten services utilised. Six of the SBOs also recorded some payment for access for primary health care services provided by GP, AHW and specialist nurses.

Supporting structures, communication and modification of the CCSS program developed at national level over the period of evaluation:

- National leadership and coordination at AGPN provided by a National Care Coordinator (funded in May 2011 to 31 December 2012). As of 30 June 2012 the Australian Medicare Local Alliance had funding in place to provide national leadership and program coordination.

¹¹⁶ DoHA, CCCS Guidelines April 2010, op cit.

- A Frequently Asked Questions document, produced by DoHA (November 2011) to provide services with clarification about what is in/out of the scope of the CCSS program was disseminated to participating services and uploaded to some DGP websites. An updated version was planned following program changes in October 2012¹¹⁷.
- DoHA disseminated information on any changes or major activities for the CCSS program through written communication to the fundholders. It was the fundholders responsibility to forward relevant information on to their subcontracted organisations.
- SBOs and DGPs produced and disseminated a range of resources to support program implementation. These included position description templates, patient referral forms, models of service delivery, case study scenarios and question and answer sheets.¹¹⁸
- With the transition to Medicare Locals, SBOs in NSW, Vic, Qld, SA and WA had their funding extended to 31 December 2012. ACT, NT and Tas, - which had Medicare Locals in place from 1 July 2012 - had funding provision until 31 December 2012 to align with the SBO schedules. From 1 January 2013, funding for the CCSS program was expected to be allocated to Medicare Locals.
- In late 2011 the eligibility criteria for the program were changed to allow CCSS referrals from Health Services not registered with the PIP Indigenous Health Incentive. A fundholder could apply to DoHA on behalf of a region for consideration to be exempted from this requirement. As of August 2012 only one region in Far North Queensland (two health centres) had applied for an exemption.
- As of 15 October 2012, DoHA approved the use of Supplementary Services funding for the purchase or hire of the following medical aids: Dose Administration Aids (DAAs), assistive breathing equipment (including asthma spacers, nebulisers, masks and Continuous Positive Airway Pressure machines and accessories); blood glucose monitoring equipment and medical footwear prescribed or fitted by a podiatrist. The 'CCSS program Guidelines for Acquisition of Medical Aids using Supplementary Services Funds' was distributed by the DoHA. The Australian Medicare Local Alliance developed a protocol on use of Supplementary Services funds in consultation with SBOs.¹¹⁹
- A National Forum for CCSS Care Coordinators was held in August 2011, providing an opportunity for networking, peer support, training and skills development.
- New CCSS guidelines were released in November 2012 and made available on the DoHA website.¹²⁰ The guidelines outlined roles and responsibilities for Medicare Locals, including working with AHSs in planning and delivering of programs to facilitate access for patients of both sectors, amongst other issues.

¹¹⁷ DoHA, 'CCSS program Guidelines for Acquisition of Medical Aids using Supplementary Services Funds' <<http://www.gpnsw.com.au/ccss>> (accessed 9 November 2012).

¹¹⁸ General Practice NSW [website] <<http://www.gpnsw.com.au/ccss>> (accessed 9 November 2012).

¹¹⁹ General Practice NSW [website], op cit.

¹²⁰ DoHA, CCSS Guidelines November 2012 <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/CA2578620005D837CA257AC3000DEA58/\\$File/Care%20coordination%20guidelines%20REVISED%20Nov%202012.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/CA2578620005D837CA257AC3000DEA58/$File/Care%20coordination%20guidelines%20REVISED%20Nov%202012.pdf)> (accessed 7 December 2012).

8.3. Findings from the Sentinel Sites

8.3.1. LOCAL LEVEL MODELS OF IMPLEMENTATION AND PERCEPTIONS OF THE PROGRAM

KEY POINTS

- Collaborative development of local CCSS program arrangements led to some initial delays but allowed for detailed planning and broad consultation.
- Set up activities did not appear to be well reflected in reporting frameworks, which tended to focus on the numbers of patients receiving services and numbers of services delivered.
- SBOs most commonly funded DGPs (and later, Medicare Locals) to implement the CCSS program, either through allocation, or through an application process. AHSs were less commonly funded for the program – with only few instances of this identified in the Sentinel Sites. In one case, a regional support organisation was funded for implementation of the program.
- The host organisation (DGP or Medicare Local) typically used the funding to create a dedicated care coordination position, based in the DGP or Medicare Local, or less often, in an AHS.
- Care Coordinators based in DGPs or Medicare Locals received referrals from GPs in PIP Indigenous Health Incentive registered Health Services, and identified potential patients through community networks, with the support of OWs, and through self-referrals. These Care Coordinators tended not to have access to patients' medical records.
- Care Coordinators based in AHSs used clinical information systems to identify potential patients, and also received referrals from GPs, primarily from the AHS.
- Use of funding to expand services (rather than creating a dedicated position) was not considered successful in the one site in which it had been implemented.
- The program was positively regarded by most interviewees in Sentinel Sites. Some concern was expressed about sustainability if the program funding was to be removed.

Program development

The CCSS program was an innovative first-in-kind program that evolved over time. Local implementation of this measure was reasonably complex, requiring considerable stakeholder engagement and a number of steps in order to deliver services in accordance with measure guidelines.

The CCSS program funding was allocated to the SBOs (and later Medicare Locals) who acted as fundholders. Each fundholder either called for expressions of interest or released targeted funding to organisations within their State or Territory ('host organisations'). Expressions of interest required a detailed work plan outlining how the care coordination service would be developed and operate.

At site-level, interviewees indicated that it took considerable time to set up the program. Set-up activities included; development of funding submissions and, after funding was allocated to the host organisation, identification of local services and stakeholders, and refinement of the implementation model.

In early evaluation cycles, there was evidence of considerable uncertainty in Sentinel Sites about how to implement the program, and about the role of the Care Coordinators. Interviewees were also concerned about the lack of similar or existing positions or programs on which to build or model the care coordination service.

'It's just such a new program. One of the barriers is there is nothing existing so we cannot go by example ... it is starting up something completely new.' (Care Coordinator)

The measure guidelines envisaged the development of local models that took local contextual factors into account. Foundations for local care coordination models were expected to be laid through development of work plans and/or funding submissions by DGPs. This approach and preparatory work was valued in the Sentinel Sites, as were the guidelines developed by SBOs. By the final evaluation cycle about three quarters (16/22) of interviewees agreed that the development of the CCSS program had involved a collaborative process with local services, and there were increasingly positive trends in perceptions of the CCSS program across a range of indicators (Table 8.1).

Although perceptions of the program were generally positive, interviewees tended to be less positive about the potential sustainability of the program (Table 8.1). Several interviewees noted that without the funding for the dedicated care coordination role and the Supplementary Services funding, the program would not be sustainable.

Table 8.1: Trends in perceptions of ICDP funded Care Coordination and Supplementary Services (% who responded 'strongly agree' or 'partly agree'), overall and by rurality

Evaluation cycle	Three	Four	Five
The development of local care coordination services has involved a collaborative approach with a range of services in the region. MS, CC ^a	60% (n= 15)	79% (n=34)	73% (n=22)
Care coordination services have enhanced existing care coordination structures rather than created new structures. MS, CS, CC ^a	26% (n=23)	58% (n=45)	59% (n=29)
New systems for coordinated care are sustainable. CC, MS ^a	36% (n= 14)	42% (n=33)	57% (n=21)
There is a greater ability to meet the aims of established care plans due to the care coordination service available. CS, CC ^a	50% (n= 10)	75% (n=16)	78% (n=9)
The care coordination service has assisted patients to access different providers as required. CS, MS, CC ^a	27% (n= 22)	76% (n=45)	89% (n=28)
The care coordination service has resulted in an improvement in communication between the range of different providers about the care provided by or required to patients. CS, MS ^a	30% (n= 20)	63% (n=41)	68% (n=22)
The care coordination Service has resulted in an improvement of care for patients who need to access care from a number of health care professionals. CC, CS, MS ^a	27% (n=22)	73% (n=44)	86% (n=28)
Supplementary Service funding has enabled patients to access services required through the private sector. CC, CS, MS ^a	9% (n=22)	60% (n=45)	71% (n=28)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

Funding allocation models

Funding allocation models implemented across the Sentinel Sites included:

- funding to DGP through an allocation basis
- funding to DGP through an application process
- targeted funding to individual AHSs
- targeted funding to regional providers, which they in turn administer.

The first two models were predominant in the Sentinel Sites. During the evaluation period, a few instances of an individual AHS administering the funding as a host organisation were identified; only one example was identified in which funds were allocated to a regional provider.

Use of funding at local level

In the Sentinel Sites where CCSS program funding was allocated, it was most commonly used to employ a Care Coordinator based in the DGP or Medicare Local, and less commonly to employ a Care Coordinator based in an AHS. There was one (unsuccessful) example identified of the care coordination funding being used to extend existing care coordination services, such as in topping up salaries of existing staff. Models identified in the Sentinel Sites showing the different ways funding was used are described below.

Direct employment of a Care Coordinator based in DGP or Medicare Local

In this model, the Care Coordinator was typically a clinical position, based in the DGP or Medicare Local, and received referrals from GPs, with service provision being from the host organisation. In a few instances, the Care Coordinator spent time at General Practices on a rotational basis. Care Coordinators working in these ways often did not have access to clinical information systems.

Patients were referred to Care Coordinators from PIP Indigenous Health Incentive registered General Practices and AHSs and from other organisations such as community health and housing. Potential patients were also identified through self-referral and through community networks (especially with assistance from OW). In these cases the Care Coordinator would identify the patient's regular Health Service and obtain required referral documentation from the GP. Where no regular Health Service could be identified, the Care Coordinator would assist the patient to access an appropriate service.

In one site this model was applied through employment of a Care Coordinator in an organisation that provided support to AHSs in the region. The Care Coordinator was typically a clinical position that worked across a number of AHSs, or based within an AHS.

Direct employment of a Care Coordinator based in an AHS

Where the Care Coordinator was based in an AHS, the Care Coordinator typically was granted access to the clinical information system, and used this, together with word-of-mouth referrals, to identify patients who may benefit from the services.

Expansion of existing services

In one site, the DGP (later Medicare Local) used the funding available under the measure to fund an AHS to increase care coordination activities. The intention was to expand existing care coordination

services in the AHS, rather than fund a new or dedicated position. This model was not considered successful and was changed to one of employment of a Care Coordinator based in the AHS.

8.3.2. PROGRAM ESTABLISHMENT

KEY POINTS

- Recruitment of Care Coordinators was slow initially, reaching the highest point by early 2012 in the Sentinel Sites, with no major differences noted between remote, regional and urban sites.
- Some Care Coordinators employed within Sentinel Sites worked outside site boundaries, to avoid overlaps with pre-existing programs, or for other reasons; in one instance, the work of one Care Coordinator encompassed several of the urban Sentinel Sites.
- The lack of clear correspondence between the areas of operation of the CCSS program, and the Sentinel Site boundaries, complicated the interpretation of program data from the Sentinel Sites, and in some cases, service delivery. Program data on numbers of patients receiving services and numbers of services received were unavailable disaggregated by site.
- Clinician and practice manager awareness of Care Coordinator positions fluctuated over the evaluation period – some of this may have been due to interviewees not distinguishing between different positions with similar functions and names.
- At the time of the final evaluation cycle GP acceptance of the role of Care Coordinator and confidence in the CCSS program was still developing. Care Coordinators were not generally being accepted as having an important role within General Practice clinical teams, or were not being supported to take on this role (for example, through having access to patient clinical records).
- It was important for Care Coordinators to have good communication skills, and knowledge of primary health care and the health service environment in order to establish their role.

Recruitment

At the time of the final evaluation cycle, recruitment to Care Coordinator positions was well established in Sentinel Sites, with 85% of eligible sites having Care Coordinator positions recruited, and with high levels of recruitment to urban, regional and remote sites (Table 8.2). Data shown in Table 8.2 are based on data provided by DoHA and supplemented with data gathered by the SSE through evaluation visits.

Sites with Care Coordinator positions were, urban (7), regional (10) and remote (3) locations. Six of the eight case study sites had funding for care coordination. At the time of the final evaluation cycle the length of time that Care Coordinators had been employed varied - several had recently commenced, others had been in positions for up to two years.

At the final evaluation cycle, 20 of the 24 Sentinel Sites had Care Coordinator positions allocated to key organisations for the sites. All except three sites had recruited to all allocated positions. Of those sites with new recruitment since the previous evaluation period, three sites had recruitment to existing teams and four sites had recruitment to newly established programs. All three vacant positions were had followed staff resignations.

In addition to ICDP funded Care Coordinator positions, there have been similar positions funded through some state programs. This added to complexity in the service delivery arrangements and also to interpretation of program data. For example, because there were existing state funded care

coordination services in some Sentinel Sites in NSW and Qld, some organisations in Sentinel Sites with ICDP funded Care Coordinator positions chose to deploy the ICDP Care Coordinator services outside the Sentinel Site area. This was further complicated by changes in these arrangements over time, with ICDP funded positions being allocated in locations where there were existing state positions and vice versa. In two remote sites the ICDP funded Care Coordinators were primarily providing services in areas outside the Sentinel Site boundaries, due to the large distances between sites and funded organisations.

Care coordinator positions varied by FTE status, with no clear trends in FTE status evident between sites in urban, regional, or remote locations. The final evaluation cycle data showed 0.4 to 4.7 FTE recruited per site with a median of 1.0 FTE – broadly similar to the fourth evaluation cycle.

Most allocated positions were based in DGPs or, more recently, Medicare Locals. However, the number of AHS host organisations increased over the period of the evaluation from three in June 2011, to five in December 2011 and to six in June 2012. One regional support organisation that had been expanding Care Coordinator services had responsibility for an area that encompassed three urban Sentinel Sites.

Table 8.2 Progress with recruitment to Care Coordinator positions in Sentinel Sites

Evaluation cycle	Three	Four	Five
Sentinel Sites with CCSS investment	63% (15/24)	88% (21/24)	83% (20/24)
Sentinel Sites with positions recruited	60% (9/15)	90% (19/21)	85% (17/20)
Urban sites with positions recruited ^a	4/7	7/8	7/7
Regional sites with positions recruited	5/7	9/10	8/10
Remote sites with positions recruited ^b	0/1	3/3	2/3

^a In the third evaluation cycle there were two urban sites included in the data that were in the region covered by the ICDP Care Coordinator service but due to a pre-existing state-based service, the ICDP Care Coordinators focused work outside the sites. In the fourth cycle this was the case for one urban site.

^b Two of the remote sites have Care Coordinators allocated to the regions but the roles do not cover the sites – usually due to barriers of distance from the host organisation.

Sources: DoHA, ICDP Care Coordinator workforce as at 30 June 2011, 31 December 2011, 30 June 2012 and interview data (up to October 2012).

Awareness

Over the evaluation period, the levels of awareness of Care Coordinators in the Sentinel Sites have fluctuated. In the final evaluation cycle, of the 48 clinicians and managers interviewed, 54% were aware of the Care Coordinators positions compared to 76% (39/51) in the fourth evaluation cycle. This decline in awareness was evident in urban and in remote sites. Reasons for this lower awareness in the final evaluation cycle appeared to be related to differing understanding about who the question was referring to in successive cycles.

As expected, there were low levels of awareness of Care Coordinator positions in sites where the Care Coordinators were not focusing their work. Interviewees in these sites expressed confusion about who the evaluation team was referring to when asked about the ICDP funded position, due to state-funded and/or local initiatives with similar functions that included employment of Care Plan Coordinators and Chronic Disease Nurses. In all evaluation cycles, time was taken to ensure that responses to the SSE evaluation questions pertained to the ICDP funded position.

Community focus group participants were generally unaware of Care Coordinator positions. Given the relatively small and specific group expected to be targeted for care coordination – people with chronic disease who are considered particularly likely to benefit from the program - this finding was not surprising. There was one example identified in the final evaluation cycle, in which a community focus group participant reported positively on the CCSS program through her experience of having a family member who had been successfully supported to access a specialist. It was difficult to ascertain whether or not the person met the criteria of the program and whether or he/she would have been able to access specialist care in the absence of the program.

Confidence in the program

Some interviewees indicated that it was taking time to gain confidence and trust in the CCSS program. A number of interviewees expressed concern about confidentiality, stating they would rather use in-house capacity. Some Care Coordinators felt that where the position was not embedded into the Health Service the effectiveness of the role was diminished – possibly owing to the inability to access clinical information systems and greater challenges of engaging with Health Service staff as an ‘outsider’.

Good communication skills and an understanding of the Health Service and primary health care environment were needed to get the program up and running. Interviewees noted that the role was complex, and required time for establishment. As this was a new program, the individual needed to have the ability to form relationships and develop and establish a role in the local system. The appointment of a skilled professional in the Care Coordinator role who had good local knowledge and relationships with AHS providers was critical for developing confidence in the program.

‘The Care Coordinator comes with both people skills and clinical skills which is good.’ (DGP, Program Manager)

8.3.3. REFERRALS TO CARE COORDINATION SERVICES

KEY POINTS

- Overall numbers of patients receiving care coordination services remains low nationally, with evidence of wide variation in levels of referral by different GPs. One GP had reportedly referred over 460 patients (or 7% of the total number of referrals nationally) while many GPs with access to Care Coordinators had not made any referrals.
- By the final evaluation cycle Care Coordinators in some sites were overwhelmed with referrals, prompting the development of processes to identify patients most in need. Referrals in other sites remained low.
- The requirement that the patient needed to be referred with a care plan was generally interpreted as requirement for the patient to have a GPMP or TCA. Some sites instituted additional administrative requirements, including adult health assessments.
- Factors influencing ability of Health Services to follow the required referral processes included:
 - lack of orientation to using standard care plans in many services, and the requirement in some locations for completion of specific types of care plans (such as GPMPs or TCAs)
 - lack of establishment and use of systems (for example disease registers) to identify and follow-up patients with complex care needs, and who would benefit from the program

- low proportion of Aboriginal and Torres Strait Islander patients in some practices, with low General Practice awareness of the CCSS program – and other aspects of the ICDP – and generally low demand for Care Coordinator services (from GPs and patients)
- unwillingness, or lack of capability, in many services to change practice (and practice systems) to enable more systematic and team based approaches to chronic illness care.
- Strategies used by Care Coordinators to establish a patient base included:
 - Identifying eligible patients through community groups and meetings, with the assistance of OWs; working with hospital discharge programs; and reviewing disease registers, and GPMPs and TCAs to identify eligible patients. These alternate pathways to referral may have resulted in better reach to marginalised patients than reliance on GP referrals with GPMP/TCAs.
 - In some sites Care Coordinators struggled with high patient load, possibly due to inappropriate referrals. In general both Health Services and the CCSS program had difficulty with development of systems and processes to identify those patients most in need.
- Strategies to discharge patients from the CCSS program were not well developed with some suggestions of an apparent contradiction, or growing tension, between the long term needs of many patients with complex care needs, and self-management goals.
- Current reporting frameworks were noted to discourage discharge in situations where there are few referrals, and expectations that Care Coordinators maintain a full patient load to justify their role. In general, it was noted that numbers of patients seen, and number of services delivered, are not necessarily good indicators of success or levels of activity as they do not reflect the diversity and complexity of roles undertaken by Care Coordinators.

Referrals and interpretation of requirements

At least initially, Care Coordinators struggled to establish a client base, and to obtain appropriate referrals from GPs. There was evidence of increased referrals being made by the final evaluation cycle, but referrals did not appear to be done in a systematic or uniform manner. This was consistent with the large range in numbers of referrals per GP, and different experiences reported in different Sentinel Sites (one GP had reportedly referred over 460 patients (or 7% of the total number of referrals nationally) while many GPs with access to Care Coordinators are not making any referrals). By the final evaluation cycle, in some sites Care Coordinators were overwhelmed with referrals, prompting development of systems to identify patients most in need. The SSE team noted that there were inconsistencies between data obtained on the ground in some Sentinel Sites, and the program data reported to DoHA (which is the basis of the national data). These discrepancies appeared to be related to a range of factors, including that some positions had been allocated, but not yet recruited to; that funding was allocated to host organisations, and in some cases these organisations were taking some time to establish a clear model for care coordination; the care coordination may have been recruited to the funded organisation, but was working outside the Sentinel Site boundaries; timing of reporting of program data in relation to evaluation visits, and progress on the ground between the time of submission of reports and the time of the evaluation visit.

The greatest number of referrals occurred in sites in which Care Coordinators had been established in their positions for some time, where they had pre-existing relationships with the Health Services, and

where they had previously been employed in the AHS. Many of these sites also had complementary initiatives in place, such as dedicated staff capacity, to expand the use of TCAs and GPMPs.

In most of the Sentinel Sites, the requirement that patients are referred with a care plan had been interpreted as a requirement for a GPMP and/or TCA to have been completed. In one of the sites, the CCSS program based at the DGP required that referred patients had a completed an adult health assessment and a GPMP/TCA. The rationale behind this was in order to a) encourage completion of the MBS item numbers by Health Services; b) ensure the CCSS program was integrated into the broader system of chronic disease management plans, avoiding creation of new pathways; c) allow the Care Coordinator to have access to good information about services required for the patient; and d) to increase access to allied health items as patients with a completed adult health assessment are also eligible for the follow-up items from a health assessment (bringing eligibility from 5 to 15 allied health items p.a.).

Factors influencing ability to follow referral processes

The following factors were identified at local level as barriers to following the referral requirements for the CCSS program:

- **Under-development of systems to identify and follow-up patients with complex care needs** - many Health Services do not have well established or functional chronic disease registers. The registers were often not up to date, or lacked required information to identify those patients that may benefit from the service, and there were no other well established systems to identify and prioritise such patients (see Appendix E for a discussion of the state of development of practice systems in the Sentinel Sites related to ICDP implementation).
- **Lack of orientation to using GPMP/TCA or other team care planning** - low use of GPMPs and TCAs, together with the perception by Care Coordinators that without GPMPs and TCAs patients were not eligible for access to the Care Coordinator service, resulted in limited numbers of referrals in some cases. In other instances, administratively burdensome processes were occurring, including for example, Care Coordinators motivating for GPMPs and TCAs to be in place for particular patients, and then following up with GPs until this requirement was met. Care Coordinators across all sites indicated that they were spending significant time following up with practices that had referred patients (or patients the Care Coordinator had identified) to ensure the patients had GPMPs and/or TCAs and to determine the services required.
- **Little incentive for some General Practices to follow referral processes** – those General Practices with a low proportion of their service populations being Aboriginal and Torres Strait Islander patients were in general not alert to the potential to refer to the CCSS program and had little incentive to familiarise themselves with referral processes that were possibly relevant to only a few of their patients. Practices that referred patients tended to be those with a higher proportion of Aboriginal and Torres Strait Islander patients.

The potential scale of these combined barriers to Care Coordinator referrals was highlighted by the very low rates of PIP Indigenous Health Tier 1 payments triggered nationally (Tier 1 payments are triggered for PIP Indigenous Health registered patients with a TCA/GPMP) (Chapter 7).

Strategies used by Care Coordinators to establish a patient base

There were a number of different strategies used by Care Coordinators to establish a patient base. As indicated below, these required Care Coordinators to be proactive and well networked with other service providers, and with other members of the primary health care team. Some of these strategies

were administratively burdensome or time consuming for the Care Coordinators, and sometimes for the Health Services referring to them. These strategies included:

- Attending community groups/organisations and functions and identifying community members who would benefit from the program, then taking the patient back to the Health Service and advocating for a referral and for development of a GPMP/TCA.

'[Name of Care Coordinator] is working in a community engagement model where she attends community events and programs and identifies patients this way. The model being advocated by DoHA is that the Care Coordinator accepts referrals from PIP registered practices of patients with a GPMP/TCA. [Name of Care Coordinator] is working the other way and identifying community members who may need additional assistance then working with their regular GP to get the patient on a GPMP/TCA. If they don't have a GP then identify to patient the practices and arrange an appointment.' (DGP, program manager)

As shown in the quotation above, this interviewee recognised that this was not the 'DoHA model'.

'The gold star is the GPMP referral but this is not how it usually works. Usually we have community services referring into the program or self-referral ...alternative pathways are happening everywhere, it is the model being used (alternative pathways) but it is not to be talked about openly. I think it works after using this approach as we are often now seeing the most marginalised people and linking them into health care. People that may have used the hospital emergency before and do not have a GP.' (DGP, Care Coordinator)

- Working with other programs and services such as hospital discharge programs to identify patients likely to benefit from the program.
- Working with practices to identify patients through reviewing disease registers and expired GPMP and TCAs.

'A lot of referrals are from the local population health workforce, the allied health staff including diabetic educator and the dietitian. There have also been referrals from aged care and from a variety of other areas including some GPs and the AMS.' (DGP, Care Coordinator)

- Engaging patients opportunistically, and developing relationships with GPs who would then be more likely to refer in the future.

'Sometimes GPs aren't referring ... and what's happening is that the Care Coordinators are engaging patients prior to GPs, so [the Care Coordinators] are engaging patients opportunistically through community, through their patients or a number of other circumstances and then the Care Coordinators are working to engage the patients with the GP and get them onto a care plan. It is a bit of a back door approach ... but referrals start coming as soon as a relationship is established between the GP and the Care Coordinator.' (SBO, program manager)

As indicated in the quotations above, these 'back door' approaches may have resulted in a greater reach to the more marginalised groups – for example, those who do not have a regular GP, compared to the approach of trying to get busy GPs to identify and triage patients appropriately and then refer those most in need.

It was noted in some cases that despite considerable investment of time, Care Coordinators have had limited success in getting services to make appropriate referrals. This was particularly challenging in

practices with small numbers of patients potentially eligible for the program, where clinical information systems were inadequately developed, and where practice staff were not already oriented to doing care plans such as GPMPs and TCAs.

Examples of sites with high patient load

Although referrals were in general low, by the final evaluation cycle there were some sites in which Care Coordinators reported being swamped by referrals. For example, in one regional site, the AHS had a dedicated nurse who was responsible for developing GPMP/TCA and all patients with a GPMP/TCA were being referred to the Care Coordinator based in the Medicare Local, with no apparent attention given to prioritisation in relation to need (see Vignette below). This had come about at least partly because the Care Coordinator had previously worked at the AHS as a nurse, and the clinicians at the AHS felt confident that the Care Coordinator would provide a good service. Referrals from General Practices in the site were very low.

‘Referrals mainly coming from [AHS name] I have working relationships with them because I used to work there.’ (DGP, Care Coordinator)

In an urban site, the Care Coordinator had been employed for a long period of time and indicated that she received referrals from both the AHS and General Practice. Several different factors appeared to have led to high referrals to the CCSS program in this site. The Care Coordinator had linked with practice support teams based at the DGP and worked through these teams as a way of establishing relationships with General Practices. The DGP had also employed contract nurses to work in General Practices with specific roles to develop health assessments and GPMPs/TCAs. Patients were referred to the Care Coordinator with GPMPs/TCAs, and this enhanced the service the Care Coordinator was able to provide. The AHS had also developed a strategy of dedicating time for their staff to develop GPMPs/TCAs. By the final evaluation cycle this AHS was also referring patients with completed GPMPs/TCAs.

By the final evaluation cycle there was also an emerging awareness in Health Services of the potential to access the Supplementary Services funding for patients who were referred to the CCSS program. Access to this funding was identified as providing motivation for GP referrals to Care Coordinators in some areas.

Exit strategies

It was widely recognised by Care Coordinators who were interviewed in the Sentinel Sites that the program would be unworkable if patients remained on the CCSS program indefinitely. In some sites, Care Coordinators became aware that those referred (and commenced receiving care coordination services) may not necessarily be those most in need of the service – but it was difficult for Care Coordinators to discharge them. Some Care Coordinators spoke of a need to triage patients, and trying to ensure equity through an assessment of risk.

‘We are so delighted when we get referrals in, but they have got to make way for other people ... by putting patients in high, medium or low risk categories has helped. High risk patients naturally receive more of the funding ... with scarce resources the name of the game is movement in out and out and a waiting list.’ (DGP, Care Coordinator)

By the final evaluation cycle, Care Coordinators increasingly spoke about challenges they experienced in trying to ‘exit’ patients from their lists. There were often new issues emerging for their patients, meaning these patients required ongoing assistance.

'When I try to exit I inevitably find other issues that need addressing, these referrals have chronic conditions ... I know other Care Coordinators do exit but I'm buggered if I know how they do.' (DGP, Care Coordinator)

Processes for prioritising patients and systems of ensuring a flow of patients who were benefiting from the Care Coordinator service varied between sites but in general were under-developed and there were no models identified in the Sentinel Sites that were providing real workable solutions to some of the identified challenges.

'Have not had to discharge a patient. If I had to it is because they have passed on.' (DGP, Care Coordinator)

There was some concern expressed by interviewees that the structure of the reporting framework - which requires reporting on number of patients rather than number of patients supported and moved onto a self-management model - was inhibiting the work of the Care Coordinators. Care Coordinators may be 'holding on to patients' rather than encouraging and supporting patients (or their families) to develop their own ability to access relevant care or to develop supportive networks for this purpose. This concern was particularly evident in sites where referrals were low - since those discharged may not easily be replaced, and this would not look good on the reports to DoHA.

Vignette

This Vignette illustrates some of the issues identified above.

A Medicare Local in a regional site has funding for a Care Coordinator. The Care Coordinator previously worked at the AHS and there is a good established relationship. The staff at the AHS know and trust the Care Coordinator. Their process is for the practice nurse to prepare the GPMP/TCA for the GP, and for the GP to sign off on these. The nurse then immediately refers everyone that is on a GPMP/TCA to the Care Coordinator in the Medicare Local.

Most of the patients that have a GPMP/TCA have referrals to the specialists and allied health professionals they need to see. The Care Coordinator gets a copy of the GPMP/TCA and this forms the basis of the referral. This is the only type of referral accepted by the Care Coordinator. The Care Coordinator then contacts the patient and organises the visits to the providers marked on the TCA.

At that time of the final evaluation cycle the GPs reported that they had just been told to refer Aboriginal patients with a chronic disease and on a GPMP/TCA. The nurse indicated that she just wants to get the patients into the system. The GPs were aware that the process 'may be clogging up the system', but felt it was up to the Medicare Local to develop more specific guidelines in consultation with the AHS.

'We refer everyone and they have now said that they can't take any more referrals.'

The GPs at the AHS know the Care Coordinator, as she previously worked as a nurse at the AHS. AHS staff believed that this relationship made the process easier, although it continued to be challenging for some of the GPs at the AHS.

'It is hard to trust someone to look after a patient that you're responsible for and this makes me uncomfortable.'

The GP who made the above comment suggested that the issue of trust may be a reason why other

practices don't refer as they don't have a link from previous employment with the nurse in the Care Coordinator role, and that it would take time to develop trust in the new process, and in the specific Care Coordinator.

Other GPs at the AHS also indicated that it is hard to refer patients to an external person, as they needed to have trust in the person, and in the process, that appropriate care would be provided. The GPs also expressed concern that they are not getting feedback from the Care Coordinator about their patients' progress.

'Don't get the feedback about the patients' progress - no sharing of information.'

8.3.4. ROLES OF CARE COORDINATORS AND POPULATION HEALTH CONSIDERATIONS

KEY POINTS

- Care Coordinator positions had limited population coverage (even in reaching specific vulnerable groups who would stand to benefit most from the program) because of small numbers of positions with responsibility for covering large geographic areas or large populations. This also applied to access to Supplementary Services funding, since in the current implementation models, access to the funding is dependent on being enrolled with a Care Coordinator.
- Service navigation was identified as the main emphasis of the work of Care Coordinators in Sentinel Sites, with relatively less emphasis on coordination of clinical interventions.
- Administrative requirements of the role threatened the workability of the program for some, with a significant administrative burden linked to how the Supplementary Services funding was rolled out, and related reporting requirements.
- Joint participation in networking workshops with OWs and IHPOs facilitated linkages between Care Coordinators and other ICDP workforce. Care Coordinators and OWs worked closely together in some sites. Care Coordinators in Sentinel Sites attended self-management training – possibly also influencing the development of their roles, and focus.
- There was little or no training reported to be accessed by Care Coordinators in population-health approaches to chronic illness management, and use of clinical information systems.
- Geographic targeting of CCSS program resources was evident in many sites, but the population health rationale for this was not always apparent, and equity concerns were raised by some interviewees.
- Although by the end of the evaluation period, perceptions of the value of Care Coordinators were generally positive, there were remaining questions regarding the sustainability, equity and transparency of the program design and models of implementation.

Roles identified at local level

The CCSS program was perceived as administratively burdensome by most interviewees, including Care Coordinators and program managers. The specific activities undertaken by Care Coordinators that were described in the Sentinel Sites included:

- Identifying visiting and existing services and stakeholders in the region to ensure services were not duplicated.
- Identifying and linking with existing state-funded care coordination programs and identifying other avenues of funding and how to access them. This was to ensure that prior to use of the Supplementary Services funding, all other applicable funding sources were exhausted (as specified in the program guidelines).
- Encouraging specialists and allied health professionals to contribute to the program, either through advocating for bulk-billing patients who were referred through the CCSS program, or defining processes for paying the 'gap' fee through Supplementary Services funding, so that patients were not out of pocket.

'Today I have had a patient referred to access two specialists services but I haven't actually had any contact with them. So these two services I will have to go down and talk to and try to establish a relationship with them. That's why it is time consuming at this stage.' (DGP, Care Coordinator)

- Developing or adapting documentation such as referral templates and brochures.
- Approaching Health Services to encourage referrals and raising awareness of the Care Coordinator service amongst GPs.
- Coordinating services for patients.
- Arranging use of the Supplementary Services funding and associated billing and administrative work (described further in Section 8.3.5)

In addition to administration requirements of accessing the Supplementary Services funding for their patients, sources of administrative burden that were identified by some interviewees included the frequency of reporting, and the diversity of aspects of activity that needed to be reported on.

'... Reporting is six monthly, quarterly and monthly. Each month supplementary fund, quarterly we report the number of services I have referred to or used. We have a twelve-month work plan – goals, strategy, outcome, it's hard to plan ahead... The job's not clinical. This is office work. If they structured the role better RNs would stay.' (DGP, Care Coordinator)

In the final evaluation cycle, some interviewees suggested that the administrative requirements of the job threatened the workability of the model and that administrative requirements could not be fulfilled without additional administrative support.

'I love that word administratively burdensome ... it is huge ... the clerical side is keeping me away from the patient side. I find myself doing paperwork continually I never get to the bottom of the stack on the right hand side of my desk we need a dedicated funded admin person I don't see the program moving forward without that support.' (DGP, Care Coordinator)

In some instances, IHPOs and OWs were assisting with administrative tasks and in one DGP the Care Coordinator established a linkage with the Commonwealth funded Healthy for Life program for support with administration.

'The CCSS program is really paperwork intensive – it requires enough paper work to demonstrate that the right patients are in for the right reason, as well as the actual payment mechanism. It is very admin heavy.' (SBO, program manager)

Effect of training and support

The orientation and networking workshops held for Care Coordinators were highly valued by the Care Coordinators interviewed in the Sentinel Sites. Networking, sharing of program implementation experiences, and clarification of guidelines were particularly appreciated. In these workshops, the SBOS brought together the Care Coordinators with other ICDP funded workers based in DGPs, including OWs and IHPOs. It was reported that some of the SBOs also invited workers funded through complementary state-funded programs, such as Connecting Care in NSW. The ICDP funded Regional Tackling Smoking and Healthy Lifestyle teams (predominately based in AHSs) did not participate in these workshops. We were not able to determine through the SSE whether or not these teams were invited to participate.

There was concern expressed at site level about how the Care Coordinator workforce and program more broadly would be supported following the transition to Medicare Locals in December 2012, and the possible disappearance of the SBOs in this transition process.

'There is a big hole around the transition planning SBO are trying to fill at the moment – this is a change in the last six months. There is little direction from DoHA of how the transition will happen and who will cover the role of the SBO after December 2012. 'Issues that are emerging are: how the contracts will be executed with the sites (SBO is the fundholder and currently managing this process), what is going to happen with the data collection. The MMeX system is the national requirement for reporting on the CCSS program. Who is going to educate the new Care Coordinator on MMeX, who is going to review the data, who is going to answer the questions from people who are having the problem with the data collection? Who is going to handle the communication to keep the coordinators up-to-date?' (SBO, program manager)

Some Care Coordinators also participated in the ICDP funded Flinders Chronic Disease Self-Management training (see Chapter 9).

There were notable gaps in training and skills development around population based chronic illness care, use of clinical information systems and chronic disease management from a population health perspective. There is possibly an incorrect assumption that if the Care Coordinator is a nurse/AHW that they come with these skills, and an orientation to developing and implementing an equity-oriented CCSS program.

Needs for population health approaches and system planning

The extent to which Care Coordinator were reaching the target population (or just the easiest to reach) was difficult to ascertain from the data available to the SSE. Within Sentinel Sites, the Care Coordinator positions have generally been based within DGPs and have been expected to cover the whole Division. Some key informants saw the large areas Care Coordinators were required to cover as a constraint on their effectiveness and on their ability to reach a reasonable proportion of the people in those areas who could benefit from their services.

In many of the DGPs, particularly those that cover large geographic areas, Care Coordinators were directed to work in specific locations and to focus their efforts where need is seen to be greatest. Some informants expressed concern about the lack of equity inherent in this approach.

'... the Division made the decision that the care coordination program will be available only in the [area name]. This is unfair in [service name] point of view. That means that Aboriginal people in [area name] of whom there are about 3000 do not have access to the Care Coordinator. This should be available for whole area.' (DGP, program manager)

There were indications by the final evaluation cycle, that Medicare Locals in at least two of the Sentinel Sites had re-directed resourcing of Care Coordinators from areas that had low uptake to areas of greater need. It was unclear on what basis this targeting of resources was being made – whether geographic targeting, or targeting based on patterns of service use or some other criteria. It was too early to determine the effectiveness of these initiatives in achieving greater equity and program efficiency.

DoHA has recognised the need for structures, systems and processes to ensure equitable access – for example through suggestions that clinical governance committees are set up. The data presented from the Sentinel Sites confirms the need for stronger guidance and system development around the population health aspect of this measure.

8.3.5. UPTAKE AND EFFECTIVENESS OF SUPPLEMENTARY SERVICES FUNDING

KEY POINTS

- Uptake of the Supplementary Services funding has generally been low across the evaluation period, with some increases evident over time.
- Low uptake was attributed to:
 - Time taken to establish roles and relationships and establish local guidelines to ensure equitable access
 - Program requirement that the Supplementary Services funding is for use by Care Coordinators when they need to expedite access to allied or specialist services, coupled with the low/limited areas of operation of the Care Coordinators
 - Requirement to fully utilise existing funding sources prior to use of Supplementary Services funding
 - Perceived administrative burden
 - Agreement by some specialists and allied health professionals to bulk-bill (due to advocacy for this from the Care Coordinators), which has alleviated some of the need to cover specialist and allied health costs through the Supplementary Services funding.
- Items most commonly funded using Supplementary Services funding included patient transport, and less commonly, gap payments for specialist and allied health consultations.
- Intended changes to program guidelines to allow use of Supplementary Services funding for purchase of certain medical aids was positively regarded by interviewees in the final evaluation cycle.

- There were remaining difficulties for patients in obtaining funding for patient escorts, for example when travelling from remote areas; coverage of gap payments for medications; dose administration aids; and surgical procedures, particularly ophthalmology.
- Emerging tensions were evident between the philosophy of the MSOAP-ICD/USOAP and the CCSS, including concerns about the viability of bringing specialists to health centres in some contexts, and tensions related to unequal compensation for specialists, depending on whether they were funded through MSOAP/USOAP or CCSS.

Awareness of funding

Limited uptake of Supplementary Services funding did not appear to be a result of lack of awareness. By the final evaluation cycle there was a reasonably high level of awareness of the Supplementary Services funding across remote, regional and urban sites (Table 8.3). Some of this increased awareness may have been due to the visits of the Sentinel Sites team over the first four evaluation cycles.

In the final evaluation cycle, just over half of all interviewees indicated that they were aware of the Supplementary Services funding; awareness was highest in regional areas, and in the General Practice sector (Table 8.3). Overall levels of awareness in the final evaluation cycle were lower than in the previous evaluation cycle, and the lower levels of awareness are evident in remote and regional sites and in both the General Practice and the AHS sectors (Table 8.3).

Table 8.3: Trends in managers' and clinicians' awareness of the availability of Supplementary Services funding (% who responded 'yes'), overall and by rurality and sector

Evaluation cycle	Three	Four	Five
Overall	38% (n=13)	73% (n=49)	58% (n=48)
Remote	>5	77% (n=13)	36% (n=11)
Regional	>5	93% (n=14)	78% (n=9)
Urban	56% (n=9)	59% (n=22)	61% (n=28)
Aboriginal Health Sector	>5	65% (n=20)	50% (n=26)
General Practice Sector	>5	79% (n=29)	67% (n=21)

Notes: Type of interview respondent, see Appendix C for listing of interview types and respondent types.

n = number of people who responded.

Aboriginal Health Sector includes: AHSs, NACCHO State and Territory affiliates. General Practice Sector includes: General Practice, DGP and Division State-Based Organisations.

These lower levels of awareness of Supplementary Services funding in the final evaluation cycle were somewhat inconsistent with increased use of this funding overall, as evident in state level program data provided by DoHA. The lower levels of awareness were also apparently inconsistent with reports from the Sentinel Sites of increased understanding of the use of funding, and the greater establishment of the Care Coordinator service evident by the final evaluation cycle.

'Now the care coordination service has been in place for a while there is more confidence re the use of the Supplementary Services money ... so Supplementary Service funding uptake has dramatically increased in the last six months.' (DGP, Care Coordinator)

Possible explanations for the irregular responses to the statement regarding awareness of the Supplementary Services include ongoing uncertainty regarding the guidelines and availability of the funding, and the small numbers of interviewees (the difference in responses between the fourth and fifth evaluation cycles is not statistically significant, meaning there is increased likelihood that the apparent decline in awareness is an aberration, and does not reflect a real decline in awareness).

Barriers to use

A range of barriers to use of Supplementary Services funding was identified over the evaluation period. To a large extent these barriers were still evident in the sites in the final evaluation cycle. These barriers provide some insight into the reasons for the overall under spend of Supplementary Services funding. These are outlined below.

- **Time taken to establish roles and relationships and establish local guidelines to ensure equitable access.** Care Coordinators reported spending considerable time trying to develop an understanding of how to effectively use and implement this funding in a way that meets guidelines while addressing patient needs. Each of the Sentinel Sites appeared to be developing and implementing local decision making processes for allocation of the Supplementary Services funding. In most sites, the time required to understand the requirements and develop local guidelines meant that utilisation of Supplementary Services funding commenced several months after the Care Coordinator was recruited. Managers and Care Coordinators wanted to ensure the guidelines were understood and comprehensive before accessing Supplementary Services funding as they were concerned about managing community expectations.
- **Program requirement that the Supplementary Services funding is for use by Care Coordinators when they need to expedite access to allied or specialist services, coupled with the low/limited areas of operation of the Care Coordinators.** In some of the Sentinel Sites, AHSs were seeking to access the Supplementary Services funding to expedite access to allied or specialist services for their patients, but did not have or require the services of the Care Coordinator.
- **Requirement to fully utilise existing funding sources prior to use of Supplementary Services funding, for example, using the patient assistance transport scheme rather than Supplementary Services funding for transport.**
- **Perceived heavy administrative requirements, particularly of using funding to cover gap payments.** Several Care Coordinators indicated that they prefer to get the accounts paid prior to a consultation to avoid the patient being requested to pay, and possibly being embarrassed and becoming disengaged.

'Care Coordinators have a lot of administrative work with the Supplementary Services. To get the gap paid the Care Coordinator pays allied health who invoices AMS for full amount ... Care Coordinator has to authorise through finance to pay and then get back the rebate through Medicare. Admin can't do this in the AHS as there is private information so the Care Coordinator finds herself doing a lot of admin.' (Feedback provided from tracking site)

'This model of paying the gap payment is considered the most administratively burdensome and the Care Coordinator spends a lot of time undertaking the paperwork requirements to pay gap and reconcile Supplementary Services accounts.' (DGP, program manager)

- **Greater agreement from specialists and allied health professionals to bulk-bill Aboriginal and Torres Strait Islander patients as a result of the work of the Care Coordinators.** As indicated earlier, some Care Coordinators advocate for bulk-billing by specialists and allied health

professionals. Where this advocacy has been successful, the Supplementary Services funding is not required.

In early evaluation cycles, there was considerable confusion evident about what services and activities are eligible for Supplementary Services funding and how to access the funding. There was also some confusion evident around whether a DGP can claim a Medicare rebate when, for example, Supplementary Services funds are used to pay specialist fees. However by the final evaluation cycle, confusion around these issues were no longer apparent. In the final evaluation visits, interviewees noted the positive role of the DoHA fact sheet on Supplementary Services (including the Frequently Asked Questions), the assistance provided by SBOs in providing guidance on use of Supplementary Services funds and the email list-serves moderated by the SBOs.

Conflicting approaches to improving access through different measures

There were also some emerging tensions evident between the philosophy of the MSOAP-ICD/USOAP and Supplementary Services funding (for more information on the USOAP and MSOAP-ICD see Chapters 10 and 11 measures). Some interviewees were concerned about the viability of bringing specialists to health centres in some contexts, suggesting that in some areas it was preferable for specialists to consult in their own rooms. Some interviewees believed that it was beneficial to use CCSS funding to 'top up' the fees paid to specialists – particularly where there had been difficulty recruiting – in order to encourage them to see Aboriginal and Torres Strait Islander patients.

'The limited access to bulk-billing specialists is just such an issue and it may not be the best model to have someone come for a day, as often they sit there with no patients turn up. It may be better to divert money to paying for services locally – the gap payment.' (DGP, program manager)

Others (particularly interviewees from workforce agencies that manage the MSOAP-ICD and USOAP programs) felt that the CCSS program was undermining what they were trying to achieve. There were tensions related to unequal compensation for specialists, depending on whether they were funded through MSOAP-ICD/USOAP or CCSS. The approach of topping up specialists' fees was conflicting with efforts to reduce cost barriers to access through encouraging specialists to bulk-bill for their services. Specialist who agreed to bulk-bill were thus being disadvantaged financially in relation to colleagues in other specialties, sometimes working in the same town, who were having their fees topped up through the Supplementary Services funding.

'Supplementary funding is to pay for the gap fee for specialists which is then defeating the purpose of MSOAP-ICD and USOAP which is trying to get specialists to come to a Health Service and bulk-bill. How can we have a situation where one specialist is coming under USOAP to a Health Service and expected to bulk-bill then have another specialist down the road accessing gap payments under Supplementary Services funding. This undermines all of our established relationships with specialists.' (Workforce Agency, program manager)

'This Supplementary Services funding only pushes providers' fees up, whereas we are trying to drive them down to bulk-bill. This is definitely not the direction we are trying to go in, is with increased fees. It also infers that the Medicare rebate is not enough. It appears to be opening a whole can of worms in regards to rebates and what is adequate compensation.' (orkforce Agency, program manager)

Some interviewees suggested that the USOAP or MSOAP-ICD programs should be modified to facilitate access for patients to see specialist in their regular consulting rooms.

The workforce agency and SBO have been collaborating to ensure the measures are working in a complementary rather than conflicting way. Both agencies pointed to difficulties that stemmed from programs being run out of different parts of DoHA, possibly with different vision about what is required to increase access to specialist and allied health care.

Funding gaps

Across the evaluation cycles, interviewees identified the difficulties faced in accessing funding for equipment required by patients with chronic conditions – for example, orthotics, glucose monitors, shower chairs and rails. Changes to allow for the use of Supplementary Services funding for certain medical aids were instituted from October 2012 (see Section 8.2). Although these changes were not in place at the time of the final round of evaluation visits, a number of interviewees were aware of the impending changes, and were positive about them.

Remaining gaps in relation to the funding criteria that were identified by interviewees across the evaluation period included:

- Provision for patient escorts, particularly when travelling from remote sites, or for a person to meet and assist the patient on arrival for health care.
- Coverage of gap payments for medications where patients are in-eligible for free medications.
- Dose administration aids such as Webster packs for Health Services that are not receiving QUMAX funding.

‘Webster packs are in demand to be provided for free but the pharmacies can’t do that and the CCSS can’t also subsidise this - which is a barrier. The feeling is that it is so simple but not covered [when it] can prevent so much.’ (SBO, program manager)

- Funding for surgical procedures, in particular those related to ophthalmology.

‘CCSS cannot provide surgical care. The value of medical consultation then gets wasted if the patients cannot afford the surgery that is recommended in the consultation. It is a benefit that patients can access the specialists for their medical management under the CCSS program but [no] surgery is definitely a barrier.’ (SBO, program manager)

The change in guidelines around funding for medical aids was welcomed by interviewees in the Sentinel Sites. However, it was noted by some interviewees that there may be implications for the work of Care Coordinators in sourcing of equipment, and also in ‘discharging’ patients from their services when there may be expectations of ongoing supply of these devices. There is a risk that the Care Coordinator role may become more administratively burdensome with the need to source equipment, develop risk management procedures and be involved in (or at least liaise with) clinical governance committees.

Effects of funding

Where Supplementary Services funding had been accessed, it was valued and used to purchase a range of services and support, particularly transport for health-related visits and, to a lesser extent, gap payments to specialists and allied health professionals.

Community focus group participants commonly highlighted the substantial barrier that transport can present to attendance at appointments, and valued efforts to overcome transport barriers, specifically including measures to reduce the costs of transport. While they did not specifically mention the

Supplementary Services funding, it is clear that many community members would value the availability of funds to assist with the cost of transport for the purpose of accessing health care.

Of managers, clinicians and Care Coordinators interviewed in those sites with access to the CCSS program, almost all (25/28) agreed that the Care Coordinator was assisting with patients accessing a variety of different health care professionals and that there has been a subsequent improvement of care for patients.

While there is general support for the CCSS measure, important questions remain about appropriate targeting and relative potential for population benefit of the measure. These questions are critical to successful and cost-effective implementation of the measure – for example whether or not the CCSS program design and systems established to support it, were reaching those most in need of services, and were sustainable and equitable. Some of these issues are discussed in Section 8.3.6 below.

Vignette - Use of CCSS funding to access specialist services

In a regional Sentinel Site, cost, travel and cultural safety are barriers to Aboriginal and Torres Strait islander patients attending specialist appointments. One patient with a very serious medical problem regularly needed specialist services that were only available in another regional city. The CCSS funding and the availability of the Care Coordinator to 'walk with her' enabled her to get the treatment she needed.

'By offering the Supplementary Services through care coordination we are actually getting the patients to the service. It works, it's not rocket science. We take out the facts that prevented [patients from] going which is cost or transport. Now they are going. We do not have to re-invent the wheel. We have actually enhanced the existing structure'.

Supplementary Services funding, together with advocacy and support from the Care Coordinator, has enabled patient access to care.

8.3.6. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the CCSS program would mean that care coordination services are embedded in primary health care, with equitable access for the most vulnerable Aboriginal and Torres Strait Islander people with complex care needs.
- The program worked through: achieving a practical and workable design at site level; effective collaborative arrangements and service planning; establishment of Care Coordinators in their role; Supplementary Services used to overcome barriers to care and; complementarity and linkages with other ICDP funded activities.
- These mechanisms were found to be influenced by a range of factors – including how well the program focus was defined, which in turn was influenced by strong and expert leadership; organisational capacity for funding submission and development; past experience in inter-sectoral collaboration and good working relationships; skills and attributes of individuals recruited to Care Coordinator positions; training, networking and support for people in these positions; and having a common or well networked host organisation with encouragement of linkages between people employed through different ICDP measures and other relevant programs.

Effective implementation of this measure would result in care coordination embedded in primary care, with equitable access for the most vulnerable Aboriginal and Torres Strait Islanders with chronic disease as shown in Figure 8.1 below.

As is evident through the analysis presented above, progress with implementation of the CCSS program has varied substantially between different Sentinel Sites. It is clear from the evaluation that this variation in progress with implementation cannot be simply attributed to geographic location or any other specific characteristic of specific sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective implementation can be achieved and the influences that enable and constrain the operation of these mechanisms.

The success stories presented provide evidence to suggest that the program enabled some patients with chronic illness to reach a level of care that they otherwise would not have been able to reach in the absence of the program. The CCSS program was highly valued by those who accessed it. Whilst considering how the CCSS program was able to make a difference at the individual level was an important part of developing an understanding of the mechanisms of successful implementation (for example, understanding how the program addressed barriers to care for individuals), we also considered evidence for how and under what circumstances the program appeared to meet principles of efficiency, effectiveness and equity at a community or population level in the Sentinel Sites.

Our analysis identified five broad mechanisms of change for effective implementation of the CCSS program (Figure 8.1). These mechanisms indicate how the program was seen to work in the Sentinel Sites. Contextual factors that enabled or constrained the operation of each mechanism were identified. These are shown in the figure, and a textual explanation, together with some examples from the data, provided below the figure.

In general, an overarching consideration was the extent to which population health approaches were evident in program design, service planning and program implementation. As shown in various points in the text below, there were few examples of this, and few examples of good leadership evident in relation to the use of population health approaches. There were no instances identified of a clearly articulated program logic at site level, including how change was expected to come about, where resources would be deployed to achieve maximum impact and related monitoring and evaluation. The extent to which these issues were required to be addressed in the process of allocating funding was unclear, and the issues may be more clearly addressed as the program evolves and more on-the-ground experience is gained. Nevertheless, our analysis indicates a lack of leadership in population health orientation for the program across a number of the mechanisms through which effective implementation of the measure could occur.

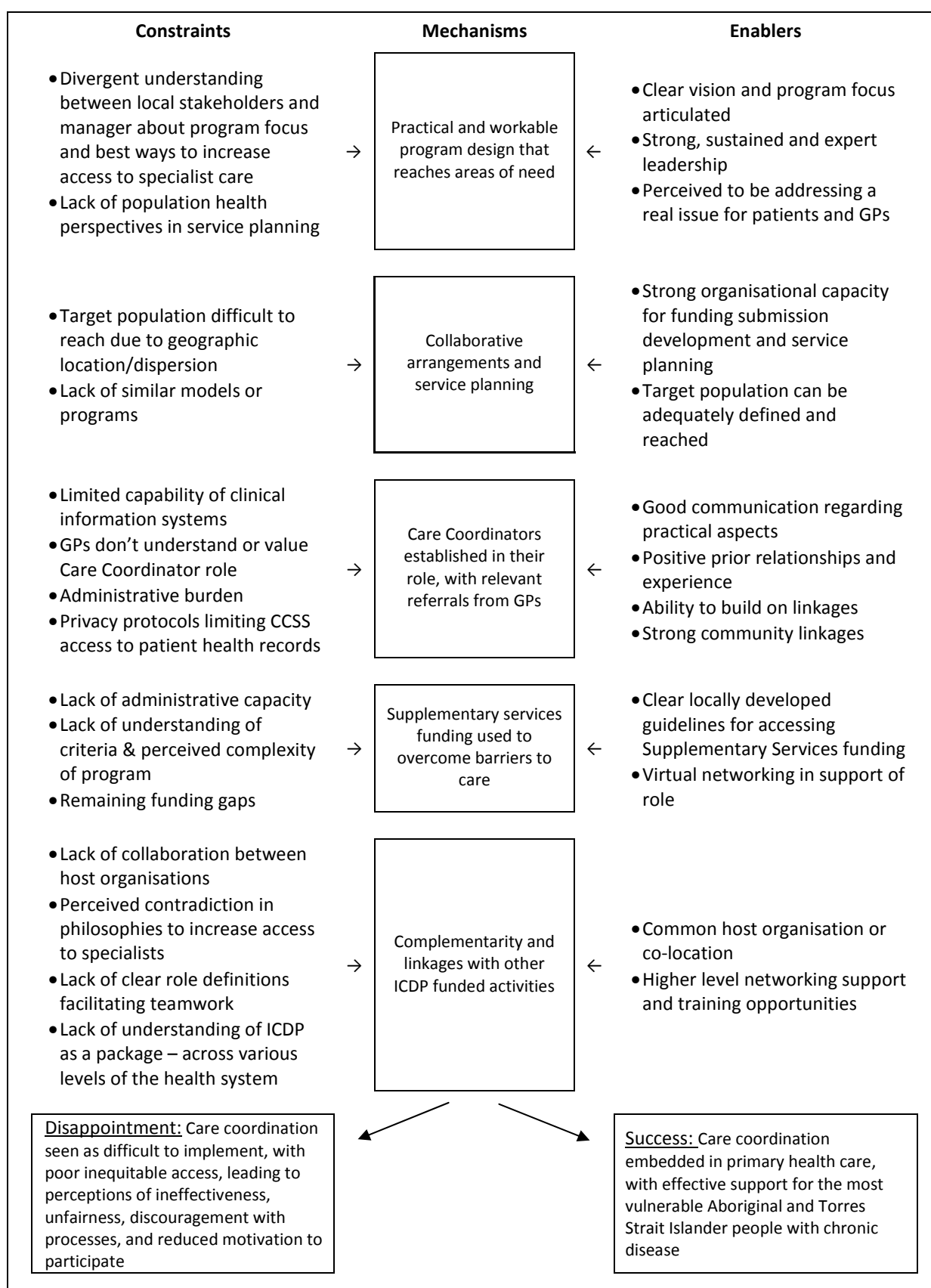


Figure 8.1: Enablers and constraints to effective implementation of the Care Coordination and Supplementary Services measure

Practical and workable program design functional at site level

A functional program design would also take into account the reality of the absolute numbers and proportions of potential Aboriginal and Torres Strait Islander patients in the area who could benefit from the service and the best way to reach those most in need. If this mechanism was operating, we would anticipate that key stakeholders and implementers in the site would understand the rationale of the program, its intended beneficiaries and service delivery mechanisms, who should be involved in planning, delivery and ongoing monitoring, what their roles were, and how the program fitted in to the overarching goal of the ICDP and Health Service delivery in the area. Key factors that appeared to influence the extent to which the program design at site level was practical, workable and functional are outlined below.

A lack of shared understanding about the appropriate focus for the program in some areas constrained the development of a practical and workable program design. The appropriate focus may differ between locations depending on a range of factors, including population and disease profiles and availability of other resources and services – this was recognised in program guidelines that specified the development of locally appropriate models. In contexts in which the program focus was not clearly identified for the local area and communicated effectively, the development of a practical program design was constrained. For example in some sites, Care Coordinators spoke of a ‘back door’ approach to establishing a patient base, such as working through hospital discharge programs, or working through community events, and finding a GP prepared to refer, who would then need to complete a TCA/GPMP. In general, these ‘back door’ approaches appeared to be developed ‘ground up’, did not appear to be built on strategic decisions about program focus from the SBO level, and were not always appropriately directed or adequately supported. In other sites, some stakeholders may have considered that the program focus should be to reach a larger number of patients with complex care needs with a less intensive care coordination service – for example, in one site, an AHS requested Supplementary Services funding, but did not think it appropriate to involve a Care Coordinator case management and service navigation function. It was unclear whether or not this vision was widely shared in the site. The development and communication of this shared vision about what the CCSS program would look like at local level was one of the functions of good leadership at site level. Where this was not present the development of practical and workable program designs was constrained.

Although Care Coordinators in all sites sought to engage clinicians, for the most part, GP referrals, particularly from General Practice, remained fairly low. There was no evidence in the sites of exploration of other possible ways to focus the program that may be more suited to these kinds of contexts, such as expansion of the capacity of GP providers in providing greater care coordination to their patients – for example, providing quick access to telephone assistance for arranging funding for transport, or specialist visits, without individuals necessarily being referred to and formally accepted by the CCSS program. There was limited evidence that GPs were engaged in development or refinement of programs in a way that they believed would work for them.

In some sites, SBOs and other stakeholders held widely differing views about the best way to increase patients’ access to specialist care. This extended to differing views about appropriate compensation models for specialists, with implications for CCSS as well as for the MSOAP-ICD and USOP measures. Where differing views could not be reconciled, the development of practical and workable designs at site level was constrained. This constraint was also relevant to the potential complementarity and linkages between the CCSS program and other ICDP measures – and is discussed further below in relation to Mechanism 5.

Conversely where there was good leadership about the program, and its practical implementation, the development of a practical and workable program design was enabled. Leadership functioned to help to establish and communicate a vision for the program at site level, establish clear criteria and processes for how resources could best be used, and to provide practical support in meeting implementation requirements. In this respect, the leadership and coordinating role of SBOs in relation to the CCSS program was noted by many interviewees in the Sentinel Sites as being a key factor for some aspects of successful implementation. In particular, interviewees noted that SBOs linked Care Coordinators to the other ICDP measures and provided them with practical support in their role and performance reporting.

SBOs/DGPs provided leadership and supported the targeting of CCSS program resources in the Sentinel Sites. SBOs and DGPs worked to refine criteria and processes to enable better access to Supplementary Services funding. This was appreciated where it occurred, with Care Coordinators developing greater confidence in their ability to access this funding to expedite patient care. Many DGPs provided directives to Care Coordinators to work in certain geographic locations and not others. In some cases this was because of other overlapping programs, for example, state-run programs, and the service was not seen to be required in some areas but not in others. In other cases, this was to make the job more manageable, given the vast geographic regions covered by some of the DGPs, and distribution of eligible population. The rationale for care coordination services to be available in some geographic areas and not others was not always clear to interviewees in the Sentinel Sites. In some cases, this led to perceptions of inequity and implementers questioning the logic behind these decisions. Although such a program design may have been workable and functional, it was not necessarily widely accepted in the site or optimally effective in reaching those most in need of the Care Coordinator services.

Collaborative arrangements and service planning

The CCSS program design specified collaborative planning between the General Practice and AHS sectors, and inclusion of different stakeholders in the sites. Where this worked well, stakeholders and service providers worked together to develop shared expectations about what was to be achieved through the program and jointly planned how the program would be implemented in their site. Although all sites seeking to access CCSS program funding needed to put forward expressions of interest for funding with a detailed work plan developed jointly by DGPs/AHSs, this was done differently in different contexts, leading to different outcomes. While it was usually clear that DGPs were involved in planning processes, as indicated above, there was limited evidence that GPs were engaged in development or refinement of programs in a way that they believed would work for them.

Where there was good organisational capacity for developing funding submissions, coupled with good inter-sectoral working relationships, the development of collaborative arrangements for the CCSS program and service planning was enabled. For example, in one site, some of the success of the CCSS program was attributed by interviewees to planning of joint and complementary roles for program implementation during development of the funding application. The DGP in this site had a strong Aboriginal health team, and stakeholders in the site with positive prior experience of working together.

Constraints to the development of collaborative arrangements and service planning included the large geographic area covered by the CCSS program in each site, coupled with difficulties defining the target population. These factors, together with a lack of similar models or programs from which to draw guidance, constrained the ability of the host organisations in sites to develop appropriate arrangements and plan for the service in a way that was satisfactory to stakeholders and seen to be meeting local needs. There was evidence towards the end of the evaluation period that the newly established Medicare Locals in some sites were redirecting Care Coordinators from areas that had low uptake of

the service, to areas of perceived higher need; whilst it was too early to tell the effect of this, it may indicate the potential for greater capacity in service planning through Medicare Locals in the future, and that some ongoing flexibility in service delivery models may be required.

Care Coordinators established in their role with relevant referrals from GPs

Where Care Coordinators were established and effective in their roles, some of this had to do with the Care Coordinators competence and local knowledge, not necessarily the service environment. This was the case for example, in one urban site, where the Care Coordinator received referrals from General Practice, state based Care Coordinators and from the AHS.

‘... a wonderful resource ... with [lots of] contacts ... knows who does what.’ (AHS GP)

One constraint to the establishment of Care Coordinators in their role included the limited ability to use clinical information systems to identify or follow-up patients who might benefit from the service. Clinical information systems are often not adequately set up to support proactive approaches to chronic illness care, and Health Service staff often lack the skills and knowledge to use clinical information systems for this purpose. Health Service processes to identify Aboriginal and Torres Strait Islander patients (or to record Indigenous status in clinical information systems) were not well developed in many areas, and acted as an additional system constraint at the organisation and practitioner level. This was compounded by privacy protocols limiting access by the Care Coordinator to patient health records if the Care Coordinator was not part of Health Service staff – for example, those Care Coordinators based in the DGP did not always have access to shared patient records from General Practices. In addition, in the absence of strong linkages and relationships, some GPs had not developed sufficient trust in the process or in the Care Coordinator to refer patients for assistance with coordination of their care.

Establishment of the care coordination role was also enabled by a clear vision for how the care coordination function fits with other roles of the health team, including the ICDP workforce. This was also relevant to Mechanism 5. For example, in one site, the successful establishment of the care coordination role included an arrangement in which the Care Coordinator based in the DGP worked closely with the Aboriginal health team at the DGP in order to enhance links with patients, and the Aboriginal Health team worked with community members to promote the Care Coordinator’s role. The DGP based OW and AHW assisted with transport arrangements and the IHPO with performance reporting and administration requirements for the CCSS program.

Working with other team members appeared to be a particularly important enabler in those sites where it was difficult, at least initially, to engage GPs – for example in urban areas with larger numbers of potential GPs, and relatively fewer numbers of Aboriginal and Torres Strait Islander patients per GP. In these sites, the successful Care Coordinators tended to work ‘backwards’, relying on other members of the health team such as OWs to find eligible patients and bring them in to the care coordination service - involving GPs at a later point in the process for completion of the referral and TCA/GPMP documentation.

Supplementary Services funding used to overcome barriers to care

Access to the flexible funding pool available through the CCSS program was increasingly recognised as an important motivator for some GPs to refer patients to the CCSS program, and was also valued by other members of the ICDP workforce, such as OWs, who felt that through their connection to the CCSS program, they had something tangible to offer community members - for example, taxi vouchers to attend appointments or removal of other cost barriers to following recommended care.

The use of Supplementary Services funding was enabled where there were clearly defined guidelines for accessing the funding. A further enabling factor was the presence of a 'virtual community' where Care Coordinators obtained peer support and guidance in support of their role generally, including appropriately accessing Supplementary Services funding. The main barriers identified related to the lack of administrative capacity, some remaining confusion regarding funding criteria, and the perception that the important barriers to following guideline-indicated care for patients with complex conditions were not covered by the funding (for example, procedures that might be ordered by specialists, or ophthalmology services).

Complementarity and linkages with other ICDP funded activities

Some of the ways in which other ICDP funded activities were complementary to and supported the establishment of the CCSS program have been outlined above in relation to the previous two mechanisms. There was evidence of considerable local level efforts to ensure that the care coordination positions were complementing and being coordinated with positions with similar roles funded through other sources, and with other ICDP funded workers and programs.

An enabling factor for the development of complementary linkages between Care Coordinators and other ICDP workforce was a common employing host organisation – typically a DGP - and promotion of team-based approaches within the organisation. The funding process itself was also identified as an enabling factor.

'[The] process of applying gave us time to think through linkages and how to operationalise the program.' (DGP, program manager)

Other enabling factors included the support provided by SBOs that provided a structure within which Care Coordinators could operate, and facilitated the linkage of ICDP workers.

There were positive instances of linkages with other ICDP initiatives. However, these linkages were not always made without some challenges, and a number of factors were identified that constrained the extent to which these linkages were complementary and contributed to success of the CCSS program. As outlined in the analysis presented in this chapter, in some sites, Care Coordinators and OWs worked fairly closely together. This occurred partly through the joint training and networking opportunities provided to them, and was necessitated by the 'alternative' referral pathways that Care Coordinators developed in response to difficulties with attracting direct and appropriate referrals from GPs. In some instances, these joint working relationships worked well. However in other instances, since the OWs were working with chronically ill people with complex care needs, they were in roles that they had not been employed to work in; as entry-level workers, OWs were not necessarily equipped to provide accurate advice, and the legal and social ramifications of this were raised by some DGP staff. These staff felt that if joint working relationships were to be the desired model in the future, they would seek to employ people to the OW role who already have established clinical skills, and that this role should move towards a more clinical position. There were no clear instances identified in the Sentinel Sites of OW recruitment being influenced in this way. The consequences of this sort of change, and the potential for associated loss of other valued attributes of OWs as reflected in their current role, such as their community connections, were unknown.

The perceived contradictions between the philosophies of the MSOAP-ICD and USOP programs and the CCSS program also presented constraints for this mechanism. Interviewees noted that these differing philosophies had the potential to create 'bidding wars' for services of specialists to provide care to Aboriginal and Torres Strait Islander people with complex care needs, and potential to drive costs up.

Vignette – OWs and Care Coordinators work together, bringing local knowledge that can enable access to services

A community member in a regional site recounted the outcome of a home visit from the DGP based OW and Care Coordinator.

A family's GP had referred a family member to a private specialist imaging service in a town 75 kms away. However, no transport was available and the patient was faced with the prospect of missing the appointment. The OW and Care Coordinator were aware of the family's circumstances and knew the service was available at the town's public hospital. The referring GP was contacted and the referral was changed to the local provider. The OW was able to supply a taxi voucher to assist the family with transport to have the procedure done at the local hospital.

8.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 8.4). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key points, and the third part identifies some key policy considerations emerging from the SSE.

8.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 8.4: Summary of key findings in relation to the program logic – Care Coordination and Supplementary Services measure

	Summary of key findings
Outputs for year 1 and beyond	
Collaborative development of local CCSS arrangements, strengthening linkages between General Practice, AHSs, Divisions, specialist and allied health.	Collaborative development of local CCSS arrangements has been a strength of the program. The latest guidelines on the CCSS program disseminated by DoHA indicate that it is necessary for the GP sector to consult with AHS sector. Opportunities for networking, learning from the experience of others, and collaborative problem solving appear to have been valued. While Care Coordinators face significant challenges in establishing how they can work most effectively with the range of local service providers and community networks, and the program is at an early stage of implementation, there are signs of strengthening of linkages in some locations. A major challenge in many locations has been the lack of referrals by GPs, which probably reflects a lack of meaningful engagement of GPs in the program design. SBOs have played an important role in enhancing collaborative learning, and there is concern that responsibility for this important role may not be carried forward in the transition to Medicare Locals.
Care Coordinators are trained and established in their roles.	There were some concerns raised about training for the Care Coordinators. There is no evidence of core competencies having been defined for this role, and provision of training that builds core competencies for care coordination is an area for further work. Networking opportunities were valued, and facilitation of networking should be continued. Implementation of this measure has been staggered, and establishment of Care Coordinators in their roles has possibly been slower than anticipated. Various models of operation for the Care Coordinator function are emerging, although these models appear less diverse than was anticipated by the program guidelines. Experience of operation of various models in local organisations is increasing, models are being refined and strategies are being developed to overcome challenges in the operation of various models. There is little evidence of good engagement of local level programs with clinicians.
Assistance is provided by the CCSS in line with measure guidelines.	It is clear that in many locations there is a need to refine processes for referral, for prioritisation of which patients should be referred, for improving the flow of patients who can benefit from the CCSS measure, to enhance equity of access and specifically to ensure access for those patients who are most in need, and to enhance integration with other measures designed to enhance chronic illness care. National guidelines for the CCSS measure have recently been refined and these address a number of issues that have been identified through the SSE. This includes clarification of the potential to use funding for administrative support and medical aids.
Expected early results for years 2 – 4	
Aboriginal and Torres Strait Islander people with chronic disease are able to obtain the health services recommended in care plans.	There is early evidence that some community members are benefiting from and valuing the service provided through the CCSS. The extent to which this result is realised in the future will depend on effective wide scale implementation of the CCSS program as well as ensuring synergies and complementarity between the CCSS and other measures, most importantly MSOAP-ICD and USOAP and measures to enhance support for care planning and coordination and self-management.
Appropriate referral to the CCSS becomes normal practice for General Practices.	Processes for referral are still being developed and refined. Many practices and practitioners still have limited awareness of the program, and it is clear it will be some time before use of the CCSS program will be normal practice on a wide scale.

Summary of key findings	
Expected medium term results for years 4+	
Barriers to accessing services necessary in the management of chronic diseases are overcome.	Implementation of the CCSS program has clearly resulted in opportunities and resources to overcome important barriers to accessing necessary services, but as indicated above and as anticipated in the program logic, it will take some time and considerable developmental work before the program has the potential for wide impact at a population level.
Increased capacity in local networks of health professionals to provide coordinated care for Aboriginal and Torres Strait Islander people with chronic disease	As above, implementation of the CCSS program has resulted in enhanced potential for local networks to provide coordinated care. As expected, it will be some time before the program has wide impact at a population level. The extent to which potential in this area is realised will depend on how the networking facilitation role played to date (largely by SBOs) is developed and sustained.

8.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Care Coordination and Supplementary Services measure.

Local level models of implementation and perceptions of the program

The design of the measure incorporated requirements that stakeholders at local level (typically DGP, AHS and later Medicare Locals) worked together to design a locally appropriate model of implementation of the CCSS program for their area. It is evident from the SSE that the extent of collaborative development of local CCSS program arrangements varied between sites. Sites where there was relatively strong organisational capacity for developing funding submissions and planning services appeared to be more successful in getting programs off the ground. Although collaborative planning led to some initial delays, it allowed for broad consultation, and this was a strength of the program.

In the absence of examples of innovative implementation models, the employment of a nurse as a 'Care Coordinator' based in the DGP or Medicare Local (less commonly in an AHS) became the usual model. There was an apparent contradiction between program guidelines, which outlined roles of a designated Care Coordinator, and those aspects of guidelines that emphasised that the funding could be used in different ways to meet local needs (for example through topping up salaries or expansion of existing activities).

Set up activities, and the more developmental roles of Care Coordinators, such as advocating for bulk-billing by specialists or advocating for the use of care plans, were not well reflected in reporting frameworks, which focused on the numbers of patients receiving services and numbers of services delivered.

The program was positively regarded by most interviewees in Sentinel Sites, but with some concern expressed about equity and sustainability.

Program establishment

The care coordination position was a newly created position, and recruitment and establishment of Care Coordinators in their role was slow initially. Care Coordinators were often allocated specific geographic areas in which to work, leading to perceptions of inequity. Similar roles were performed by other types of workers, funded for example through state programs, making it more complex for clinicians and managers to clearly identify the work of Care Coordinators in some areas. To establish their role, Care Coordinators needed good communication skills, and knowledge of primary health care and the health service environment. Positive relationships and experience, including connection with Aboriginal and Torres Strait Islander communities, was also important for establishment of the program.

One of the comparative advantages of the CCSS program over other care coordination programs is its close linkages with the other aspects of the ICDP – but these are not functioning optimally in some sites owing to a lack of clear role definition, and potential problems introduced through alternate funding mechanisms being available for specialists to participate in the ICDP (via MSOAP-ICD/USOAP in addition to top up payments from Supplementary Services funding).

Referrals to care coordination services

Whilst it is acknowledged that the CCSS program is of limited scale, and was not intended to be available to all Aboriginal and Torres Strait Islander patients with chronic disease, but only those most in need of the assistance, the case load per Care Coordinator in many sites appeared to be lower than anticipated, and lower than comparable programs in other countries. This was at least partly due to low numbers of referrals received, and Care Coordinators spending considerable time doing their own ‘case finding’.

The requirement that the patient needed to be referred with a care plan, was generally interpreted as requirement to have a GPMP or TCA and these arrangements were seldom in place. Some sites instituted additional service requirements, including adult health assessments. These requirements led to a bottleneck in the process, with potential for the ‘inverse care’ law coming into play, whereby those already receiving good care are more likely to get more, and those without regular GPs attending to team-based care, remaining marginalised from the system. In other cases, these resulted in convoluted and inefficient processes in which Care Coordinators advocated for the development of GPMPs and TCAs for individuals they felt would benefit from their services.

Despite considerable investment by Care Coordinators in building relationships with GPs, referrals from GPs were slow in coming, not perceived to be equitable (depending on the attitude and receptivity of the GP, and his/her time to get involved in team care arrangements) and few examples of standard criteria having been adopted. There were overall low referrals from General Practice, with pockets of unrealistically high numbers of referrals from some AHSs. Some sites were beginning to develop more systematic ways to identify patients most in need as a way to cope with inappropriate referrals, through a triaging process.

Alternative pathways to referrals, including identifying eligible patients through community support groups and meetings and working with hospital discharge programs were reported as successful in some sites. These may have resulted in better reach to marginalised patients than reliance on GP referrals with GPMP/TCAs.

Once a patient was receiving services from the CCSS program, it was difficult to discharge them owing to evolution of need, and in some cases to lack of other sources of support. Current reporting frameworks that emphasise numbers of patients seen (not those supported to self-manage and discharged) may discourage discharge, particularly in situations where there are low numbers of GP referrals.

Roles of Care Coordinators, and required training and skills

Care Coordinator positions have limited population coverage (even in reaching specific vulnerable groups who would stand to benefit most from the program) because of small numbers of positions with responsibility for covering large geographic areas or large populations.

Service navigation was the main emphasis of the work of many Care Coordinators, with lower emphasis on coordination of clinical services. Administrative requirements of the role threatened the workability of the program for some, with a significant administrative burden linked to how the Supplementary Services funding was rolled out, and related reporting requirements.

Joint participation in training with OWs and IHPOs enabled networking between the CCSS program and the other ICDP workforce - primarily through Care Coordinators and OWs working closely together in some sites, and Care Coordinators passing on some of the administrative burden of their role to IHPOs and OWs. Most Care Coordinators in Sentinel Sites had attended self-management training.

There was little or no training accessed by Care Coordinators in population-health approaches to chronic illness management, and use of clinical information systems.

The diversity and complexity of roles undertaken by Care Coordinators – encouraging GPs to complete TCAs/GPMPs as part of referral requirements, advocacy in relation to bulk-billing, and so on – did not appear to be well reflected in the reporting framework for the CCSS program, or in the National Framework.

Uptake and effectiveness of Supplementary Services funding

Arranging access to the Supplementary Services funding was a substantial administrative task for many Care Coordinators. The requirement to fully utilise existing funding sources prior to use of Supplementary Services funding, constrained uptake and was perceived to be burdensome. The requirement that the Supplementary Services funding is for use by Care Coordinators (on patients behalf) also constrained greater uptake, due to limited numbers of Care Coordinators, and low patient load. Nevertheless, uptake of funding appears to be increasing, and for some GPs, is emerging as an incentive for referral to the Care Coordinator. Roles and relationships, and local guidelines for use of the funding were largely in place by the end of the evaluation period

Supplementary Services funding was primarily used for client transport and less commonly to cover gap payments for specialist and allied health consultations. Use of the funding for gap payments was perceived to be more administratively burdensome.

The role taken on by some Care Coordinators in advocating for greater bulk-billing by specialists and allied providers was successful in some areas, and had the effect of lessening the need for Supplementary Services funding.

Recent changes to program guidelines to allow use of Supplementary Services funding for purchase of certain medical aids was appreciated by interviewees in the final evaluation cycle, but may add to the Care Coordinators' responsibilities in new ways, and may make it harder to discharge patients.

Remaining funding gaps included: difficulties for patients in obtaining funding for patient escorts, for example if travelling from remote areas; coverage of gap payments for medications; dose administration aids; and surgical procedures, particularly ophthalmology.

8.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Consider ways to strengthen the population health aspect of this measure, including specifically how the program can most effectively reach those most in need of assistance with coordination of their care.
- b) Consider how guidelines can be further clarified, with provision of a range of examples of innovative models for care coordination (including approaches to more effective engagement with clinicians, establishing a patient base, transitioning patients through the program, provision of access to medical aids beyond the period for which patients are supported by the Care Coordinator), in order to help program implementers in different sites to consider how their programs may be strengthened or redesigned.
- c) Consider how administrative requirements can be streamlined, and how administrative support could be more made more efficient and effective.
- d) Ensure that the diversity and complexity of roles undertaken by Care Coordinators are properly supported, monitored and evaluated in future program roll out.
- e) Work with stakeholders to clarify allowable uses for the Supplementary Services funding, as well as processes for its use, and the involvement of Care Coordinators in accessing Supplementary Services funding. This goes to the design of the program, and its intended focus and reach.
- f) Work with stakeholders in each jurisdiction to ensure that the roles of Care Coordinators are defined in relation to a comprehensive workforce strategy and effective interfaces with other programs, including what it is reasonable for a program of this scale to achieve and how the workforce can be most effectively deployed.

9. HELPING INDIGENOUS PEOPLE SELF-MANAGE THEIR RISK OF CHRONIC DISEASE (*MEASURE B4*)

9.1. Description of measure

This measure aimed to increase the capacity of Aboriginal and Torres Strait Islander people living with chronic disease to optimally manage their health condition and slow disease progression, through increasing the capacity of participating Health Services to support self-management. At the level of the patient, self-management has been defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their conditions. From the health provider perspective, self-management involves both a portfolio of techniques and tools to help patients choose health behaviours, and a fundamental transformation of the patient-caregiver relationship into a collaborative partnership.

This measure provided funding for the development and delivery of accredited self-management training for health care providers specifically for Aboriginal and Torres Strait Islander context. Under this measure, funding was provided to Flinders University, the Flinders Human Behaviour and Health Research Unit, for this purpose. The Flinders Closing the Gap Program of Chronic Condition Self-Management (herein referred to as 'Flinders CDSM') training is available to health professionals (nurses, AHWs, GPs and allied health professionals) across Australia. Professional development units for GPs and registered nurses are available. Health practitioners who complete the Flinders CDSM training receive a certificate of competency which includes three Vocational Education and Training competencies that can be credited towards a Health Care Certificate IV.¹²¹

Post-training support for participating health professionals included mentoring (face-to-face, telephone and email) to support practitioners to apply the Flinders CDSM tools to patient care planning and to integrate this into the Health Service practice. Follow-up training comprised smaller group sessions; one to one support with individual 'shadowing' sessions of patient contact; general certificate of competency follow-up for care plans and telephone mentoring. Some of these activities took place at participants' workplaces and others at a central location.¹²²

The measure aimed to provide accredited chronic disease self-management training to up to 400 members of the primary health care workforce providing care to Aboriginal and Torres Strait Islander people.¹²³

¹²¹ Flinders University [website] <<http://www.flinders.edu.au/medicine/sites/fhbhru/atsi-ccm/>> (accessed 12 December 2012).

¹²² Ibid.

¹²³ DoHA, Improving Indigenous participation in health care through chronic disease self-management – Fact sheet <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/chronic-disease-self-management/\\$file/DHA6136%20B4%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/chronic-disease-self-management/$file/DHA6136%20B4%20Factsheet.pdf)> (accessed 12 December 2012).

9.2. State of implementation – national context

At the time of the final evaluation cycle, information provided by DoHA indicated that the main achievements of the program at a national level included:

- The number of health professionals trained in the Flinders CDSM exceeded the target of 400, in a shorter timeframe than anticipated. It was anticipated that training will continue with new and higher targets being negotiated.¹²⁴
- A pilot training course of 18 health workers in Far North Queensland was held during December 2010.
- Training had been conducted across the States and Territories, with most health professionals being trained from Queensland workplaces at 31 August 2012 (Table 9.1).
- DoHA reported that the Flinders CDSM course had been undertaken mainly by allied health professionals, nurses and medical doctors with an estimated split (in that order) at: 60%, 30%, 10%. A few administrative staff also received training, which is seen as useful for building an understanding of the model and training and potentially encouraging or directing other health staff to attend.
- In November 2011 a two-day Flinders CDSM workshop was held in Sydney, initially arranged for the ICDP funded Care Coordinators. As some participant places were not filled, the training was made available to OWs and IHPOs.¹²⁵
- DoHA stated that Flinders University SA has been asked to incorporate an additional unit into their Closing the Gap CDSM support course that specifically addresses tobacco smoking. This unit will be a compulsory unit for future participants undertaking the course. It will also be offered retrospectively to those who have already completed the course.
- During 2012-2013, Flinders University SA will receive \$3.417M for future training.
- The Flinders Closing the Gap™ program identify and recruit the health professionals through their chronic disease network. DoHA has requested the fundholder to target a few specific groups including Medicare Locals.

¹²⁴ DoHA B4 update, 31 August 2012.

¹²⁵ General Practice NSW Closing-the-Gap e-communication, 3 November 2011.

Table 9.1: Flinders chronic disease self-management training participant numbers at 31 December 2011 and 31 August 2012

State	Participant number December 2010 to 31 December 2011	Participant number 1 January 2012 -31 August 2012	Total number of participants trained
Queensland	100	53	153
Victoria	91	22	113
Western Australia	20	63	83
South Australia	41	29	70
New South Wales	40	11	51
Northern Territory	20	15	35
ACT	1	5	6
Tasmania	0	0	0
Total	313	198	511

Note: Date of the first pilot workshop was December 2010.

Source: DoHA, Helping Indigenous People Self-manage Their Risk of Chronic Disease, measure updates, 31 December 2011 and 31 August 2012.

Further implementation updates for 2012 were published in the Chronic Condition Management News.^{126,127}

- Chronic Condition Coordinators in the Pilbara and Kimberley Health Services, Western Australia, were engaged to facilitate the integration of the Flinders CDSM tools into patient management systems. This project is separate to the ICDP.
- Flinders University is working with the University of Western Australia Centre for Software Practice, to embed the Flinders CDSM program as an on-line component within Medical Message Exchange (MMEx) clinical software system. Pilot testing in the Pilbara and Kimberley regions of Western Australia is project managed through the Puntukurnu Aboriginal Medical Service in the East Pilbara.
- Region-based planning meetings, led by Flinders CDSM program staff and supported by local accredited trainers, are planned at a number of locations across Australia to assist in consolidating regional approaches to implementation of the Flinders CDSM Program including provision of ongoing local support to trainers. A meeting was planned in Victoria for July 2012.

¹²⁶ Chronic Condition Management News, Flinders Human Behaviour and Health Research Unit vol 9 no 1, April 2012.

¹²⁷ Chronic Condition Management News, Flinders Human Behaviour and Health Research Unit vol 9 no 2, June 2012.

9.3. Findings from the Sentinel Sites

Due to the design of this measure together with the nature of the SSE, the availability of data at the local site level has been limited. The early stage of implementation within Sentinel Sites meant that this measure was not evaluated during the first three evaluation periods. The findings presented here are based on data collected during the fourth and final evaluation periods, from a small number of sites and from a relatively small number of key informants. Some informants volunteered general comments on self-management tools and techniques that were different to, or adapted, versions of the Flinders CDSM: these are included where relevant to assist with interpretation of the self-management training measure.

9.3.1. TRAINING PARTICIPATION AND ABILITY TO APPLY SELF-MANAGEMENT CONCEPTS IN PRACTICE

KEY POINTS

- Participation in Flinders CDSM training was low across sites, with resulting low rates of accreditation and no clear trends in awareness levels of the training across geographic locations.
- Relatively few stakeholders interviewed in Sentinel Sites had participated, but participant numbers by the end of August 2012 included staff from organisations in 16 of the 24 Sentinel Sites. Training was generally valued by those who attended, particularly those in care coordination roles.
- It appeared that the initiative was not well supported by GPs.
- Lack of participation was due to lack of interest in self-management approaches and use of other self-management models.
- The training did not necessarily target those staff who were in a position to utilise the skills with patients.
- Those who attended training were not necessarily in positions to influence uptake of the Flinders CDSM tools and techniques by colleagues.

Amongst stakeholders interviewed in the Sentinel Sites, there were relatively few who had participated in Flinders self-management training. Amongst those interviewed, factors reportedly contributing to the lack of participation by some groups of workers, particularly GPs, included perceived lack of interest in self-management approaches and, for some organisations, other self-management models being used. Amongst those individuals who had participated in training, training was valued. Training appeared to be particularly well regarded by Care Coordinators and others playing similar care coordination roles, partly due to perceived synergies between self-management approaches and care plans. As shown below, across the Sentinel Sites, the impact has been influenced by small numbers of health professionals trained and accredited in organisations, and their ability to pass on the benefits of providing self-management support for people in the community – either directly or by influencing colleagues self-management practices.

Overall awareness, uptake and implementation of self-management training

By the final evaluation cycle, there was no clear trend in awareness levels of the Flinders CDSM training across geographic locations. In the final evaluation period, of the 55 key informants interviewed, about half (51%) were aware of the training compared to 55% (26/47) in the fourth evaluation period. In the final evaluation period, levels of awareness of the training were greater in remote sites [67% (8/12)] than in urban sites [50% (15/30)] and were lowest in regional sites [38% (5/13)]. Awareness in the AHS sector increased from 48% (11/23) in the fourth evaluation period to 56% (15/27) in the final evaluation period. This was in contrast to a decline in awareness in the General Practice sector in the final evaluation period to 46% (13/28) period compared to 63% (15/24) in the fourth evaluation period. The higher levels of awareness in remote sites and across AHSs, appears to be influenced by the additional investment and emphasis on self-management training in AHSs in one remote case study site. Some of this awareness may also have been influenced by an existing knowledge of a similar Flinders self-management course, together with visits by the Sentinel Sites team over the first four evaluation cycles.

'I am aware of the Flinders training purely because I did a year long course in chronic disease management and that course was part of that. If I hadn't done that, I wouldn't have known.'
(General Practice, urban site)

'I'm aware of the Flinders training as a number of staff have done it but not as part of ICDP.'
(Medicare Local, urban site)

Staff from organisations in 16 of the 24 Sentinel Sites had participated in Flinders CDSM training by 31 August 2012. The number of staff participating at each site varied, with most sites having six or fewer staff trained, and four having 11- 75 trained. This however does not inform the evaluation of whether any of the health professionals were from the stakeholder organisations. In the final evaluation period, when asked *'have staff in your practice undertaken training on chronic disease self-management programs – specifically training that has been organised through ICDP?'* less than one third (29% (9/31)) of key informants responded 'yes'. Smaller numbers of staff have received accreditation following the training. For one informant, it appeared that lack of post-training support was a barrier to completing the accreditation requirements.

Two of the sites hosted train the trainer workshops for the Flinders CDSM during 2012, with participants from around Australia.¹²⁸ A further site had commenced a pilot study to embed the Flinders CDSM tools into existing GPMP/TCA processes. This example is discussed further in the section 9.3.4 in regard to complementary linkages with other ICDP funded activities.

Positions of people participating in the training

Across the evaluation cycles, the SSE identified and interviewed some Care Coordinators who had undergone the Flinders CDSM training, but identified far fewer GPs or nurse practitioners who had done so. Whilst this may have been linked to the roles of people interviewed at the sites (particularly those working in state departments of health, who tended not to be interviewed), it also reflects a perception that the initiative was not well supported by GPs, as indicated below.

¹²⁸ Chronic Condition Management News, Flinders Human Behaviour and Health Research Unit vol 9 no 1, April 2012.

'The training was oversubscribed but filled up with people who may not necessarily use it in a clinical role, for example Department Nurses. No GPs attended. I am worried it was not hitting the correct audience. It was overloaded with government staff.' (General Practice, regional site)

There was a perception that reluctance to changing established practice influenced the lack of participation by doctors.

'Doctors don't like change; they are not taking this on board.' (DGP, urban site)

There were some GPs and Health Service staff who participated in the train the trainer courses. These interviewees commented that the Flinders CDSM tools do not integrate well with some care plans and Medicare item numbers. The comments contrasted with Care Coordinators' comments that the training was able to strengthen and 'round out' care plans.

'The Flinders training, it was worthwhile. The care plan is better as it is holistic, patients set their own goals.' (DGP, regional site)

This differing interpretation of the interface of self-management with care planning arrangements possibly reflects the greater role played by GPs in Medicare billing and other differences in the ways in which people in different positions carry out their work.

Ability to apply training and to change practice

Related to the general lack of participation in training by GPs in the Sentinel Sites, there were some concerns raised in the sites about the ability of those attending self-management training to use the skills gained, given their roles. In some cases, concerns appeared to be linked to the limited population reach of the positions (for example ICDP funded Care Coordinators) and in other cases, positions occupied by training participants did not provide them with opportunities to influence self-management of patients, or the practice of colleagues in relation to supporting patient self-management.

'I am not rolling this out with clinical staff – I can pass those skills on to people – but practices have their own way of doing things. It's a time thing (40 minutes to do a plan). Until someone makes it policy, there is always need for acute care, until people understand primary health care.' (Medicare Local, regional site)

The extent to which there are expectations that a person trained in self-management will promote the approach more broadly within their Health Service was not able to be ascertained in the Sentinel Sites. However, as suggested by the quotations above and below, it seemed that self-management was generally a stand alone or 'vertical' initiative, rather than as part of a broader based re-orientation towards a chronic care model within participating Health Services.

'To make this work, you need someone with ownership, leadership and passion. There was concern [about] the time required for the care plans, that is why [the organisation] have appointed specifically a staff member to do the care plans process.' (AHS, remote site)

9.3.2. PERCEIVED APPROPRIATENESS OF THE MODEL FOR DIFFERENT STAKEHOLDERS AT THE LOCAL LEVEL

KEY POINTS

- Alternative self-management training opportunities and models were being used in some sites, due to their pre-existence and prior staff training, because they were perceived to be more appropriate in Aboriginal and Torres Strait Islander contexts or because they were included in some pre-qualification AHW training courses.
- There were divergent views about the appropriateness of the Flinders CDSM model in two remote sites. Concern focused on the level of patient health literacy and availability of patient support options assumed within the model, while in the other site an accredited trainer had trained over 300 staff in the wider region. Interpretation of the model appeared to be different between the two regions.

Across the evaluation cycles, it was noted that in some Sentinel Sites the workforce were participating in other self-management training opportunities (not through the ICDP). In some cases these other approaches were already being used prior to the roll out of the Flinders CDSM training, and Health Services saw no need to change. In other cases, the alternative models were considered to be more appropriate to the local context or organisational culture. It was also noted that self-management training is included in some existing courses undertaken by AHWs, such as in the Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care.

As outlined further below, there were divergent views in the two remote case study sites regarding the appropriateness of the model to their context, resulting in differing responses to the training available under this measure. One case study site declined participation in the training, deeming it inappropriate to their service population. The AHS had been involved in an original trial of self-management training, and had determined the approach unsuitable for their context as it was text heavy, required a high level of health literacy, and assumed the availability of a range of problem solving options for patients.

'Self-management training is very valuable for a health literate population. [In any case] there is no problem solving here, there are no options [after] we complete a one hour adult health check [and] one hour self-management on top.' (AHS, remote site)

'Sometimes the process can be quite lengthy, particularly with the Flinders model because you have to write everything as you go with patients. The patients can get bored with it.' (AHS, remote site)

'It's too long a time commitment - our mob aren't going to sit down for 20 mins to talk to the Doc and some of those forms are so time consuming.' (AHS, regional site)

In contrast, the other remote case study site has been actively implementing the model and has integrated self-management work into other care coordination type activities. A staff member in the AHS is an accredited trainer and has trained over 300 staff in the wider region in the approach, including the AHS program manager and the Chronic Disease Nurse (not ICDP funded).

Reasons for the divergence in views about the suitability of the Flinders CDSM model in these sites are unknown. However, it may be that prior experience with the model influenced some key informants

perceptions about its limited applicability and/or inflexibility. It should be noted that the interpretation of the Flinders model being applied in one remote site appeared to differ in some important respects from the model perceived as inappropriate in the other remote site.

It was found that some of the Health Services in Sentinel Sites were already implementing self-management models and approaches. For these sites, interviewees indicated that the Flinders CDSM and training was considered unnecessary and sometimes it became confusing if workers were trained in different models of self-management.

'I am aware of the training, though it's not being rolled out here. We have developed [name of program], which we are rolling out over the region – it's not ICDP.' (AHS, urban site)

'I'm aware of the training program in chronic disease self-management offered by AH&MRC. Nursing staff and the health worker from [Health Service] attended one last year. All of our nurses are competent in chronic disease self-management.' (AHS, regional site)

'Some non-Indigenous staff members here also are engaged with the Stanford model of the self-management training. This makes it confusing [regarding] who has done what model of the training.' (DGP, urban site)

'Staff are trained already and implementing self-management approaches/techniques for other population groups.' (General Practice, regional site)

The SSE identified a variety of alternative CDSM models. One self-management model being implemented at the time of the final evaluation cycle was the 'Work it Out' program. Piloted in one AHS in collaboration with the Institute of Urban Indigenous Health in Brisbane, key factors identified as contributing to the program's success were support from senior staff and clinicians and availability of appropriate facilities. Lack of appropriate facilities was identified as a reason for slow uptake of the program in other AHSs in the region.

'The success factor of the 'work-it-out' program is the support from ATSICHS main clinic – a couple of doctors are the 'champions' ... who [refer] patients into the program. Another factor of the success is the facility at the rehab gym.' (AHS, urban site)

'The 'work-it-out' program has been fairly successful in Woolloongabba and it has been hard to get going in Logan. There are some changes ... going on with the program in Logan in terms of timing and other factors. The facilities [which are small] might have been part of the problem ... in Logan.' (AHS, urban site)

'[The program is] very good and the time spent in sessions is good although the number of sessions held could be increased. However, the space used for the equipment is too small and uncomfortable.' (Community focus group, urban site)

Based on the success of the pilot, funding has been sought to implement this program within AHSs across the Brisbane South, Logan/Woodridge and North Lakes/Caboolture Sentinel Sites. By the final evaluation cycle, it was evident from the high levels of awareness amongst health professionals and community focus group participants that the 'Work it Out' self-management program was gaining momentum.

9.3.3. LINKAGES WITH ICDP FUNDED AND OTHER ACTIVITIES AND SERVICES

KEY POINTS

- In several sites, the Care Coordinators, (predominately those based in DGPs), took up the Flinders CDSM training with enthusiasm and incorporated self-management principles into aspects of their work.
- In one remote site, an AHS is training staff in seven AHSs across the region in the Flinders CDSM program with the aim of standardising the approach to self-management. The strategy includes key roles for health promotion staff, clinical staff and the care plan coordinator to work with patients to develop care plan.
- There is potential for these initiatives to increase uptake of relevant ICDP MBS items, and trigger PIP Indigenous Health Incentive Tier 1 payments for target levels of service delivery to participating patients, through the strengthening of the GPMP/TCA arrangements.

In several sites, the Care Coordinators, (predominately those based DGPs), took up the Flinders CDSM training funded under this measure with enthusiasm and incorporated self-management principles into aspects of their work. This was not part of the original program logic, but was an emergent behaviour – some implications are discussed further in the overall ICDP chapter (Chapter 17).

As mentioned above, in one site an AHS has been funded to train staff in seven AHSs in the Flinders CDSM program - five in the Kimberley and two in Pilbara regions - with the aim of standardising the approach to self-management across the region. The strategy includes key roles for health promotion staff, clinical staff and the care plan coordinator to work with patients to develop care plans.

Vignette – Embedding the Flinders CDSM tools into regional health service delivery

In one remote site, the AHS has been funded to train staff in the Flinders CDSM program across seven AHSs in the region, with the aim of standardising the regional approach to self-management. The AHS's Care Coordinator (non ICDP funded) completed the program to become an accredited trainer for the Flinders CDSM program. She has taken a leadership role and works closely with Care Plan Coordinators within each participating service to develop, implement and support the model. An important aspect of the role is to help services integrate CDSM tools into existing GPMP/TCA structures. Workflow diagrams have been developed to support staff in this process.

It is evident this approach is involving team approaches and developing service-wide commitment to integrating CDSM processes into patient care.

'Health promotion people will be working closely with the clinic staff in remote communities in doing the care plans ... The complete care plan team will include a GP, a podiatrist, a diabetes educator, a dietitian, an AHW, a RN [registered nurse], and someone from the healthy lifestyle team. Together they develop a GPMP or a care plan. ... The health promotion workers seem to be holding this together, they liaise with others in the team to work through the care plan.'
(AHS, CEO)

'We are going to link the CDSM, GPMP/TCA process with the health promotion team to ensure it

is an integrated seamless approach rather than siloed teams.’ (AHS, clinician)

A systematic approach is being used to identify and prioritise patients.

The care plan coordinator ... is coming once a week [to] the clinic and [spends] an hour and a half to go through all the patients records that we have been seen during the previous week and find out who are the patients who could benefit from the self-management program.’ (AHS, GP)

Staff who are using the model’s approach in patient interactions are finding it supports patient self-management and care planning.

‘...Clients begin by self-assessing what they know about their condition, how they interact with Health Services, how they manage, how they work with their symptoms, how it affects all the different components of their life, their physical health, their social health, their cultural health, what measures they are putting in; and then you go through a lengthy questionnaire with the client, recording their language, their words... Then you cross check and rate [responses ... for inclusion] in the care plan. If the client knows very little about their chronic disease, being informed and providing information becomes part of the care plan. Problem assessments and goals [are set] around the client’s life. The client is helped to break down the information into feelings and impacts, giving clients problem solving skills. A medium term goal is worked out to address the problem and that becomes the framework for their care plan.’ (AHS, program manager)

There is clearly potential for these initiatives to increase uptake of relevant ICDP MBS items, and trigger PIP Indigenous Health Incentive Tier 1 payments for target levels of service delivery to participating patients through the strengthening of the GPMP/TCA arrangements.

In two sites (as referred to above and below), workers within Regional Tackling Smoking and Healthy Lifestyle teams were involved in the self-management models being implemented in their regions.

‘The service delivery model is about services and linkages. TAWs and HLWs are geared to having whatever they do linked to the local AHS clinic. ATSICHS Logan clinic have been linked in with IUIH for Community Days and will also be available at the BBQ day planned for early November 2012 with the re-launch of the ‘Work It Out’ program at the Woodridge Clinic and the ‘Talking About the Smokes’ research project through NAACHO.’ (AHS, urban site)

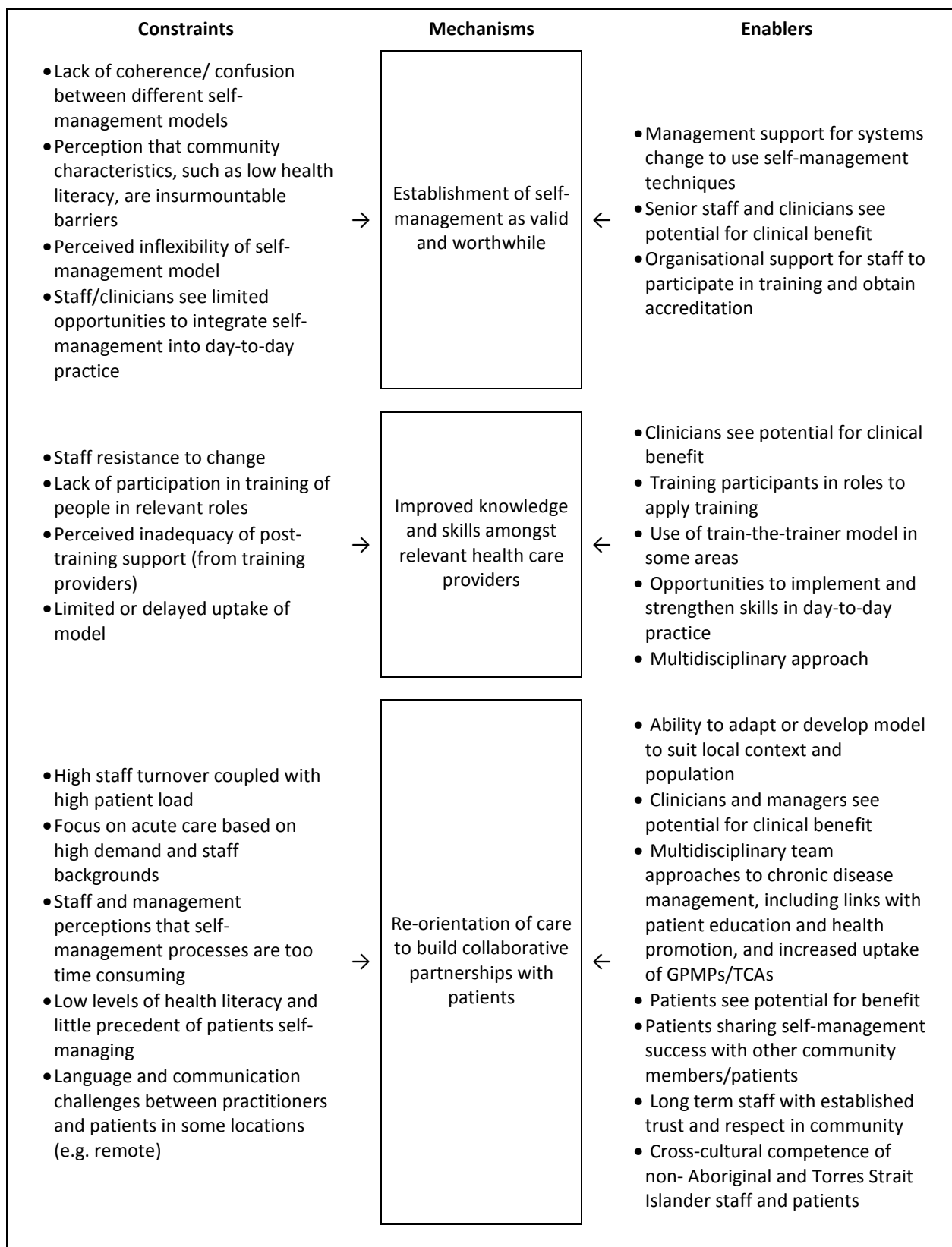
9.3.4. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Establishment of self-management approaches as valid and worthwhile tools and techniques was enabled at an individual level by training participation. However, lack of self-management being valued in a more fundamental way, as a core part of primary health care re-orientation, constrained implementation.
- Where a self-management approach was valued, it appeared to be driven by 'top down' (or at least 'middle-level') support in the form of regional implementation strategies.
- Implementation appeared to be constrained by use of a specified self-management model, which some Health Services considered inappropriate for population groups with low levels of health literacy, limited English language skills and/or strong traditional culture. Some organisations had developed their own self-management approach or had tailored existing models to better suit local contexts.
- Training an adequate number of people in relevant roles, with openness to changing care approaches, was crucial if Aboriginal and Torres Strait Islander people were to benefit from this measure.
- There appeared to be a lack of guidelines for Health Service managers to identify or target appropriate staff to attend self-management training.
- Self-management requires a level of patient readiness, community interest and acceptance of a changing relationship with health care providers.
- Re-orientation of care to build collaborative partnerships with patients was enabled by awareness of potential for clinical benefit by staff and patients, ability to adapt model to suit local context, multidisciplinary team approaches, increased uptake of GPMPs/TCA and, staff with established trust and respect in community, and cross-cultural competence.
- High staff turnover and high patient load, combined with perceptions that self-management processes are too time consuming, a focus on acute care, low levels of health literacy and lack of precedent for self-management, language and communication challenges in some locations constrained re-orientation.
- The measure was supported by complementary linkages with other ICDP funded activities, enabled by regional implementation with a systems perspective, organisational capacity to identify linkages and commit to integrating the Flinders CDSM program into care coordination, understanding of relevance of the Flinders CDSM program to health promotion activities implemented through the Regional Tackling Smoking and Healthy Lifestyle teams.

Effective implementation of this measure as envisaged in the program logic would result in a greater number of people working in the health workforce who are trained to support Aboriginal and Torres Strait Islander people with chronic disease in self-management, and that self-management approaches are embedded in care delivery systems with a re-orientation of care towards a chronic care model. This chapter has identified a range of enablers and constraints that influenced the extent to which effective implementation was able to be achieved at local level.

Our analysis identified four main mechanisms through which the measure appeared to achieve change in different contexts. These are shown in the central boxes in Figure 9.2 below. Enablers and constraints related to each of these main mechanisms are shown in the Figure, and described below.



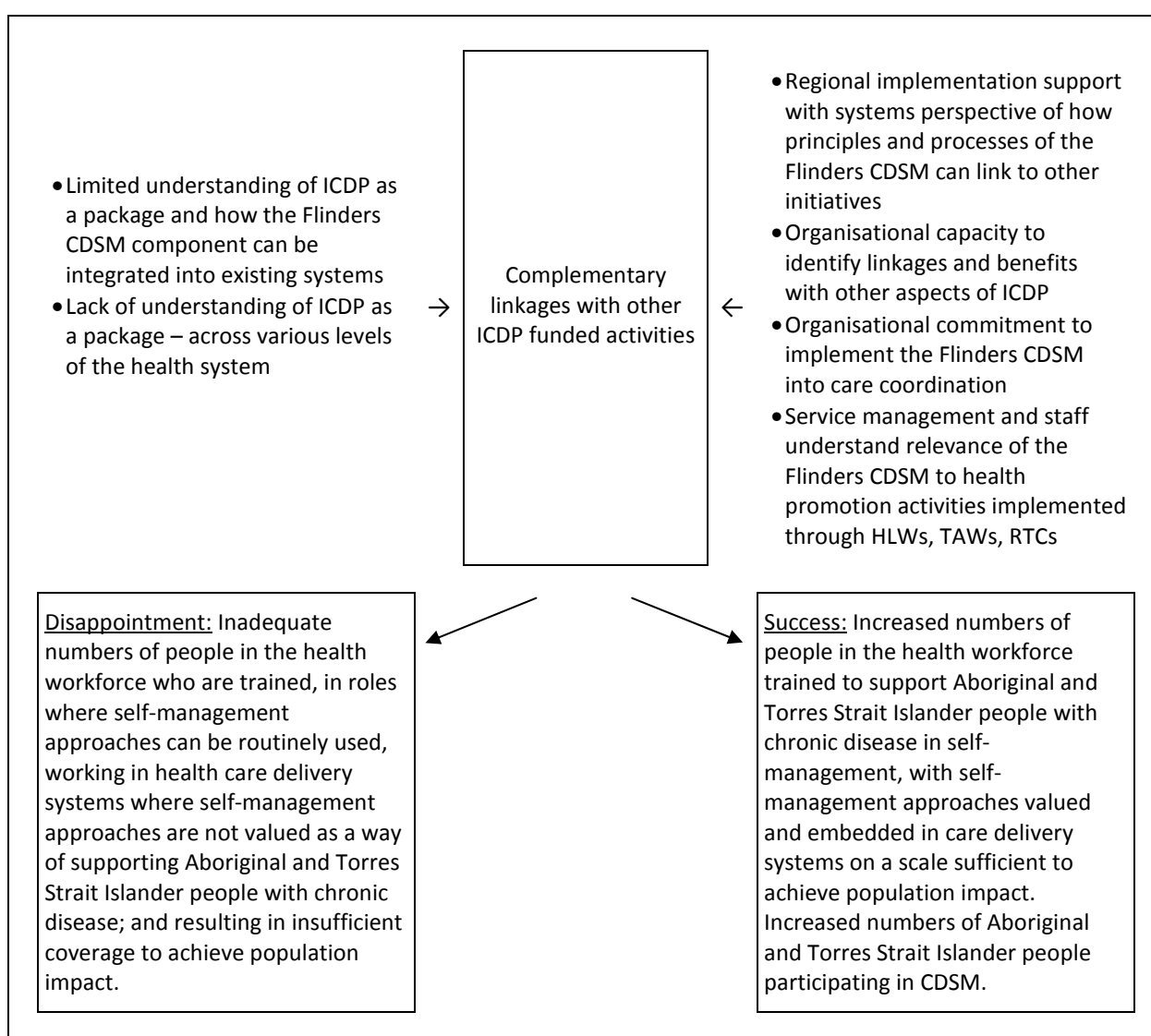


Figure 9.1: Enablers and constraints to effective implementation of initiatives helping Aboriginal and Torres Strait Islander people self-manage their risk of chronic disease

Establishment of self-management approach as valid and worthwhile

The establishment of self-management approaches as valid and worthwhile tools and techniques was a key mechanism through which this measure could achieve the goal of increasing Health Service capacity to support Aboriginal and Torres Strait Islander people to self-manage their chronic disease. Funding was provided primarily to train health care providers in self-management techniques. While the measure did not include any activities that resourced Health Services to participate it was expected that participating Health Services would support health workers to attend training delivered through Flinders University in venues around Australia and complete the necessary requirements to obtain accreditation, on the basis that this would further develop the capacity of Health Services to support self-management.

In Sentinel Sites, some services appeared to acknowledge the value of the tools and techniques available to them or their staff members through self-management training. However, there was limited evidence in the sites of self-management being valued in a more fundamental way, such as changing the nature of relationships between patients and health care providers and developing policies and work plans to embed self-management into workplace systems. Not all of the stakeholders

interviewed appeared to value the self-management approach as a core part of primary health care re-orientation. Where there were indications that a self-management approach was valued, it appeared to be enabled by 'top down' (or at least 'middle-level') support in the form of regional implementation strategies. Examples were the utilisation of a train-the-trainer model to achieve wide staff reach, and the encouragement of staff employed at various levels in Health Services to attend training in self-management - for example, Care Coordinators, AHS program managers, nurses, GPs and AHWs.

A factor that appeared to inhibit the effective implementation of this measure was the use of a specified self-management model. We found that Health Service staff in some locations did not participate in available training because the model being taught was considered inappropriate for their community/patient needs; for example for population groups with low levels of health literacy, limited English language skills and/or strong traditional culture. Furthermore, some organisations had developed (or were developing) their own self-management approach or had tailored existing models to better suit for their local context.

Improved knowledge and skills amongst relevant health care providers

The extent to which Aboriginal and Torres Strait Islander people could be supported to self-manage their chronic condition is, in part, dependent on increasing the number of health care providers with the knowledge and skills to apply self-management techniques. On the other hand, there also needs to be a level of patient readiness, community interest and acceptance of a changing relationship with their health care provider, in order for self-management techniques to be effectively applied.

In the Sentinel Sites where training had been made available, it was evident that training an adequate number of the 'right' people was crucial if Aboriginal and Torres Strait Islander populations were to benefit from this measure.

Factors that enabled (or constrained) health care providers to improve knowledge and skills included individual practitioner motivation (i.e., a willingness to attend training and to alter practice) and services' ability to elect appropriate staff to undertake the training. Individual practitioner motivation appeared to be influenced by the way self-management tools and techniques aligned (or failed to align) with health professionals roles, their ability to use the skills learnt in day-to-day practice and in a way that would influence self-management of patients and/or the self-management practices of their colleagues. For example, our analysis identified that some practitioners were highly motivated to attend the training but were not in a position to apply these skills in day-to-day work (for example, people in management and administration positions) and conversely, people who were reluctant to participate in self-management training but whose roles were to provide direct support to Aboriginal and Torres Strait Islander patients with chronic disease (for example, GPs, nurse practitioners and Care Coordinators directly involved in care planning). Factors constraining the development of knowledge and skills were a lack of participation by people in relevant roles, individual worker resistance to change and concerns over the adequacy of post-training support. At a site level, there appeared to be no clear mandate or guidelines for Health Service managers to identify or target appropriate staff to attend self-management training. This lack of clarity appears to have contributed to training some workers who were not well placed to directly support targeted populations.

Health services' provision of policy and practical support for staff to apply and strengthen the skills gained through training in their day-to-day roles was also an important enabler for improving self-management skills and knowledge. This organisational support was also considered important for staff to complete accreditation requirements following attendance at training.

While this measure did not include any community level activities, it was observed that where Health Services had established self-management approaches as valid and worthwhile (as discussed above),

there appeared to be greater community and patient interest in techniques and resources that might support people to self-manage their chronic disease. This was particularly evident in one urban site, where community focus group participants spoke positively about their experiences and the support received through attending the self-management program operating in their region.

Re-orientation of care to incorporate collaborative partnerships with patients

While this is an important mechanism for a chronic disease self-management approach to operate effectively, there was little data collected to suggest that this mechanism was being successfully activated across the Sentinel Sites.

For this mechanism to be activated, services needed to have the ability to adapt or develop the Flinders CDSM model to suit the local context and population. Clinicians and managers needed to see the potential for clinical benefit and there needed to be multidisciplinary team approaches to chronic disease management in place, including links with patient education and health promotion programs and activities, and increased uptake of GPMPs/TCAs. The presence of a champion in the Health Service was an enabling factor evident in a few sites, and it was important that training participants held roles that provided opportunities to apply and build on skills learnt. The train the trainer model used in one region appeared to contribute to re-orientation, mainly due to the number of people trained, as did commitment to a multidisciplinary approach that involved health promotion staff.

There was very limited evidence to indicate that these enablers of re-orientation were in place across services – the examples provided come from informants in a very small number of sites, as do data to indicate that patients shared self-management success with other community members/patients. It was evident that where re-orientation was occurring, non-Aboriginal and Torres Strait Islander staff and Aboriginal and Torres Strait Islander patients were communicating to set self-management processes and goals in place and that a significant factor was that Health Service staff involved were respected and had established relationships with patients/community members.

While factors that hindered re-orientation of care to incorporate collaborative partnerships with patients were generally the converse of the enabling factors, it was evident that constraints to re-orientation included the high demand for acute care and high patient load and the associated perceptions that self-management processes are too time consuming, and current consultation times too limited to establish the relationship between practitioner and patient necessary to undertake collaborative self-management assessment, goal setting and planning. High staff turnover in some Health Services was a related factor.

In remote sites in particular, language and communication challenges between practitioners and patients constrained adoption of the Flinders CDSM processes. Low levels of health literacy and little precedent of patients self-managing were additional constraining factors in remote and other site types.

Complementary linkages with ICDP funded and other activities and services

While the measure design did not specifically identify how self-management was to be linked with other aspects of the ICDP, at a site level linkages with other aspects of the package were evident. Firstly, we noted that some ICDP funded Care Coordinators and, in at least one instance Indigenous Health Project Officers and Outreach Workers, attended the training under this measure, and were incorporating self-management principles into aspects of their work. Secondly, at an organisational level, there were attempts to develop a care delivery model which integrated aspects of the ICDP risk reduction and prevention and management of chronic disease measures into existing health service systems. Where this occurred, linkages with ICDP funded and other activities and services appeared to

be facilitated by a 'whole of team' or multidisciplinary approach across clinical and health promotion roles, which was supported and led by management and senior staff.

9.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 9.2). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

9.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 9.2: Summary of key findings in relation to program logic – helping Aboriginal and Torres Strait Islander people self-manage their risk of chronic disease measure

	Summary of key findings
Outputs for year 1 and beyond	
There are strong participation rates for measure B4 activities.	There were relatively few who had participated in Flinders CDSM training within the Sentinel Sites and there were no clear trends in awareness of the availability of the training across geographic locations.
Accredited courses successfully provide the necessary skills and information to deliver B4	In some sites, there were concerns about the appropriateness of the self-management model and the existence of other models meant the accredited course was considered unnecessary. Furthermore, there were concerns that those participating in the training may not be in roles where these skills can be applied.
Expected early results for years 2 – 4	
Participants in measure B4 activities have an improved understanding of their health condition and chronic disease.	Not able to be ascertained through SSE.
Participants in measure B4 activities are better able to plan for and implement personal health goals.	Not able to be ascertained through the SSE.
Primary health care services involved in measure B4 are able to offer more support services for Aboriginal and Torres Strait Islander people with chronic disease.	Issue of population coverage/reach with low numbers of relevant health professionals trained. Stand alone or vertical programs and not established as valid or worthwhile in organisations. Clearly where there is additional investment and emphasis across the team (and leadership by senior staff and clinicians), there is greater uptake of tools and techniques (not necessarily Flinders CDSM model).
The workforce implementing measure B4 is adequately trained and resourced to deliver this measure	Perception that self-management processes are too time consuming, especially when staff are busy with clinical/acute care. Requires change in nature of relationship between health professional and client. Status quo difficult to change, particularly amongst GPs. Workers trained in different CDSM models creates confusion within organisations.

9.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Helping Aboriginal and Torres Strait Islander People Self-manage their Chronic Conditions measure.

Training participation and ability to apply self-management concepts in practice

Participation in Flinders CDSM training was low across sites, with resulting low rates of accreditation and no clear trends in awareness of the training.

Relatively few stakeholders interviewed in Sentinel Sites had participated, but participant numbers by end of August 2012 included staff from organisations in 16 of the 24 Sentinel Sites. Training was generally valued by those who attended, particularly those in care coordination roles.

It appeared that the initiative was not well supported by GPs.

Lack of participation was due to lack of interest in self-management approaches and use of other self-management models.

The training did not necessarily target those staff who were in a position to utilise the skills with patients, and those who attended training were not necessarily in positions to influence uptake of CDSM tools and techniques by colleagues.

Perceived appropriateness of the model for different stakeholders at local level

Alternative self-management training opportunities and models were being used in some sites, due to their pre-existence and, in at least one instance, modification to local context (across urban sites), because they were perceived to be more appropriate or because they were included in some pre-qualification AHW training courses.

There were divergent views about the appropriateness of the Flinders CDSM model in two remote sites. Concern focused on the level of patient health literacy and availability of patient support options assumed within the model, while the remote site with positive perceptions of the model delivered extensive training across the region.

Linkages with ICDP funded and other activities and services

In several sites, the Care Coordinators, (predominately those based in DGPs), took up the Flinders CDSM training with enthusiasm and incorporated self-management principles into aspects of their work.

In one remote site, an AHS is training staff in seven AHSs across the region in the CDSM Flinders program with the aim of standardising the approach to self-management. The strategy includes key roles for health promotion staff (Regional Tackling Smoking and Healthy Lifestyle teams), clinical staff and the care plan coordinator to work with patients to develop care plans.

There is potential for these initiatives to increase uptake of relevant ICDP MBS items, and trigger PIP Indigenous Health Incentive Tier 1 payments for target levels of service delivery to participating patients, through the strengthening of the GPMP/TCA arrangements.

9.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) The challenge with the future of this measure is establishing self-management as a valid and worthwhile approach in Health Services, particularly amongst health professionals whose roles can provide direct support to Aboriginal and Torres Strait Islander patients with chronic disease (for example, GPs, nurse practitioners and Care Coordinators directly involved in care planning). There is a need to overcome barriers and resistance to change at health system and individual practitioner levels. Communicating the demonstrable (clinical) benefit of a self-management approach to both patients and health care providers may be an important future strategy.
- b) Work with stakeholders at various levels, including providers of education to health professional and Health Service accreditation bodies, to re-orient primary health care systems towards providing integrated chronic disease services that include CDSM as part of best practice. At a local level, encourage Health Services' use of primary health care quality improvement tools that include assessment of systems for patient self-management. Consider providing resources to assist Health

Services in strengthening systems for patient self-management, aligned with quality improvement processes and including support to meet staff training needs identified through these processes.

- c) Work with community and Health Service stakeholders to develop and deliver targeted community and patient education about chronic disease self-management. Health promotion workers (including Regional Tackling Smoking and Healthy Lifestyle teams) would be key to implementing this strategy.

10. INCREASING ACCESS TO SPECIALISTS AND MULTIDISCIPLINARY TEAM CARE (MEASURE B5 PART A)

10.1. Description of measure

The Urban Specialist Outreach Assistance Program (USOAP) aims to improve access to medical specialists for Aboriginal and Torres Islander people living in urban and inner regional areas. Through bringing specialists into primary care settings that are culturally sensitive to the needs of Aboriginal and Torres Strait Islander people, the intention is to reduce cost and other access barriers for patients, increase cultural appropriateness of specialist care, and contribute to better linkages between primary care and specialist services in management and treatment of chronic disease.¹²⁹

An outreach service is defined as a medical specialist visiting and providing a consultation or treatment to an individual patient at a location approved by the DoHA for the purpose of the USOAP. The USOAP is available in areas that are classified Major Cities or Inner Regional as identified by the Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA). Areas that are classified as ASGC-RA 2 Inner Regional can attract both MSOAP-ICD (Chapter 11) and USOAP funding.¹³⁰

Medical specialists participating in the USOAP were strongly encouraged, but not required, to bulk-bill their services to Medicare. USOAP program funding provided for an 'absence from practice allowance', to compensate for loss of business opportunity due to time spent travelling to and from the host organisation; backfilling for salaried medical specialists and; travel and accommodation costs for support staff and specialists. If specialists provided training and/or professional support (for example over the telephone) to staff at the host organisation, this can also be claimed through USOAP. Specialists and any accompanying support staff were required to undergo appropriate cultural awareness and safety training, or be willing to undertake training prior to commencement of the outreach service. The host organisation was eligible to receive limited funding to assist with administrative support and establishment costs.

The USOAP program funding was mostly allocated to workforce agencies in each jurisdiction who acted as fundholders. The same fundholder tended to administer both USOAP and MSOAP-ICD funding in those sites participating in both programs. Each fundholder called for expressions from organisations within their State or Territory ('host organisations') to host the service. Expressions of interest were expected to be based on a needs assessment and include consultation with other service providers in the local area.

Service agreements were entered into between the fundholder and the host organisation for delivery of the program and also between the host organisation and medical specialist. Proposals for delivery of specific specialist services were to be endorsed by a Program Advisory Committee established for this purpose, and approved by DoHA. Specialists were to be identified and contracted by the fundholder, the host organisation, or in some cases, a regional intermediary organisation responsible for a group of services. The fundholder was responsible for ensuring that contracted specialists were oriented to the USOAP and received cultural awareness training.

¹²⁹ DoHA, USOAP Program Funding Guidelines <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary/\\$FILE/Increasing-Specialist-Follow-up-Care.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary/$FILE/Increasing-Specialist-Follow-up-Care.pdf)> (accessed 30 October 2012).

¹³⁰ DoHA, USOAP Program Funding Guidelines, op. cit.

10.2. State of implementation – national context

The program was implemented in stages, commencing with a small number of sites in 2009 and expanding over subsequent years. Priority areas for early funding allocation were identified by DoHA in consultation with the Indigenous Health Partnership Forums.¹³¹

At the time of the final evaluation cycle, information provided by DoHA indicated that at a national level:

- A Program Advisory Committee had been established in each jurisdiction to assess submissions for funding. The committee included representatives from Aboriginal and Torres Strait Islander health related organisations such as the NACCHO affiliates, state/territory health departments, and medical specialist, General Practice and consumer organisations.¹³²
- Fundholding arrangements were in place across all jurisdictions, with Tas and SA being the last fundholders engaged in December 2011. In most jurisdictions, the fundholder administered a number of related programs, for example along with USOAP, the fundholder may have separate agreements with DoHA for MSOAP, MSOAP-ICD and MSOAP-Maternity.
- Over the period of evaluation, several modifications were made to accommodate different jurisdictions' needs and to progress implementation. The Tasmanian Medicare Local funding agreements were terminated at the fundholder's request and new provider arrangements put in place. Variations to agreements with fundholders in NSW, WA, Qld and Vic were executed in December 2011 to provide additional funding until 30 June 2013. The fundholder in NSW was contracted to deliver services in the ACT. New funding agreements were planned to apply from 30 June 2013.
- By the commencement of the final evaluation cycle, USOAP activities had commenced across all jurisdictions with the exception of SA and the ACT. DoHA communication indicated that service delivery was scheduled to commence in these remaining jurisdictions during July and August 2012. Implementation was reported to be under way in NSW by May 2010, in Qld and Vic early in the in the 2010-2011 year and in WA by September 2011.¹³³ The delay in implementation in WA was reported to be due to recruitment, training and orientation processes taking longer than anticipated, and competing priorities with the transition to Medicare Locals.
- The USOAP was underspent. The DoHA identified that this was at least partly due to difficulty recruiting specialists. DoHA reports from September 2011 indicated that constraints on workforce availability had resulted in some variations from the specialties and/or service sites identified in the implementation plans. Fundholders were to submit revised or new implementation plans in early 2012.
- National and jurisdictional-level communication about the USOAP was through a number of different channels. Program guidelines were published on the ICDP website in November 2010. The Program Advisory Committee was required to liaise closely with the Indigenous Health Partnership Forums in each jurisdiction. Regular ICDP newsletters included updated USOAP information.¹³⁴

¹³¹ DoHA, USOAP Program Funding Guidelines, op. cit.

¹³² DoHA, USOAP Program Funding Guidelines, op. cit.

¹³³ DoHA, The Indigenous Chronic Disease Package in 2009-10 Annual Progress Report, November 2010

<[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/publications/\\$file/ICDP-Yearly-Report-0910.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/publications/$file/ICDP-Yearly-Report-0910.pdf)> (accessed 30 October 2012).

¹³⁴ DoHA, USOAP Program Funding Guidelines, op. cit.

10.3. Findings from Sentinel Sites

10.3.1. NEEDS ASSESSMENTS AND PROGRAM SET UP

KEY POINTS

- About two thirds of the Sentinel Sites eligible to participate in USOAP (8/13) were participating in the program by the final evaluation cycle.
- Implementation was at an early stage, with most participating sites having delivered services for a year or less at the time of the final evaluation cycle.
- Needs assessments showed that access to specialists prior to program implementation was perceived to be fragmented and uneven. Needs were influenced by services already available through other programs, and the number and availability of specialists who were prepared to bulk-bill. AHSs in many sites had developed relationships with preferred providers – using preparedness to bulk-bill, and perceived cultural appropriateness as important considerations.
- AHSs hosted the program in all of the participating sites. This may be different from models of program implementation in the rest of urban and inner regional Australia.
- The most commonly funded specialist services were cardiology and psychiatry services, followed by endocrinology, ophthalmology, surgical orthopaedics and general physician services.
- Revision of the needs assessment was undertaken in some sites in response to low patient volume. In particular, general physicians were favoured over specialists in some revised implementation plans owing to the greater scope of services they could deliver.

Site participation

Thirteen of the 24 Sentinel Sites were eligible to access the USOAP in accordance with the funding guidelines, including eight urban sites and five inner regional sites. USOAP activity was evident in DoHA program data in six of the eight eligible urban sites and two of the five eligible inner regional sites – eight sites in total.

Of the two eligible urban sites not participating, one was reported to be investigating the potential of the program in the final evaluation cycle and the other was a tracking site and we were not able to establish the reasons for lack of participation.

Of the three inner regional sites not participating, the first indicated that they had service needs met through MSOAP-ICD and did not require USOAP funding. The second site identified four areas of need, two of which were being met by MSOAP-ICD (respiratory and cardiology services) and the other two (diabetes and cancer) still outstanding. The third site was in the process of organising to commence USOAP services.

One of the inner regional sites was accessing both USOAP and MSOAP-ICD and another was potentially going to be participating in both programs by the end of 2012.

Assessment of needs for specialist services

The host organisation in all participating Sentinel Sites was an AHS. This may not have been typical of the rest of Australia, where other organisations may have been hosting the program.

Most needs assessments identified gaps in access to specialist services. However in one of the jurisdictions, it was reported from the workforce agency that their early needs assessment process which involved consultation with AHSs indicated that there was already a good range of specialist services available to Aboriginal and Torres Strait Islander people with chronic disease, and that USOAP funding was not needed. Although this was not typical of all sites, first, it raised some questions about what 'good access' comprises, and if all stakeholders shared the same definition of good access. Some AHSs reported having needs for specialists met to some extent through participation in other programs, including Indigenous Specialist Outreach Assistance (ISOAP), MSOAP, and MSOAP-ICD. Although there appeared to be some pockets of 'good access', there was in general no clear sense of an overarching shared vision and strategy of how to improve access to specialists for Aboriginal and Torres Strait Islander people in urban and inner regional areas. Second, it was apparent that many AHSs had established relationships with specialists prepared to bulk-bill, and the GPs at the AHS tended to refer to these specialists, thus lessening the need for the USOAP. The extent that specialists (not funded under USOAP) were prepared to bulk-bill appeared to vary considerably between sites, with no clear patterns evident. The issue of bulk-billing and its relationship to access to care is discussed further in Section 10.3.4.

The extent to which the findings from the needs assessments were used in determining funding of specialists varied between sites. In the final evaluation cycle 94% (17/18) of clinicians and managers agreed that arrangements for specialist services available under USOAP meet the needs of Aboriginal and Torres Strait Islander people (Table 10.1), with evidence of increasing agreement over the evaluation period. Managers and clinicians responses were similar. Despite this high level of agreement, there have been some reports of specialists being funded based on their availability, rather than on locally identified needs. As we were not privy to the original needs assessments it was not possible to assess the extent to which recruitment of specialists was consistent with the needs assessments.

Table 10.1: Trends in managers and clinicians perceptions of USOAP service within relevant Sentinel Site (% who responded 'strongly agree' or 'partly agree').

Evaluation cycle	Three	Four	Five
Arrangements for specialist services available under USOAP meet the needs of Aboriginal and Torres Strait Islander people in this area. MS, CS ^a	70% (n=10)	78% (n=18)	94% (n=18)
The referral process between GPs and USOAP specialists is well established and functions well. MS, CS ^a	50% (n=10)	61% (n=18)	88% (n=17)
There is good coordination of care for patients, between service providers and USOAP specialists. MS, CS ^a	60% (n=10)	72% (n=18)	88% (n=17)
There is good communication of relevant patient information between GPs and specialists funded through USOAP. MS, CS ^a	60% (n=10)	83% (n=18)	88% (n=17)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded. Included in the denominator are the respondents who indicated 'don't know/can't say'.

It was sometimes considered beneficial to revise implementation plans (and reconsider the recommendations of needs assessments) on the basis of lack of patient volume for services that had been prioritised, and also on the basis of inability to recruit the kinds of specialists that had been requested. For example, one site, which had identified the need for certain specialists, struggled to get sufficient numbers of patients attending to make the service worthwhile. They revised their model to one of contracting general physicians, who could then see a wider range of patients at a single visit to the AHS. In another site, a workforce agency indicated that although several host organisations in their jurisdiction had identified needs for endocrinology services, given the paucity of endocrinologists they were also considering allocating general physicians to these organisations.

'At first services requested just about everything, but over time it has become more specific. In the early days quite a few clinics requested high end specialists for example the respiratory physician, however, after consultation it was deemed more appropriate to have a generalist on board. A general physician can deal with most chronic disease conditions. We had several early meetings with practice managers to identify the specific needs then approached [name of fundholder]. We have a lot more structured approach now.' (AHS, GP)

Types of services provided

Across the eligible Sentinel Sites, a range of specialist services were funded through USOAP, with the number and type of specialists funded increasing over the evaluation period.

During the final evaluation cycle, the most commonly funded specialist services were cardiology and psychiatry services (funded in five sites each) followed by endocrinology, surgical orthopaedics, paediatrics and general physician services (funded in three to four sites each) (Table 10.2).

Table 10.2 Number of Sentinel Sites in which various types of health professionals were funded through Urban Specialist Outreach Assistance Program to 30 June 2012

Medical Specialists	Number of sites (8)
Cardiology / Physician Cardiology	5
Psychiatry	5
Endocrinology / Physician Endocrinology	4
Orthopaedic Surgery	3
Physician – General	3
Paediatrics	3
Dermatology	2
Physician-Respiratory	2
Ophthalmology	1
Obstetrics	1
Paediatrics - Ear Nose Throat	1
Physician – Geriatrics	1
Oncology	1

Note: These data show the types of health professionals funded in Sentinel Sites. Where the early data listed a planned service but no further data were received, the service was not included in the table. This applied to one neurosurgery service and three ophthalmology services. Services were included if listed as 'under recruitment' (one ophthalmology, obstetrics, oncology and endocrinology service), 'due to start' (one endocrinology, one cardiology) or where data were received with incomplete numbers (six services).

Source: DoHA, Increasing Access to Specialist and Multidisciplinary Team Care, USOAP as at 31 December 2011 and 1 July 2011 to 30 June 2012

By 30 June 2012 there were between two and six USOAP funded specialists providing care or being organised to provide a service in each of the sites in which USOAP was operating. The majority of the specialist services had been established over the 2011-2012 year and by June 2012 most services were operational. The number of health professional visits to a host organisation, at the time of the final evaluation cycle, varied from 0 to 20 visits per annum and the reported number of attending patients ranged from 0 to 104 per annum (with between 1 and 22 patients per health professional visit).

Data on types and numbers of outreach services provided through USOAP were derived from routine program reports to DoHA and supplemented by case study and enhanced tracking site visits. Some discrepancies were noted in the different data sources in relation to information on specialty types and locations, and some data were incomplete. These issues applied across the program, and are discussed in Section 10.3.5.

10.3.2. RECRUITMENT AND ENGAGEMENT OF SPECIALISTS

KEY POINTS

- Dedicated time and organisational capacity were needed for recruitment and establishment of the program; in most cases, this was best achieved through the fundholder and AHS working together.
- Some sites reported that they had more specialists than they could place, and others were unable to identify or attract the required specialists to the program.
- Recruitment strategies differed in different sites depending on the networks and past experience of the fundholder and the host organisation and the distribution of specialists and their working arrangements.
- Different approaches to recruitment included:
 - Networking with teaching hospitals and specialist colleges;
 - Using ‘word-of-mouth’, particularly to identify those specialists trusted for their cultural appropriateness.
- Factors influencing availability and retention of specialists were overlapping to some extent and included:
 - Lack of priority afforded to outreach in urban area, linked to perception that outreach was not needed in urban areas
 - Lack of access to equipment in host organisations
 - Perceived administrative burden and lack of clear shared expectations about billing and reimbursement arrangements
 - De-motivation resulting from low patient volume.

Recruitment processes

Fundholders and AHSs shared the responsibility for identifying and attracting specialists to work in the program in some sites. In other sites either the fundholder or the AHS did this work fairly independently. In most of the sites, specialists were directly contracted by the host organisation. In some cases, the fundholder contracted an intermediary organisation, such as a regional body, to deliver the services, with the regional body responsible for contracting individual service providers that would then work in the AHS to deliver the services. If the fundholder intervenes completely and finds a

specialist due to lack of capacity of organisation then it is likely the host organisation will be unable to manage specialists clinics once recruited due to lack of support capacity generally.

USOAP service providers potentially included specialists practicing under various arrangements: in private practices with no or limited involvement with public hospitals; in private practices with visiting specialist roles at public hospitals; and staff specialists employed by public hospitals.

In those Sentinel Sites where recruitment was left to the AHS, with little support from the fundholder, and the AHS lacked dedicated time or organisational capacity for recruitment, it appeared that the program was delayed. For example, in one of the Sentinel Sites, a GP at the AHS had been allocated responsibility for recruiting specialists, but progress had been slow. At the time of the final evaluation visit, only one of the five approved positions at this site was well established; two positions remained vacant, and two were recently recruited. In this site, it appeared that the fundholder had not taken an active role in recruitment, and the GP had been left without support. In general, recruitment of specialists appeared to work more effectively where recruitment was not left to the Health Service or individual GPs, but included active involvement from the fundholder or from a regional organisation with capacity to take on this role.

In some sites, recruitment was reported to progress satisfactorily through the use of networks with specialist colleges. One fundholder for example, reported that recruitment had proceeded well, and interviewees attributed success to effective use of networks such as teaching hospitals and specialist colleges. In other sites, local informal networks were used by fundholders (and AHSs) to recruit specialists, targeting those specialists who were known and trusted as culturally appropriate providers.

Factors influencing specialist availability

Limited availability of specialists hindered recruitment in some sites. Local level factors influencing specialist availability are outlined below. In urban areas, specialists may have been reluctant to get involved in the USOAP owing to competing or differing perceptions of priorities. Interviewees observed that many host organisations were located close to specialist rooms or to hospitals with specialist services, and that specialists were reluctant to travel the short distance to provide a service in the AHS.

This reluctance to provide services away from the usual place of work was compounded by the perceived high risk of patients not attending appointments. It was noted that providing outreach services may be less financially rewarding for a specialist than working in his/her own practice rooms because time involved in travelling cuts into time that could be used for consultations, and if patients do not attend the outreach clinics, it creates a further financial disincentive. This issue is discussed further in relation to patient attendance following referrals in Section 10.3.4.

A further challenge identified was that some specialists did not consider urban work as outreach work, which reduced their motivation to participate in the USOAP.

‘Going from Liverpool to Campbelltown, a few kilometres down the road. There is no diversity in scenery on an outreach [visit] like that. Often they would prefer (if going to do outreach) to do outreach to more remote places like Bourke.’ (Workforce Agency, program manager)

Vignette – recruiting specialists is challenging

One large, long established AHS in a capital city has found achievement of the USOAP aim of increasing access to specialists and multidisciplinary team care challenging. Lack of a dedicated person to recruit specialists and manage their bookings has resulted in gaps in scheduling of appointments, provision of services, and appropriate follow-up. *‘Often it is left up to the GP to recruit and coordinate and they are already very time poor.’*

Being located a few kilometres from a public hospital has also hindered recruitment to the outreach program. *‘... it is a big ask to try and get a specialist to leave their hospital rooms that are only 5 kilometres down the road to attend a session at the Aboriginal Medical Service.’*

Specialists question the gain in doing outreach work at a local urban location. *‘I have a room full of people to see already. People don’t turn up for appointments at the AMS, why not just bring the patients to me?’*

The service feels that the notion of ‘outreach’ has more appeal for providers when it involves a change of scenery, remote places and a sense of altruism.

Lack of access to the usual range of equipment was also identified as a disincentive to specialist participation in USOAP. For this reason some stakeholders suggested the program focus on improving patient access to specialists in their usual facilities, through funding of gap payments, or transport assistance for patients rather than supporting specialists to see patients in primary care facilities. Negotiation between one workforce agency and a USOAP specialist had resulted in an agreement that patients be transported to the specialist’s rooms, a few kilometres up the road, and bulk-billed. Whilst this arrangement was satisfactory to the specialist and increased access to specialist care for the patients at the AHS, it did not fulfil the program intent of locating specialists within the primary health care service.

We were unable to ascertain whether there were differences in specialist availability for USOAP between the urban and the inner regional areas, although it would be expected that lack of availability (rather than lack of interest to participate) may have been more of an issue in the inner regional areas. One workforce agency reported in its early needs assessment process (which involved consultation with AHSs) that most AHSs in Major Cities (RA1) reported that specialists bulk-bill their patients, removing a significant access barrier. Conversely, in this AHS, with a geographical classification of Inner Regional (RA2) indicated that specialist services were perceived to be patchy, with access problems due to lack of bulk-billing.

Factors related to specialist reimbursement and billing impacted on both recruitment and retention. There was a lack of overarching procedural guidance around this issue, with differing expectations of specialists and host organisations regarding how billing and reimbursement for services would work. This is discussed further in Section 10.3.4.

Retention

Poor retention of specialists in USOAP was a concern in several of the Sentinel Sites, and was raised by a range of interviewees. There were a number of inter-linked drivers of poor retention as identified in the Sentinel Sites. These included low patient volume, limited referrals of patients to USOAP services, lack of coordination, patient non-attendance, specialists not being well orientated or intolerant in

coping with these realities and, in a few cases, AHSs terminating services of specialists owing to cultural inappropriateness or 'poor fit' with the service model. Perceived administrative hurdles may also have played a role. As indicated elsewhere in this chapter, some specialists recruited into the program were not well prepared or able to adjust to different billing arrangements.

Responses to retention difficulties noted in the Sentinel Sites included a reduction in frequency of visits to the host organisation, and contracting of general physicians, rather than specialists. It was intended that this would increase numbers of patients per visit and therefore improve specialist motivation to continue providing services.

'There have been a number [of services] where lack of referrals or 'did not attends' aren't supporting the service, so the specialist discontinues. This is a valid response and particularly relevant to urban services, where specialists come from a very busy home practice. How to overcome? We have initiated discussions how to overcome lack of referrals or 'did not attends'. A strategy may include doing service with less frequency.' (AHS, CEO)

As these were fairly recent responses at the time of the final evaluation visits, the SSE was unable to ascertain the extent to which they had been effective.

10.3.3. CULTURAL AWARENESS TRAINING

KEY POINTS

- Fundholders established networks of cultural awareness training providers who could deliver group or individual training; provide online cultural awareness training by established providers; and set up orientation visits for specialists to meet staff at host organisations.
- Gaps in training included lack of good orientation to the host organisation service environment, and lack of training for reception staff in the specialists' private rooms (where patients attended for follow-up procedures).
- The full potential of orientation visits to develop shared expectations about the outreach service and the realities of working in an AHS environment were not always well realised.
- There were no reports from key informants in the Sentinel Sites of positive effects of cultural awareness training for specialists. This contrast to positive changes reported in General Practice may be because specialists (or their staff) were not interviewed, or that the kind of training delivered, the receptivity of specialists to change, or other factors, may have limited effectiveness of cultural awareness training for specialists.
- Some AHSs were 'vetting' specialists for cultural appropriateness prior to contracting, and in at least one instance, specialist services were terminated due to perceived culturally inappropriate behaviour by a specialist.
- A clear need was identified for training of specialists in the culture of Aboriginal primary health care organisations and ways of working – not only general training around the culture of Aboriginal and Torres Strait Islander people.
- Top of mind for community focus group participants (who may not have used the services themselves) was the advantage of removal of cost barriers, and assistance with transport to get to specialist visits.

Type of training accessed and gaps

Fundholders were responsible for providing access to cultural awareness training for specialists engaged in USOAP, and verifying its completion.

Relevant strategies reported by fundholders to meet this requirement included establishing a network of cultural awareness training providers who could deliver group or individual training, provision of online cultural awareness training by established providers, and setting up orientation visits for specialists to meet staff at host organisations.

Some of the online and face-to-face training courses accessed may have been those trainings developed by RACGP or through DGPs, with the support of IHPOs and OWs, to meet cultural awareness training requirements of the PIP Indigenous Health Incentive. However the extent to which this was happening was unclear, indicating that there may be scope for greater leveraging of cultural awareness training resources that have been developed or made available through different ICDP measures. There may be specific issues relevant to cultural awareness training for urban and inner regional service providers, owing to the specific challenges faced by Aboriginal and Torres Strait Islander people living in urban areas.

Orientation visits to AHSs fulfilled a number of functions. They provided opportunities to establish expectations and discuss requirements for booking patient appointments and equipment. Some fundholders reported that AHSs used the visits to assess the 'cultural appropriateness' of the specialist and provide feedback to the fundholder about whether or not the specialist was likely to be a good fit with their organisation. Other interviewees noted that a more systematic approach was needed, with greater attention paid to preparing specialists for the reality of working in an AHS environment. The implication was that what was required of cultural awareness training was a greater focus on understanding the culture of Aboriginal and Torres Strait Islander primary health care organisations and ways of working, rather than only focusing on understanding Aboriginal and Torres Strait Islander culture more generally.

'Better induction of the specialists under the USOAP program needed. There were specialists recruited but they dropped off like hot potatoes. Why they left because we had a high number of patients not turning up for their appointments. But in our type of community there are other things take priority over going to see the specialists. This is what I would explain to the specialist but the specialists would like their full quota of patients ... if not they would say we are not coming back. So it made us look like we are not running our clinic properly. I had a specialist who came out in the hall way one day who stood their yelled at top of his voice – you will never help this people – we dismissed him there and then. The induction program the specialists went through should have been explained what to expect.' (AHS, GP)

As indicated in the quotation above, this interviewee believed that orientation or induction should have included not only cultural issues that might be covered in a basic cultural awareness training, but also what to expect in relation to patient attendance and organisational behaviour, and the need for flexibility.

Although AHS staff would have been aware that specialists participating in USOAP would be required to undergo cultural awareness training, it was apparent from a number of interviewees from both AHSs and fundholder organisations that specialists were also to an extent being 'vetted' on their cultural appropriateness prior to signing them on to provide services under the program. It appeared that AHSs were in general not involved in the cultural awareness training (apart from the orientation visits discussed above).

Community perceptions

In general, community focus group participants were positive about the commencement of specialist services at an AHS. AHSs in the Sentinel Sites had a strong reputation for delivering affordable and accessible health care. This appeared to be primarily because of removal of the cost of accessing specialist services. This contrasted with frequent comments from community focus group participants about the expense involved in accessing care outside of the AHS sector, particularly specialist care. Despite this 'reputational capital', patient attendance to USOAP specialist visits in AHSs was disappointing. Support for transport to attend specialist appointments, whether at the AHS or at the specialists' rooms, was also highly valued.

Some community focus group participants, when accessing private specialist care, reported positive experiences of culturally appropriate care; others reported negative experiences. Lack of cultural sensitivity by reception staff in specialists' private rooms, where patients may need to attend follow-up visits, was an issue for some community focus group participants. This was also reported as a wider concern by at least one DGP program manager who felt that a gap in the USOAP (or the ICDP more broadly) was the lack of cultural awareness training for front-line staff (not just USOAP funded but also for private specialist rooms) who were regarded the 'gate keepers' at times. As indicated in Section 10.1, the requirement to undergo cultural awareness training applied to specialists conducting outreach visits and any accompanying support staff. It did not apply to reception staff in the specialists' private rooms.

Effects of cultural awareness training

Overall, it was difficult to form a clear picture of the effects of the cultural awareness training component of USOAP at the local level. There were no reports from key informants in the Sentinel Sites of positive effects of cultural awareness training for specialists. This contrast to positive changes reported in General Practice may be because specialists (or their staff) were not interviewed, or that the kind of training delivered, the receptivity of specialists to change, or other factors, may have limited effectiveness of cultural awareness training for specialists.

The apparent lack of effect of USOAP cultural awareness training is in contrast to positive changes reported in Chapter 7 as a result of cultural awareness training provided through the PIP Indigenous Health Incentive to General Practice. The positive changes identified in General Practice (including making physical spaces more welcoming and inclusive of Aboriginal and Torres Strait Islander patients) changed approaches in asking about Aboriginal and Torres Strait Islander status, changed terminology in speaking about Aboriginal and Torres Strait Islander people, and increased sensitivity to cultural responsibilities. These changes would also all be appropriate responses for specialist care. There are a number of possible reasons for the relative lack of influence on specialist care. It may be that participation by specialists as individuals, in contrast to participation by General Practice as a practice, with at least two staff members attending training, may have worked against the achievement of noticeable change in cultural appropriateness of specialist services. This interpretation is supported by the nature of some of the positive effects reported for cultural awareness training through the PIP Indigenous Health Incentive, many of which were 'practice-based', requiring discussion and cooperation between people in the practice. These issues were not to be explored in any depth in the SSE, owing to the broad scope of the evaluation. Our data were also limited in that specialist visits seldom coincided with the time of site visits and we were unable to interview USOAP specialists to obtain their perspectives on the cultural awareness training (or other aspects of the USOAP) first-hand.

10.3.4. REFERRALS TO SPECIALISTS AND PATIENT ATTENDANCE

KEY POINTS

- Low patient volume was evident in DoHA program data and evident from interview data in the Sentinel Sites.
- Both numbers of referrals and patient attendance following referrals appeared to have considerable scope for increase. It was not possible to ascertain the relative contribution of referral numbers and patient attendance following referrals to low patient volume. Interview data suggested that both aspects were important.
- There were no reports of referrals to USOAP services from General Practice in the Sentinel Sites. Explanatory factors included: preference for use of AHSs by Aboriginal and Torres Strait Islander patients with chronic illness in the Sentinel Sites; low awareness of USOAP in General Practice and DGPs; perceptions in the AHS that the service was only for regular patients of the AHS, or that available appointments would be filled by AHS patients, with limited capacity to include patients from other services; and a general historical lack of service collaboration between the sectors.
- Referrals from the AHS sector were limited by the high use of locum and part-time GPs and high staff turnover, which made it challenging to sustain awareness of USOAP and establish consistent expectations and referral patterns in many AHSs.
- Referral pads and group emails (encouraging GPs to refer patients) were used to increase the volume of referrals, but the effectiveness of these strategies was not clear.
- Where referrals were being made, and patients were attending, the USOAP services appeared to be working well for clinicians, specialists and for those patients who attended the service.
- Increased accessibility and confidence in relation to accessing specialist care was noted in respect of some patients that attended AHS-hosted USOAP services.
- Although remaining funding gaps were a disincentive to access specialists for some patients, for others, specialists played a role in advocating for them to be prioritised on wait lists for procedures in the hospital system.
- There was some evidence to suggest that remaining funding gaps with respect to procedures, and sometimes follow-up visits that may be required in specialists' private rooms, limited the potential benefits of USOAP services.

Referrals from the General Practice sector

There were no instances identified in the Sentinel Sites of General Practice referring to the USOAP. All referrals came from within AHSs. The lack of referrals from General Practice may reflect particular patterns of service use in areas with a strong AHS, where the AHS may be the preferred provider for Aboriginal and Torres Strait Islanders with chronic disease, and the USOAP was hosted by the AHS. However limited awareness and historical lack of collaboration between the AHS and General Practice sectors may also have been contributing factors. There was also a perception from interviewees in the AHS that the funding and specialist service was for the AHS patients only and that in time they hope to generate enough demand (if not being achieved already) from their own patients. There was also, in general, little evidence of awareness of USOAP amongst General Practice and DGPs/Medicare Locals in the Sentinel Sites. For example, one DGP interviewee indicated that they had not heard of the program, but that General Practices in the site were struggling to find appropriate specialists to refer to. This DGP

interviewee also did not recall their organisation having been invited to contribute to a needs assessment for their area in relation to specialist care for Aboriginal and Torres Strait Islander patients.

Referrals from the Aboriginal Health Service sector

In general, there were also fairly low referrals to specialist services from within the AHSs hosting the service. However where referrals were being made, clinicians and managers in general felt that they were working well. Across the evaluation period there was increased agreement from managers and clinicians that the referral process between the GPs and the USOAP specialists was well established and working well and that there was good coordination of care and communication between GPs and USOAP specialists. In the final evaluation cycle 88% (15/17) of managers and clinicians in sites participating in USOAP agreed with these statements (Table 10.1).

There were indications that clinicians tended to be more positive about the referral process than managers, which may have reflected the greater interest in volume of referrals by managers. Managers may have been more alert to the overall low volume of patients seen, and the threat this presented to the sustainability of the service.

Some AHSs noted that they had difficulties in ensuring that their GPs were familiar with USOAP, and able to refer appropriately. This was particularly marked where AHSs were characterised by many new GPs, part-time GPs and/or locum doctors. Clinicians were not necessarily being made aware of the availability of USOAP and mechanisms for communication about USOAP within AHSs were not well developed. Some of the GPs in AHSs interviewed reported that already had established referral pathways with specialists and they were reluctant to change these patterns, particularly if patients were satisfied with the current arrangement.

Strategies to increase referrals

One fundholder organisation developed referral pads in an attempt to facilitate referrals. Some AHSs used group-email within the AHS to encourage other GPs to refer to USOAP. There was no evidence from the SSE indicating whether or not these strategies resulted in increased referrals to USOAP specialists. This may have been because the strategies were fairly recently implemented at the time of final evaluation visits, or because they were not widely or systematically applied.

Patient attendance and perceptions of USOAP

Non-attendance of booked patients was noted to reduce the motivation of specialists and the motivation of AHS staff to participate in the program.

'There have been a number [of services] where lack of referrals or 'did not attends' aren't supporting the service, so the specialist discontinues. This is a valid response and particularly relevant to urban services, where specialists come from a very busy home practice. How to overcome?' (AHS, GP)

This GP went on to suggest that their organisation was considering offering the service with less frequency, in the hope that patient volume would improve. The service had not yet been reduced in frequency by the time of the final evaluation visit, and it was unclear whether or not this strategy would be effective in increasing the volume of patients, since some of the low patient volume appeared to be attributed to 'did not attends'. A less frequent service may have drawbacks, if patients are then unable to access specialist care in a timely way.

Interviewees reported that considerable effort was being expended in ensuring patients attended specialist clinics, including offering transport and providing reminder phone calls. Transport was

consistently noted in community focus groups as a barrier to access to Health Services in general, and in some cases transport was offered to the specialist clinic.

The potential for other ICDP initiatives to facilitate patient attendance was recognised in the Sentinel Sites, but the extent to which this was happening, varied. In some sites OWs (and to a lesser extent the Care Coordinator based at the DGP) played a role in facilitating patient attendance at USOAP (and other) specialist appointments and in assisting with arranging follow-up care.

‘... but some people may not turn up because they may be afraid of seeing a specialist. The Care Coordinator and Outreach Worker play some role in supporting those people.’ (AHS, GP)

The complementarities between the USOAP and other aspects of the ICDP are discussed further in Section 10.3.6 below.

Whilst some patients were able to access specialist care through those specialists who bulk-billed, for other patients, it was apparent that having the service hosted at the AHS was particularly valued.

One GP explained that attendance at the service had started her patients on a journey they may not otherwise have had the confidence to commence. That the AHS as a trusted service provider and familiar to the patient, was implicit in this explanation.

‘A few initial barriers are knocked over as the patient talks to a specialist about condition and requirement for treatment and encouragement to get follow-up care. I have a few patients that now feel comfortable to follow-up because of initial consult with specialist at [name of AHS] and being able to do some procedural stuff on site is an issue to overcome.’ (AHS GP)

However, for this GP, and for others, access to procedures was necessary in order to complete the service, and the remaining funding gaps for procedures made this challenging. It was felt by some that until this funding gap was addressed it would be difficult for the measure to achieve its intent. This is discussed further below.

The role of follow-up and procedures

There was some evidence to suggest that remaining funding gaps with respect to procedures, and sometimes follow-up visits that may be required in specialists’ private rooms, undermined efforts to get patients to attend USOAP services. This was reported by both community focus group members and GPs. For example, a community focus group participant reported that a USOAP specialist referred her for a cortisone injection at a public facility; however to access this recommended service, she had to join a long waitlist, leading her to question the value of the consultation.

‘I’m on the waitlist for six months to have a cortisone injection at the hospital.’ (Community focus group, urban site)

Conversely, some interviewees noted that where patients had been on waiting lists for some time, the specialist consultation available through USOAP could result in their priority on the waitlist amended if appropriate. This ability of specialists to advocate on behalf of patients and assist them to be prioritised if this was clinically important was perceived to be a value of the USOAP service by some GPs.

For some, it appeared that the increased access to specialist consultations through USOAP and other initiatives had put pressure on an already stretched hospital system through increased number of referrals for follow-up procedures and surgery.

'One of the issues is the access to surgery. Now that a lot of consultative services have been implemented it is creating a backlog for surgery. This is creating a bad impression in the community in regards to the perception of the measure. After going through all the processes of identifying a patient, referrals and seeing specialists and at the end they are told that they would have to wait in the public waiting list is not good enough. It is really a big gap.' (SBO, program manager)

As noted in the quotation above, it was felt by this interview that this apparent lack of attention to the patient journey was creating negative perceptions of the USOAP, with implications for impact on future support of the service by patients.

Specialists consulting in AHSs sometimes referred patients back to their rooms for follow-up procedures that required specialised equipment. Some interviewees noted that they had had experiences of specialists not bulk-billing for these follow-up visits, and that this created difficulties for patients.

'The specialists that come under USOAP are encouraged to bulk-bill but there is no obligation to bulk-bill in the service and certainly not if they see same patient for a follow-up appointment in their private rooms. This has been an issue.' (AHS, GP)

Some interviewees suggested that specialist equipment should be available for use within the AHS and that funding should be made for this. Whilst this is unlikely to be a cost-effective solution for many AHSs reporting low patient volume for specialist services, but may be appropriate in others. This related to the capacity of AHSs to host specialist clinics, which emerged as a factor influencing the successful implementation USOAP in a number of ways.

Specific issues related to billing arrangements, and how these influenced patient attendance are outlined below.

Removal of cost and other barriers through bulk-billing and other activities

The program guidelines specified that specialists participating in the USOAP 'should be encouraged, but are not obliged to bulk-bill their services'. It appeared that specialists funded under USOAP were bulk-billing services at the AHS. There were some reports of specialists funded under USOAP not bulk-billing in private rooms for follow-up procedures.

A significant cost barrier was removed for many patients in urban and inner regional areas through bulk-billing for specialists services. A further barrier was removed if the host organisation facilitated patient attendance, for example through providing reminder and encouragement services, cultural brokerage, or provision of transport. This was reported from a number of sites.

There was considerable evidence of a lack of shared understanding between AHSs and specialists in the Sentinel Sites regarding how the administrative processes would best work. Some specialists reportedly turned up to provide services at host organisations without having considered how the billing arrangements might work and having made no preparations for billing. This highlighted an issue raised earlier, that of their lack of orientation to the service environment, and also the lack of clear procedures in place around this issue for the USOAP. Others wanted to be paid a salary and for the AHS to bill Medicare for the cost of the service. One interviewee observed that bulk-billing was not usual practice for some specialist services, and this meant that they did not have established systems to bulk-bill patients when they were consulting at the AHS under the USOAP.

'It's just about what staff ... [think is] the best way of billing. For a number of specialist services, bulk-billing isn't their usual billing stream. Work is being done to smooth this though.' (SBO, program manager)

There were reports of some specialists bringing pre-printed computerised Medicare vouchers to the AHS. This raised concerns about what could be done if the patient did not attend. Some specialists felt that the patient should pay up front, or that the AHS/host organisation should assist with administrative support for billing. Although there was provision in the USOAP for funding for administrative support for the host organisation, from the AHS perspective it was not always possible to provide assistance with billing (due to lack of capacity to do so and lack of capacity to access this funding).

Members of the ICDP workforce and other staff of SBOs, DGPs and AHSs (including Care Coordinators, and members of Aboriginal health teams in DGPs) played a role in encouraging private specialists to bulk-bill. Some of these efforts were met with success, whilst others were not. It was not apparent from the Sentinel Sites what factors made it more likely for specialists to agree to bulk-bill. This is likely to be affected by a range of factors, such as patient load, other priorities, and awareness or willingness to assist the needs of Aboriginal and Torres Strait Islander people with chronic disease.

Care coordination and clinical information systems

Some specialists used the clinical information system at the AHS, and entered relevant information onto the system, whereas others did not. The ability of the specialists to access and use the clinical information system on-site at the AHS was noted by some interviewees as contributing to better care coordination and exchange of information. Use of a shared information system also eased administrative barriers, as it enabled follow-up required to be entered and retrieved where relevant, which was helpful for the AHS in their role in sending patient reminders and follow-up support. Conversely, where specialists did not share in the use of the clinical information system either because they did not wish to or because they had not been provided access, bookings and care coordination were made more difficult. It was noted that for the most part the clinical information systems used by AHSs differed from those used by USOAP specialists. This meant that for most specialists flexibility, and an initial investment of time to learn, was required to use the clinical information system.

10.3.5. PROGRAM MONITORING AND REPORTING

KEY POINTS

- There were some discrepancies apparent between the program data received from DoHA, and on the ground findings from the Sentinel Sites evaluation visits.
- Frequency of reporting required by DoHA was felt to be too high, with a preference expressed for six monthly reporting (owing to the numerous services providers involved, and the fundholders' need to obtain and verify their reports prior to submission to DoHA).
- The respective roles of the host organisation and the service providers in reporting was not clearly apparent from the Sentinel Sites and it was unclear whether or not these were optimally structured to encourage good reporting and data verification.
- Available clinical information systems did not seem to be able to effectively identify referrals to services (whether USOAP or other specialists) and outcomes of these referrals. These data were also not available from program data submitted to DoHA.
- Gaps in indicators identified included indicators of GP involvement, including numbers of referrals made; and possibly early set up work, including advocacy for bulk-billing and establishing collaborative referral relationships, since for some sites, this is where the program effort achieved its results.

Whilst it is also to be expected that systems of reporting take some time to be embedded before they are able to provide complete data, the SSE found that fundholders (and host organisations) had difficulties in meeting reporting requirements. There was also some mismatch between reports provided to DoHA and information gathered during visits to some of the Sentinel Sites.

This section reflects on the findings from the Sentinel Sites in relation to program monitoring and reporting.

Frequency of reporting

Some interviewees believed that reports were being requested too often, and at a level of detail that was unrealistic, thereby compromising service delivery. Workforce agencies reported that the increased frequency of reporting to a three-monthly interval, as required by USOAP and MSOAP-ICD was onerous, and that six-monthly reporting would be more realistic. It was felt that the quality of reporting, and service delivery, was compromised by the quick turn-around time that DoHA requested, and what they felt was an over-focus on activity reporting.

‘We have up to thirty major submissions every year is a lot of work for a [name of state wide organisation] there are finite resources and this comes at the expense of recruiting specialists. A report is due fifteen days after the data is collected on 250 services, we negotiated with DoHA to deliver interim reports ... the reports won’t be accurate with that kind of pressure. Reports used to be every six months. The ICDP really increased the workload every 3 months ... they [the DoHA] got addicted to the information’ (Workforce Agency, program manager)

Indicators and results

It was apparent from the Sentinel Sites that some of the work done in the negotiation and consultation around USOAP arrangements was not captured in the existing program reporting or in the program logic specified in the evaluation framework. For example, activities and outcomes related to advocacy for bulk-billing and establishing collaborative referral relationships were not reflected in the program logic, or the reporting to DoHA. And yet for some sites, this is where the program effort achieved its results. For various reasons outlined earlier, the compromise arrangements that were agreed to in some sites did not include the specialist providing services from the AHS, but nonetheless the arrangement was likely to have contributed to the overall program aims. This relates to a general issue of how the scope of the program is understood, since the implementers of the program are in general engaged in many different strategies to increase specialist access. It may not always be easy to disentangle these. At the site level, interviewees discussed what had happened in their Health Service or local area to increase access to specialists. This included a range of activities, not only USOAP services. It seemed that there was a general lack of an overarching vision about the scope of different solutions to lack of access to specialist services, and a relevant and overarching monitoring and evaluation framework.

The program guidelines specify that data to be collected for a location will include total number of Aboriginal and Torres Strait Islander patients receiving specialist services; total number of services provided; and types of specialty services supported. The program logic provided in the National Framework specifies early results, but does not include the range of early set up activities, or some of the other important steps on the path to effective implementation. In particular, the number of GP referrals made to the program does not appear in either DoHA reporting guidelines, or in the program logic. It was apparent from the Sentinel Sites, that GP referrals were a key bottleneck in program effectiveness preceding patient attendance, since if patients are not referred, they cannot attend, data

on referrals made, and from which sector would appear to be important in monitoring progress. The SSE showed that there were a range of issues affecting GP referrals, including lack of engagement by GPs in General Practice, and high use of locums and staff turnover of GPs in AHSs.

Data sources

Specifying reporting requirements is one matter, but having the data sources and information flows in place to generate the indicators requested is another. Some discrepancies between data sources in relation to information on speciality types and locations were noted in the Sentinel Sites. To some extent, data discrepancies could be explained by the earlier period of reporting covered by the available program data. This was due to the lag time in these data being provided to the fundholders in each site, then to DoHA and finally to the SSE team, compared to the timing of the SSE visits. However, the issues may be broader than this, and include both the issue of whether or not the indicators are meaningful at a service delivery level, and where the data to populate the reports come from.

Processes

Monitoring, evaluation and performance monitoring of USOAP appeared to be complicated by the different stakeholders involved, and their requirements. As noted previously, the fundholder is responsible for administering the program, and reporting to DoHA, the host organisation and the specialist presumably need to cooperate in verifying the data sent to the fundholder with regards to services and patients seen. However it was unclear whether or not host organisations were involved in this verification, and how discrepancies were resolved. There is no apparent reporting by the host organisation on numbers of patients referred, making it difficult to identify the extent to which under-referral is contributing to low patient volume.

Vignette – Local strategies to meet demand for specialist care.

Interviewees in an urban Medicare Local raised concern about an acute shortage of specialists in the area and the consequences for patients. Within this Medicare Local they indicated that they had not been involved in needs assessments for USOAP despite the perceived shortage. *‘Access to specialist care is terrible here. People have to go on the long public waiting lists. People get to see a specialist here by ending up in hospital as an emergency presentation.’* To overcome the problem of specialist shortage, the relevant Medicare Local was planning to engage specialists in a tele-health trial (outcome not known). The Medicare Local had also funded ten GPs to undertake masters’ degrees in diabetes care as a strategy to meet local demand, including Aboriginal and Torres Strait Islander patient demand. As a result, GPs said they felt more confident to manage diabetes care and there were reduced specialist referrals.

There is further discussion on program monitoring and reporting in the following chapter on the MSOAP-ICD, including the important issue of development of indicators and systems for reporting on critical measures based on a clear program logic for how specialist outreach services are expected to provide benefits to people in local communities.

10.3.6. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the USOAP would result in enhanced access to specialist services for Aboriginal and Torres Strait Islander people with chronic disease through the primary health care system, with appropriate referrals, use of these services and improved chronic disease management.
- The program worked through achievement of a practical and workable program design at site level; problem-solving and development of local solutions; establishment of arrangements with host organisations and service providers and, where relevant, intermediary organisations; improved accessibility and appropriateness of specialist care; and complementarity and linkages with other ICDP funded activities
- These mechanisms were found to be influenced by a range of factors. These included the extent to which decision-making was devolved to local level; application of problem-solving, rather than solution-driven approaches; support from a well networked fundholder and/or intermediary organisation; shared expectations about how arrangements would work practically; and a shared and realistic understanding of the access barriers faced by urban Aboriginal and Torres Strait Islander patients with chronic disease.

Effective implementation of this measure would result in access to specialist services for Aboriginal and Torres Strait Islander people through the primary health care system, with increased cultural appropriateness of these services, and improved chronic disease management in primary health care.

It is clear from the evaluation that this variation in progress with implementation cannot be simply attributed to geographic location or any other specific characteristic of sites, and is due to a complex mix of local, regional and national influences, some of which vary over time. The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective implementation can be achieved and the influences that enable and constrain the operation of these mechanisms.

Our analysis has identified two broad mechanisms through which the measure appeared to achieve change in different contexts. These are shown in the central boxes in Figure 10.1 below. Enablers and constraints related to these mechanisms are shown in the figure, and described below.

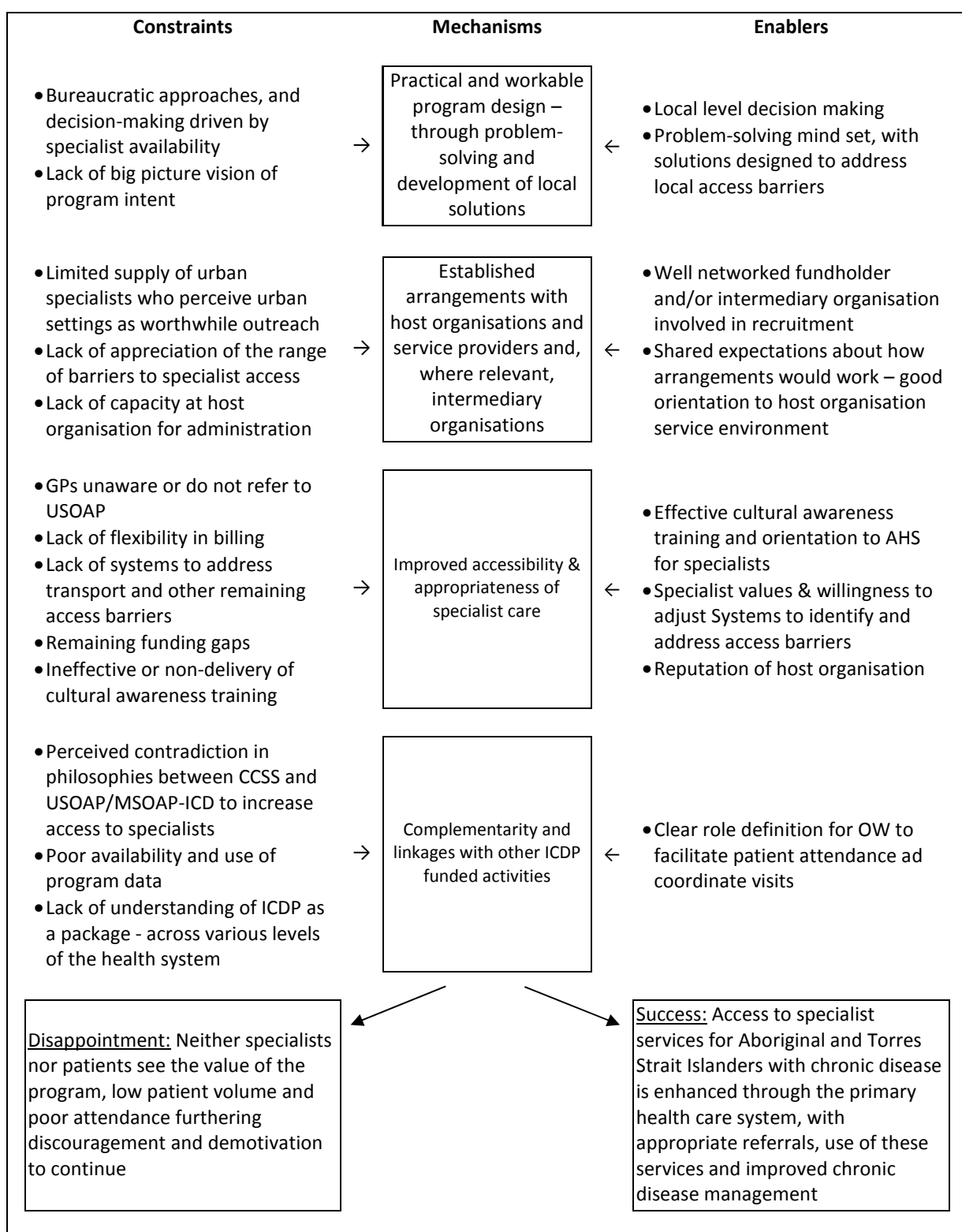


Figure 10.1: Enablers and constraints to effective implementation of the Urban Specialist Outreach Assistance Program measure¹³⁵

¹³⁵ Note: that there may be different constraints and enablers in the situation where the host organisation is not the AHS.

Practical and workable program design – through problem solving and local solutions

USOAP was a fairly small pilot program. It is evident that there are a range of other initiatives with similar aims that were being implemented in the Sentinel Sites, and that many of these involved some of the same implementing organisations. In some of the sites there were indications that success in other initiatives was a possible explanation for lower uptake or demand for USOAP. For example, some AHSs, and more recently the ICDP workforce in DGPs/Medicare Locals and in AHSs, had invested considerable effort in encouraging greater use of bulk-billing by specialists in their local areas, not only those specialists participating in USOAP. Where this had been met with success, the need or demand for USOAP was relatively less. However in many other instances, the program resources, particularly the consultations about how to implement USOAP at a local level, appeared to act as a catalyst for problem solving about how to increase specialist access. This sometimes resulted in implementation models that differed from program guidelines, and did not always use USOAP funding. For example, in at least one site, specialists invited to participate in USOAP declined full participation, but reached agreements with AHSs about bulk-billing in rooms, with AHSs providing transport and cultural brokerage service to facilitate patient attendance. Another site implemented a strategy of training GPs in specialist diabetes care, as diabetes specialists were unavailable in their area. Other sites were considering greater use of tele-health solutions to increase capacity of the primary health service to effectively manage complex care needs. As indicated by these examples, the solutions implemented did not always involve the use of USOAP funding. Positive outcomes of increased access to specialist care, and enhanced capacity of primary care to manage complex cases, would not get picked up in USOAP program data. In general, the development of a workable program design appeared to be enabled by a problem-solving mindset, and devolution of decision-making to local level.

Established arrangements with host organisations and service providers and, where relevant, intermediary organisations

The extent to which arrangements were able to be established between the service providers and host or intermediary organisations was a key enabler of effective implementation. A well-networked fundholder and/or intermediary organisation involved in recruitment enabled the development of established arrangements, as did shared expectations about how arrangements would work. There was in general a lack of clear procedural guidance available at local level about the practicalities of implementation and who was responsible for what aspect of the working of the program. For example, there were reports of specialists coming in to AHSs to deliver USOAP services expecting to be salaried, and have the AHS claim back from Medicare, and others arrived having made no apparent preparation for billing, and with little experience in or expectations of bulk-billing. Where specialists were contracted who were known to the host organisation as a 'good fit' and had positive prior experiences with working together, the establishment of arrangements was enabled. System constraints included limited spare capacity at host organisations for assisting with billing for specialist services, and setting up specialist visits, and lack of clarity about the most appropriate billing arrangements and processes. For specialists, good orientation (including not only cultural awareness training), and development of understanding about the service environment of the host organisation/AHS was also identified as an enabler for this mechanism.

Some specialists appeared to not consider urban and inner regional environments sufficiently 'exotic' for outreach, and this limitation on supply of specialists appeared to be a key constraint for arrangements to be set up in some contexts. In some cases, as noted in examples provided above, the USOAP model of delivery of specialist services in primary care settings was abandoned in favour of alternative ways of improving access.

Also constraining the development of established arrangements between the relevant organisations and service providers, were differing understandings of the range of barriers to access faced by urban Aboriginal and Torres Strait Islander patients in general, and in the local area. It was evident that arrangements that were put in place in response to the USOAP program activity or consultation about potential USOAP participation were influenced by how service providers understood access barriers. For example, some interviewees appeared to consider that geographic proximity alone was sufficient to allow access, and felt that if there was a specialist service facility close by, the USOAP was not needed. Others appreciated cost barriers to care, and agreed to bulk-bill services, believing this would be sufficient to ensure access. Where there was an understanding of the cultural, financial, organisational and systemic barriers to access, there were more likely to be specific arrangements put in place that involved greater collaboration between the host organisations and the specialists, closer in intent to the program design. These arrangements sometimes, but not always, included specialist services delivered from the AHS. High service demand and potentially good volume of patients requiring care from a particular service were also enabling factors. Where these were absent, the development and sustainability of arrangements was threatened.

Improved accessibility & appropriateness of specialist care

The USOAP was able to achieve some of its effects through improved accessibility and appropriateness of specialist care, but the way this worked varied between contexts, as outlined below.

Improved accessibility and appropriateness of specialist care was dependent on the USOAP receiving appropriate and sufficient referrals from GPs in the local area. In the Sentinel Sites, GPs in General Practice generally did not refer to the USOAP, and there was limited awareness of the USOAP by GPs in General Practice and the DGP/Medicare Local. GPs in AHSs referred to the program to varying extents. In contexts where there was a high use of locums and temporary GPs, it was difficult for the AHSs to ensure that their GPs were aware of USOAP and referring appropriately.

In contexts where specialists were well oriented to the host organisation, including its culture and ways of working, improved accessibility and appropriateness of specialist care was enabled. In some instances, AHSs recruited known and trusted specialists, who they had worked with previously. Conversely, where the specialists were not well oriented, and not a good fit with the organisation, this mechanism was constrained. Orientation visits were set up by fundholders, but these did not always achieve their potential in orienting specialists to the ways of working and what to expect in the AHS environment. Some of the specialists contracted under the program left. In some cases AHS service providers believed this was because these providers had unrealistic expectations about attendance and patient volume, and had not fully appreciated what was required of them to participate in the delivery of culturally appropriate care. In some cases, specialists were able to adjust expectations and systems, but in other cases, they appeared unable or unwilling to do so.

In contrast, the host organisation's reputation in delivering culturally safe and affordable care also appeared to be an enabler of patient attendance and access to services. Some patients were able to develop the confidence to attend for specialist appointments and follow-up through starting out with a specialist consultation based at a known and trusted service such as their regular AHS.

Several factors related to ensuring patient attendance following referrals were also identified as enablers of improved accessibility and appropriateness of specialist care. For example, the host organisation's capacity to manage appointments, follow-up patients with reminders and develop systems to support attendance at appointments and follow-up with transport. In all cases, this was related to local Health Service capacity to provide this sort of organisational support and coordination. In some cases, this was related to having an effective OW empowered to support these roles.

Complementarity and linkages with other ICDP funded activities

Unlike some of the other ICDP measures, the USOAP was not linked directly to any of the other measures in the program design. For example, there were no requirements that host organisations needed to be participating in the PIP Indigenous Health Incentive, or that patients receiving specialist care under USOAP needed to be accessing PBS Co-payment relief, and so on. Although specialists participating in the USOAP were required to participate in cultural awareness training, it was not clear if and how this training was linked with cultural awareness training provided in other aspects of the ICDP.

The OWs, IHPOs and Care Coordinators were potentially important sources of support for the USOAP. This was borne out at local level, with some reports of these workers facilitating access to USOAP specialist visits, and more generally working to increase specialist access through promoting bulk-billing, advocacy, awareness raising, and playing specific roles in relation to escorting patients to appointments, arranging transport and coordinating care.

In practice there appeared to be some overlap between the USOAP initiative and the Supplementary Services funding, and some difference in philosophy/approach. As outlined in the chapter on Care Coordination and Supplementary Services, it was evident there was a tension between these initiatives, with the potential for them to undermine one another. Some interviewees noted that they had invested a great deal of effort in getting specialists to agree to bulk-bill during negotiations about USOAP. They felt the Supplementary Services funding was undermining this effort, since specialists who did not agree to bulk-bill could have gap payments reimbursed through this funding source. This tension highlighted the need, evident in other discussion above, to develop a clear and coherent vision and strategy about how to increase access to specialist care for Aboriginal and Torres Strait Islander patients in urban and inner regional areas.

10.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 10.3). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

Although the USOAP and MSOAP-ICD were collapsed into one funding stream at the end of 2012 (Medical Outreach), it is still useful to reflect on the findings from the Sentinel Sites for each of the measures separately. We noted that some different implementation challenges were identified for urban compared to regional and remote locations. These may have implications for future development, including the development of a monitoring and evaluation framework for the combined program.

10.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 10.3: Summary of key findings in relation to program logic – Urban Specialist Outreach Assistance
Program measure

	Summary of key findings from SSE
Expected outputs for year 1 and beyond	
Effective fundholding arrangements in place	As for MSOAP, fundholding arrangements were effective at the local level where they were responsive to local needs and took a problem-solving approach to gaps in service provision and adjusted services on the basis of lessons learned from experience. This was evident in several sites. In other sites, fundholding arrangements were considered ineffective at local level. This appeared to be where the arrangements were bureaucratic, did not use problem-solving approaches and where decision-makers did not have a comprehensive understanding of access barriers.
Potential host organisations informed	Appears to have been completed in all Sentinel Sites.
Medical specialists identified	Recruitment of specialists did take some time in some locations but this has been generally completed. Concerns about retention have been raised. Some challenges with recruitment of specialists due to proximity of consulting rooms. Needs assessments do not always match up.
Specialists demonstrate cultural awareness	The specialists involved in USOAP appear in general to have a reasonable level of cultural awareness, and this is to a large extent due to host organisation involvement in the process of recruitment. There were instances where specialists showed a lack of cultural awareness. Lack of awareness of, or ability to adapt to, the organisational culture and work environment of Aboriginal and Torres Strait Islander primary health care services was more of a challenge for this program. Lack of cultural awareness among specialists reception or administrative staff also presented challenges for staff and patients of AHSs.
Increased specialist services available	Specialist outreach services through USOAP took some time to be established. The range of other initiatives involved in provision of specialist outreach type services and lack of reliable and meaningful data on availability and use of services has made it difficult to assess the extent of increase in availability of services. However, it was evident over the course of the SSE that USOAP was contributing in some locations to some increase in availability of specialist services.
Expected early results for years 2 – 4	
Aboriginal and Torres Strait Islander people utilise and value services	Participants in community focus groups generally had little or no awareness of USOAP services. Those participants who did have some awareness indicated that they valued the service. There have been significant challenges with low attendance at specialist outreach clinics, but there is no evidence that this is a result of people not valuing the service.
Increased number of specialists	There has been a clear increase over the latter half of the SSE in the numbers of specialists involved in USOAP.
Expected medium term results for years 4+	
Care coordination is improved.	There is no clear evidence that USOAP, at this stage of implementation, has contributed to improvements in care coordination.

10.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Urban Specialist Outreach Assistance Program measure.

Needs assessments and program set up

Access to specialists through USOAP was uneven, with needs apparently influenced by services already available through other programs, and the number and availability of specialists who were prepared to bulk-bill. Those specialists prepared to bulk-bill, and who were considered by AHSs to be culturally sensitive, were often already engaged in providing services (usually in their private rooms).

AHSs hosted the program in all of the participating sites. This may be different from models of program implementation in the rest of urban and inner regional Australia.

The most commonly funded specialist services were cardiology and psychiatry services, followed by endocrinology, ophthalmology, orthopaedics and general physician services. Early experience led some sites to revise their implementation plans, to favour the use of General Physicians over specialists (owing to the greater scope of services they could deliver).

Differing understandings of access barriers influenced how the program was set up to improve access. Cost barriers were recognised, and addressed through identifying providers who would bulk-bill. Cultural, organisational and systemic barriers were addressed to some extent through having the service hosted at the AHS, and by the work of OWs and IHPOs.

Recruitment and engagement of specialists

Recruitment and engagement of specialists was largely complete at the time of the final evaluation visits, with some retention difficulties becoming apparent. Recruitment was a shared responsibility between the fundholder and the host organisation, with the split of responsibility different in different sites.

Recruitment strategies differed between sites, depending on the networks and past experience of the fundholder and the host organisation and the distribution of specialists and their working arrangements. Dedicated time and organisational capacity were required and the most successful approaches were those that were collaborative.

Specialists were identified through networking with teaching hospitals and specialist colleges using “word-of-mouth”, particularly to identify those specialists trusted for their cultural awareness.

It was difficult to attract and retain specialists owing to lack of appeal of outreach in urban areas; lack of clear shared expectations about billing and reimbursement arrangements in some sites and demotivation stemming from low patient volume. Lack of access to specialised equipment on site was a disincentive to participation for some specialists.

Cultural awareness training

Some AHSs were ‘vetting’ specialists for cultural appropriateness prior to contracting. In at least one instance specialist services were terminated due to perceived cultural inappropriate behaviour by a specialist.

A clear need was identified for training of specialists in the culture of Aboriginal organisations and ways of working, not only general training around the culture of Aboriginal and Torres Strait Islander people.

Orientation visits for specialists to meet staff at host organisations were valued, but did not appear to realise their full potential.

There was little evidence to suggest that training resources were being leveraged from other ICDP measures (such as cultural awareness training developed by RACGP or DGPs), or that issues specific to urban environments were addressed in training. In general, there were fewer reports of positive effects of cultural awareness training for specialists compared to training for GPs in General Practice as part of the PIP Indigenous Health Incentive requirement. This may have to do with the training of single individuals, receptivity of specialists, complexity of urban environments, or other factors. Gaps were identified for both types of training in relation to training for reception staff.

Referrals to specialists and patient attendance

Low patient volume was identified by DoHA program data and evident from interview data in the Sentinel Sites. Both numbers of referrals and patient attendance following referrals appeared to be important contributors to low patient volume.

There appear to have been very few referrals to USOAP from General Practice. There was in general low awareness of USOAP in General Practice and DGPs. A general historical lack of service collaboration between the sectors in some locations may have contributed to this. This may be different in the rest of urban and inner regional Australia.

Referrals from the AHS sector were limited by the high use of locum and part-time GPs and high staff turnover, making it challenging to establish consistent expectations and referral patterns in many AHSs.

Where referrals were being made, and patients were attending, the USOAP services appeared to be working well for clinicians, specialists and for those patients who attended the service. Increased accessibility and confidence in relation to accessing specialist care was noted in respect of some patients that attended AHS-hosted USOAP services.

Although remaining funding gaps were a disincentive to access specialists for some patients, for others, access to specialists through USOAP was valuable in determining need for and access to further services.

OWs may have played a role in increasing access to USOAP services in some sites through facilitating transport and accompanying patients to consultations.

Program monitoring and reporting

There were some discrepancies apparent between the program data received from DoHA and the reports from the Sentinel Sites. There were a range of issues identified in relation to reporting on USOAP activities, including dissatisfaction with the frequency of reporting required to DoHA and the types of indicators required; challenges for fundholders to obtain data from services and verify their reports prior to submission to DoHA; and lack of clear role delineation in reporting. Reporting requirements did not appear to reflect critical measures based on clear program logic for how specialist outreach services are expected to provide benefits to people in local communities.

10.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Work with stakeholders to develop a clear and shared vision and strategy to improve specialist access in urban areas that is based on a comprehensive and evidence-based understanding of barriers and solutions. Consider what has led to success in other urban-based models. Ensure that program design, including monitoring and evaluation and performance reporting, is based on a clear program logic, and is sufficiently flexible to encourage problem-solving.
- b) Consider whether 'semi-regional' or 'centre of excellence' models may be more feasible in areas of low patient volume and poor specialist motivation. There may be greater incentive to attract specialists to organisations with high reputational credibility and where job satisfaction is likely to be higher. Where these models already exist, strengthening referral mechanisms and supporting communication and follow-up with smaller, less well-resourced primary care centres may be options to consider in the program design.
- c) Ensure that orientation for specialists includes specific focus on organisational culture of Aboriginal primary health care organisations and ways of working.
- d) Explore synergies with other cultural awareness training that has been developed, and possible joint training for reception staff from General Practice and specialist rooms. In this process, ensure that the training is evidence-based and includes consideration of the evidence relating to access barriers faced by urban Aboriginal and Torres Strait Islander people.
- e) Explore options to increase engagement of GPs from both sectors. Include review of communication strategies to ensure they are appropriate in contexts of high staff turnover and use of locum staff.

11. INCREASING ACCESS TO SPECIALISTS AND MULTIDISCIPLINARY TEAM CARE (*MEASURE B5 PART B*)

11.1. Description of measure

The Medical Specialist Outreach Assistance Program (MSOAP) – Indigenous Chronic Disease (ICD), implemented since 2009-2010, aims to improve access to specialists, GPs and allied health professionals for Aboriginal and Torres Strait Islander people who live in regional and remote communities through an outreach funding program.¹³⁶ MSOAP-ICD is an extension of the broader MSOAP program which has been implemented since 2000. Through bringing specialists and other health professionals into primary care services, MSOAP-ICD intends to reduce or remove the cost of care to patients, and through making it unnecessary for patients to travel to regional or urban centres for specialist consultations, reducing access barriers. Through provision of a consultation and liaison service outside the actual visit and other shared care arrangements, MSOAP-ICD also aims to up-skill primary care services to manage complex cases. Funding allocation to MSOAP-ICD was approximately \$54.4 million over four years. During the period covered by the SSE, service planning and recruitment of health professionals was the responsibility of the existing MSOAP fund holding organisations which have been expanded to accommodate the ICD component.¹³⁷

The MSOAP-ICD was targeted to locations where a significant proportion of the Aboriginal and Torres Strait Islander community in the location had chronic health conditions. The Program Advisory Forum in each jurisdiction was to consider target locations and their relative needs in recommending services under the MSOAP-ICD to the DoHA. The MSOAP-ICD guidelines stipulate that the eligible areas for services to be delivered are Aboriginal and Torres Strait Islander communities in Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA) 2 (Inner Regional) to 5 (Very Remote). However, where possible the aim was to focus delivery of services to remote and very remote areas (RA4, RA5).¹³⁸ Regions that were classified as ASGC-RA 2 Inner Regional were eligible for both MSOAP-ICD and USOAP funding (see Chapter 10).¹³⁹

The types of health services to be funded through MSOAP-ICD included those indicated for the management of chronic conditions including diabetes, cardiovascular disease, chronic respiratory disease, chronic renal disease and cancer. The composition of MSOAP-ICD multidisciplinary teams at a local level was intended to vary depending on the specific health and treatment needs of each community, and the availability of health professionals to meet these needs. Preventative health services provided by allied health professionals were eligible for support under MSOAP-ICD following referral by a medical specialist or primary health care service provider.

¹³⁶ DoHA, MSOAP-ICD 2009-2013 Guidelines.

<[http://www.health.gov.au/internet/ctg/publishing.nsf/AttachmentsByTitle/MSOAP-ICD-guidelines.pdf/\\$FILE/MSOAP-ICD-guidelines.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/AttachmentsByTitle/MSOAP-ICD-guidelines.pdf/$FILE/MSOAP-ICD-guidelines.pdf)> (10 August 2012).

¹³⁷ DoHA, Increasing Specialist and Allied Health Care follow-up – Fact Sheet, op cit.

¹³⁸ MSOAP-ICD 2009-2013 Guidelines, op cit.

¹³⁹ USOAP Program Funding Guidelines, op cit.

Health professionals participating in MSOAP-ICD were required to demonstrate they had undergone appropriate cultural awareness and safety training prior to commencing service delivery. The fundholder was responsible for verifying or arranging this training.¹⁴⁰

The measure also provided remuneration for MSOAP-ICD health professionals unable to bill Medicare; costs for registrars and associated health students who accompany teams to visits; and payments to health professionals if MBS payments could not be claimed, or patient compliance with appointments was uncertain. There was also limited provision for administrative support at the service location, equivalent to the hours undertaken by the visiting health professionals, and for a coordination payment for briefing by GPs or another team member.

11.2. State of implementation – national context

At the time of the final evaluation cycle, the DoHA indicated that the main achievements of the program at a national level included:

- All funding agreements had been signed by fundholder organisations (two each in NSW and Qld and one each in Tas, WA, SA, Vic and the NT) for the period 2009-2010 to 2012-2013.
- Service delivery had commenced across all jurisdictions by March 2011, with the Northern Territory implementing the program in a staged approach.

DoHA reported the following program refinements had been made in response to stakeholder consultation:

- Program guidelines, available on the ICDP website, had been enhanced during the period of the evaluation, following consultation with key stakeholders. For example, at November 2011 a change had been made to the guidelines to clarify the meaning of ‘local travel’.
- There had been changes to program reporting timeframes at request of fundholder organisations – for example a fundholder in SA requested changes owing to an expansion in several MSOAP programs, generating a larger workload and difficulty meeting reporting requirements within the required timeframe

¹⁴⁰ MSOAP - ICD 2009-2013 Guidelines, op cit.

11.3. Findings from Sentinel Sites

11.3.1. FUNDHOLDING AND EMERGING MODELS OF SERVICE PROVISION

KEY POINTS

- Fundholding arrangements were in place in participating Sentinel Sites by March 2011 and needs identification and service planning had been conducted.
- Effectiveness of planning processes in ensuring local needs were addressed was variable, partly owing to limitation of supply of relevant specialists and partly owing to limitations in consultation processes and fundholder responsiveness to local needs.
- Most eligible sites were accessing program funding by the final evaluation cycle, although implementation was at a fairly early stage. Reasons for non-participation included lack of capacity to manage the outreach services, perceptions that the services were not needed, uncertainty about eligibility, and perceptions of lack of availability of relevant specialists, regardless of funding availability.
- The AHS was the host organisation in the majority of Sentinel Sites.
- The most typical service delivery model was the 'outreach model' whereby service provision was provided to communities by health professionals travelling to locations from a larger town. There was confusion about what constitutes 'outreach', and there were inconsistent applications of funding guidelines with respect to the health professionals' regular place of work.
- Program set up and implementation were enabled by participants' prior experience with complementary programs, flexibility, and willingness to learn from experience.
- The extent of uptake and effectiveness of cultural awareness training was unclear. However, it was apparent that orientation to the AHS service environments was not optimal. There appeared to be a particular need for development of shared expectations and clearer delineation of roles and responsibilities of the health professional and the host organisation prior to commencement of service delivery.

Site participation

Service populations from 16 of the 24 Sentinel Sites were eligible to access the MSOAP-ICD services in accordance with the funding guidelines. By the final evaluation cycle, MSOAP-ICD activity was evident in program data from DoHA in 12 of the 16 eligible Sentinel Sites – 9 regional sites and three remote sites.

Four Sentinel Sites that were eligible for MSOAP-ICD funding were not participating or not intending to participate. Reasons for sites not participating in the program included:

- **Perception that MSOAP-ICD was not needed at the site, coupled with lack of organisational capacity to manage the service.** In one remote site, the DGP and the AHS agreed not to submit for MSOAP-ICD funding, as preparing applications and hosting health professionals was not a priority at the time. The AHS had minimal organisational capacity to manage any additional

services and there was a perception that time was not well spent preparing a funding application owing to limited supply of relevant specialists.

- **Confusion about eligibility of sites to participate and program intention from fundholders and at site level.** In two regional sites the AHS perceived themselves to not be eligible. In one site, the AHS indicated the fundholder had advised them that, being a regional site, they were not eligible for MSOAP-ICD. There was a perception this was only available for remote locations. The SBO for this site was unaware of the funding opportunities available through MSOAP-ICD. In another regional site the AHS was confused about the definition of outreach and thought they may have to access services locally (where there was already a shortage).
- **MSOAP-ICD funding was prioritised for use in areas not within the Sentinel Site boundary and access was gained to USOAP in site.** In one site MSOAP-ICD funds were secured by the DGP, but the services were placed in an area identified as a high priority outside the site boundaries. This site was also accessing USOAP funds.

Two of the 12 Sentinel Sites participating in MSOAP-ICD identified themselves as eligible to access both USOAP and MSOAP-ICD funding sources. At the time of the final evaluation cycle, one site had received both USOAP and MSOAP-ICD funding for different health professionals.

The MSOAP-ICD program was in fairly early stages of implementation during the evaluation period. Of the nine regional sites, six commenced services in 2010, two commenced in 2011 and the final site had just commenced developing services by the final evaluation visits. Three of the sites that had commenced service delivery in 2010 had expanded services each year, and the other three had remained static. Of the three remote sites, two commenced services in 2010 and one in 2011. All remote sites had expanded services since commencement.

There was evidence that changes were made in the types of services provided through MSOAP-ICD in response to changes in the service delivery environment, and as understanding of what was required developed. For example in one regional site, an MSOAP-ICD service was discontinued because a local service started up, and in others some services were discontinued because it was deemed that there was no need for them, or because of difficulty recruiting specialists. This suggests that retaining flexibility in the models is important, and that needs assessments may not get it right first time, or may become out-dated.

In the majority of Sentinel Sites, an AHS in the site was the host organisation for MSOAP-ICD. This may not be typical of the rest of Australia where other organisations, such as the DGP or Medicare Local, may host MSOAP-ICD services. The predominance of the AHS as the host organisation in the Sentinel Sites probably reflects the way the sites were selected, with one of the criteria for selection being the existence of an AHS in the site. In one of the Sentinel Sites, although the AHS was the host organisation, the DGP in the area was an intermediary organisation. This DGP had prior experience with managing MSOAP funding. During the period of evaluation, alternative hosting arrangements were made for two of the MSOAP-ICD specialists in this area due to limited capacity at the AHS to host the specialist services. This is described further in Section 11.3.4.

Programs that may compliment or conflict with MSOAP-ICD

A number of existing programs that were not part of the ICDP were identified by interviewees as having a potentially positive impact on the implementation of the MSOAP-ICD at site level:

- MSOAP funding was viewed by fundholders as a complementary program that enabled relatively rapid implementation of MSOAP-ICD because it provided previous experience of contract

negotiations with health professionals and host organisations. Thirteen of the 16 sites eligible for MSOAP-ICD had existing MSOAP funding. Of the 12 Sentinel Sites with MSOAP-ICD funding, 11 had both MSOAP and MSOAP-ICD funding. In a small number of sites MSOAP funded providers used MSOAP-ICD to expand their existing service through spending additional time at the service location.

'The Cardiologist and the Respiratory Physician were already visiting [regional centre] under MSOAP. They both expanded their service by one day, to do a day in [AHS]. This was a good recruitment model. It is cost effective and also means that we don't have to convince them to come for another trip or convince someone else to come for another trip. The DGP is well placed as it is already working with existing specialist outreach such as MSOAP and can lever off these specialists.' (Workforce Agency)

- Indigenous Specialist Outreach Assistance Program (ISOAP) is an outreach program funded by the Office for Aboriginal and Torres Strait Islander Health to increase medical specialist outreach to rural Aboriginal communities in NSW. The NSW fundholder viewed ISOAP as being complementary to MSOAP-ICD. The program had provided experience with contract negotiations, collaboration between AHSs and the workforce agency, and implementation of services in Aboriginal communities.
- The More Allied Health Services (MAHS) funding scheme, established in 2001 to increase access to allied health services for Health Services in rural areas, was believed by some fundholders to be a starting point for DGPs to become involved in contracting allied health professionals and managing these contracts and health professionals. There was only one instance identified in the SSE in which the DGP was involved as the MSOAP-ICD fundholder or intermediary organisation, but this may have been different in the rest of Australia.
- Rural Primary Health Care (RPHC) funding was established to consolidate four previously separate primary and allied health programs into the RPHC program (one being the MAHS program described above). The RPHC program was born out of a review by DoHA that indicated that many rural health programs were trying to achieve the same or similar outcomes through different strategies. It was determined that consolidation of the funding streams would enable better service coordination and responsiveness and improve access to the services identified as priorities for communities. Interviewees indicated that though the RPHC funding was perceived to be complimentary to the MSOAP-ICD funding, there had been no coordination between the two funding streams.

Effectiveness of collaborative needs assessment

The MSOAP-ICD guidelines envisaged that fundholders and local service organisations work collaboratively to assess needs, plan and develop proposals for health professionals. Proposals were funded under MSOAP-ICD at a site level with recruitment based on local needs identified during the collaborative processes.

Perceptions regarding the comprehensiveness and effectiveness of planning processes differed at local level. From the perspective of the fundholders, planning processes had been extensive and collaborative. However, informants from a number of the host organisations and other local service providers, reported mixed views. In some cases, it was felt that there had had been inadequate consultation during the needs assessment process, with little discussion between the DGP and AHSs and in some cases, clinicians based at the AHS felt that they had not been consulted.

In some sites, interviewees reported that services provided were not well related to the needs identified during planning processes (and at times questioned the planning process). Sometimes the disjuncture between planning and recruitment appeared to be due to the lack of available health professionals in the required areas. This was particularly a problem in remote sites.

'Not sure if the current service delivery model meets the needs of the local area. It is more the tail wagging the dog at the moment. The recruitment of specialists and allied health providers is based on who is available.' (NACCHO affiliate)

'We get specialists we're given, not those we need.' (AHS, GP)

The extent to which the recruitment strategies used were able to take into account needs identified through consultation with the primary health care services was a cause of concern for some sites. This concern was particular in one state where the fundholder was reported to be identifying eligible providers first based on their availability, then arranging for them to go to sites.

'Service providers decide based on commercial interests and community needs are not prioritised. It's pretty obvious if external service providers are deciding where and when to provide service what does that say about needs based assessment.' (AHS, program manager)

Some interviewees suggested that ideological or political imperatives were getting in the way of appointments based on need and availability.

'We know exactly what the holes are but we don't get asked we are just employees. Management has been going up and down over the years. [there is a] lack of stability. The way funds are spent should be based on clinical needs rather than ideological needs.' (AHS, GP)

'It is a 'grab what you can get' model. We would like to see a more negotiated model, which ... encourages ... a coordinated and consultative process ... a strategic approach where they can look at gaps and seek funding for those.' (AHS, program manager)

Less than one half of interviewees in the final evaluation cycle agreed with the statement that *'arrangements for the outreach team under MSOAP-ICD meet the needs of local Aboriginal and Torres Strait Islander people'* (Table 11.1). This was similar to the proportion who agreed with this statement in the third evaluation cycle. It differed from trends in the percent holding positive attitudes with respect to other statements about the MSOAP-ICD, which tended to show a steady increase over time. Although the numbers of interviewees are small, it suggests that the program was not considered to be optimally effective in meeting local needs. Possible reasons for this are identified at various points in this chapter, and synthesised in Section 1.3.6 under the headings *'practical and workable program design'* and *'coordinated provision of services to meet local needs'*.

Table 11.1: Trends in perceptions of MSOAP-ICD service (% who responded ‘strongly agree’ or ‘partly agree’), overall

Evaluation cycle	Three	Four	Five
Arrangements for the outreach team under MSOAP-ICD meet the needs of local Aboriginal and Torres Strait Islanders. MS, CS, MP ^a	50% (n=24)	69% (n=26)	44% (n=16)
The referral process between local health service providers and the outreach team is well established and functions well. MS, CS, MP ^a	39% (n=23)	62% (n=26)	86% (n=14)
There is good coordination of care for patients between service providers and MSOAP ICD outreach team. MS, CS, MP ^a	42% (n=24)	65% (n=26)	86% (n=14)
There is good communication of relevant patient information internally within the outreach team. MS, MP ^a	28% (n=18)	40% (n=15)	67% (n=9)
There is good communication of relevant patient information between local health service providers and the MSOAP-ICD outreach team. CS, MP ^a	67% (n=9)	50% (n=14)	88% (n=8)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded. Included in the denominator are the respondents who indicated ‘don’t know/can’t say’.

Perceptions of outreach

The MSOAP-ICD guidelines indicated that a range of flexible service delivery models could be used under this initiative to meet the aims of the MSOAP-ICD. The model preferred by DoHA was an ‘outreach model’ in which services were to be provided to host organisations by health professionals travelling to these locations from a larger town. This was the predominant service delivery model in the Sentinel Sites. Other possible models, were ‘hub and spoke models’, whereby service provision was to be provided both in a central town and the health professional travels to communities, and ‘cluster models’, whereby health professionals were located in different communities within a region and provide services to other communities within the cluster or region.

The definition of ‘outreach’ provided by DoHA in the program guidelines appeared to be interpreted differently in different contexts. For example, in some sites, interviewees reported that where health professionals were already working or living in the local area, the workforce agency had considered that their services would not be eligible to be funded through MSOAP-ICD.

‘If the person was flying in and out of Perth they would be funded but as they are based here they are not funded. This makes no sense as this person is the leader in their field to deliver this service. If the person was travelling up here every three weeks, and look at the money, look at a thirty odd thousand they would approve, but there is not anyone else based elsewhere that could do job, they are based here so the submission got knocked back.’ (AHS, CEO)

Similar situations of local providers being precluded from participation were noted in at least three sites. As indicated by the quotation above, these situations led to some frustration at site level, and a perception that the fundholder was not respecting the intent of the program. In contrast, in a number

of sites health professionals already based and delivering services at the site were funded through MSOAP-ICD to expand service delivery, or to deliver new services to the AHS.

Cultural awareness and orientation

Reports provided to DoHA from fundholders indicated that cultural awareness training and orientation were conducted in accordance with the guidelines. Since the SSE often did not interview MSOAP-ICD health professionals directly, we were unable to verify this, or explore perceptions of the training in any detail. Some AHS-based interviewees felt that from their perspective, this aspect of the program required strengthening. They felt that health professionals were not being adequately orientated to the service environment, and there needed to be greater attention paid to establishing shared expectations, and defining roles and responsibilities of health professionals and the host organisation.

Chapter 10 outlines findings from the Sentinel Sites in relation to cultural awareness training for USOAP providers. The issues identified were much the same as for MSOAP-ICD, and are not repeated here.

11.3.2. RECRUITMENT AND ENGAGEMENT OF HEALTH PROFESSIONALS

KEY POINTS

- Recruitment of health professionals to the MSOAP-ICD program was initially slow, but increased over the evaluation period.
- Health professionals had commenced service delivery in half of the eligible sites by June 2011 (8/16), and in the majority of eligible sites by June 2012 (12/16), with between 1 and 10 types of services provided per site.
- Different approaches to recruitment included:
 - Attracting ‘new’ health professionals to work in outreach – through advertisement and promotional material highlighting the rewards of outreach work; and
 - Transferring or extending contracts of health professionals already engaged in other outreach programs, to the MSOAP-ICD.
- Some recruitment strategies put in place by workforce agencies were perceived by AHS interviewees to be overly driven by the availability and interest of health professionals, and were not necessarily responsive to local needs for service delivery.
- A broad range of health professionals provided services through MSOAP-ICD, including four types of medical specialists and fifteen types of allied health professionals across the Sentinel Sites.
- Sites participating in MSOAP-ICD were funded for between one and ten different types of health professionals per site.
- No psychiatry or ophthalmology services were funded under MSOAP-ICD in the Sentinel Sites during the evaluation period; this may be due to lack of success in recruiting these specialist types, or to needs for these services being met from other sources.
- There was wide variation in number of service visits per health professional, and in numbers of patients seen per visit. Inconsistency in reporting between providers and sites complicated the interpretation of the data.

Recruitment strategies

In the first two evaluation cycles, stakeholders across all sites expressed concern that the limited number of available specialists and allied health professionals would potentially hinder recruitment to MSOAP-ICD teams. The concern was not raised as consistently in the subsequent evaluation cycles, which may indicate that marketing campaigns and recruitment strategies developed by the fundholder organisations had been successful in identifying and attracting appropriate health professionals. Strategies employed by fundholders to recruit health professionals included:

- Targeted mail-out to specialists listed on a data base held by the rural workforce agency.
- Advertisements in the e-bulletins of relevant professional groups and hospitals, and in newsletters.
- Good news stories about remote and outreach work in marketing materials.

Strategies used in specific sites to overcome recruitment challenges for MSOAP-ICD, which were identified through interviews, included:

- Focusing the marketing materials to be about the specific outreach location, with interested health professionals contacting the host organisation directly.
- Working together with stakeholders to identify specialists providing services to an existing outreach program, and negotiating with the specialists to provide additional services when visiting the region.
- Negotiating with the tertiary hospital department to roster specialists or registrars to a number of sites. It was recognised that while this approach did not necessarily provide patients with the same specialist, it at least provided a consistent specialist service overall, and this was valued.
- Transferring funding for specialists who were funded under other programs (e.g. USOAP) to work with MSOAP-ICD.

It appeared that recruitment strategies were not always successful in taking into account needs identified through consultation with the primary health care services - as discussed earlier in relation to needs assessment.

Types of services provided

Across the eligible Sentinel Sites, a range of specialist and allied health services were funded through MSOAP-ICD, with the number and type of specialists funded increasing over the evaluation period.

Between July 2010 and June 2012, there had been four types of medical specialists and 15 types of allied health professionals funded through the program in the Sentinel Sites. Table 11.2 shows the range of health professionals who provided services, and the number of sites in which each service type was provided during this period. None of the health professional types were funded in all of the Sentinel Sites, and many were funded in only 1 or 2 sites.

As shown in the Table 11.2, seven of the 12 participating Sentinel Sites had diabetes educator services funded through MSOAP-ICD, five to six sites had respiratory physicians, podiatrists, dietitians and/or AHWs funded. Health professionals that were funded in comparatively fewer of the Sentinel Sites included rehabilitation specialist physicians and prosthetists, cardiac and asthma educators, occupational therapists, sonographers, cancer health promotion workers, sleep scientists,

physiotherapists, registered nurses and GPs. Each of these types of health professionals was funded in one or two of the sites.

There were no psychiatry or ophthalmology services funded through MSOAP-ICD in the Sentinel Sites. This contrasts with the USOAP, where psychiatry was one of the most commonly funded speciality types and ophthalmology was a sought after specialty with apparent difficulty with recruitment (Chapter 10). Reasons for this contrast between MSOAP-ICD and USOAP were not clear, but may relate to funding of these specialist types through other programs, such as MSOAP, or shortages in supply of these specialists. Also in contrast to USOAP, there was no evidence of General Physicians being funded through MSOAP-ICD in the Sentinel Sites - although there were reports from some of the sites that plans were being made to contract General Physicians. Other planned uses of the MSOAP-ICD funding included for psychologists, pulmonary rehabilitation nurses, and administrative and coordination functions. These data suggest that at a local level, different members of the team may be funded through different programs. This has implications for coordination, needs assessment and reporting.

There were between 1 and 10 different types of health professionals funded under MSOAP-ICD per site during the period July 2011 to June 2012. For the majority of sites, the MSOAP-ICD funded health professionals are not being deployed in teams as originally envisaged. Data on numbers of visits by health professionals and number of patient attendances per visit are provided in Section 11.3.3.

These data were derived from routine program reports to DoHA and supplemented by case study and enhanced tracking site visits. Similar to what has been reported for USOAP in Chapter 10, some discrepancies were noted in the different data sources in relation to information on specialty types and locations, and some data were incomplete. Findings from the Sentinel Sites in relation to program monitoring and reporting are summarised in Section 11.3.5.

Table 11.2: Number of Sentinel Sites in which various types of health professionals were funded through MSOAP-ICD from 1 July 2010 - 30 June 2012

Health Professional	Regional (n=9)	Remote (n=3)	Total (n=12)
Medical specialists			
Physician - Respiratory	6	0	6
Physician - Endocrinology	3	1	4
Physician - Cardiology	2	1	3
Physician - Rehabilitation	0	1	1
Allied Health Services			
Diabetes educator	5	2	7
Podiatrist/Orthoptist	4	2	6
Aboriginal Health Worker	4	1	5
Dietitian/Nutritionist	5	0	5
Exercise Physiologist	2	1	3
Nurse specialists	3	0	3
Asthma Educator	2	0	2
Cardiac Educator	0	2	2
Registered Nurse	1	1	2
Rehabilitation -Prosthetics	0	1	1
Occupational Therapist	1	0	1
Sonographer	0	1	1
Cancer Health Promotion worker	1	0	1
Sleep Scientist	1	0	1
Physiotherapist	1	0	1
GP Services			
GP	0	1	1

Note: These data show the types of health professionals funded in Sentinel Sites.

Where a service type was provided in more than one location within a site, this is counted only once. For example there were seven AHW service locations provided across five Sentinel Sites. The latter is recorded.

Some services had been planned but not commenced. These are not included in the table. Such services include other types of health professionals: Psychologist, Pulmonary Rehabilitation Nurse, General Physician and administration and coordination functions for example.

Source: DoHA, MSOAP-ICD services in Sentinel Sites for periods 1 July 2010 to 30 June 2011 and 1 July 2011 to 30 June 2012.

Factors influencing availability and retention of health professionals

In general, Health Services in regional and remote Sentinel Sites had substantially more prior experience with outreach services than those in urban areas, and this was reflected in interviewees views of the main influences on availability and retention of health professionals in relation to MSOAP-ICD compared to USOAP. For example, there were no questions raised about the need for an outreach model of service delivery. However, as noted earlier, there were some inconsistencies across the program in relation to determining if a health professional living or already providing services in an area was eligible to provide services through MSOAP-ICD. There were no concerns about lack of access to equipment in host organisations as a factor limiting participation by health professionals, possibly because host organisations were familiar with this problem already, or had found ways to manage it.

However, similar to what was reported for USOAP, there were concerns raised in relation to the administrative requirements of the program as a barrier to participation. Interviewees noted issues regarding the complexity of claiming for reimbursables. One fundholder indicated that invoicing challenges result from the requirement that health professionals have to detail many categories when claiming funds. For example, a health professional is required to invoice for breakfast allowance, lunch allowance, travel allowance, and so on, as individual items. The fundholder identified this requirement as a barrier to engagement of health professionals in the program and was intending to simplify this process.

'...[there are] too many categories for what can be funded and some could be 'rolled up' [so we are] looking at more of a package type deal rather than individualised claims. The suggestion is to make a flat rate for these things. It is fairly complicated and, for people who are already busy, it takes them quite a while to understand [what's required].' (Workforce Agency, interviewee)

In a remote context, a fundholder indicated that patients not having Medicare cards had been a barrier to billing Medicare for the health professionals deployed as part of the MSOAP-ICD.

'We get told that the allied health provider can just use Medicare, but the majority of Indigenous patients don't have access to Medicare as they don't take up that service of follow-up from a health assessment, or commonly don't have a Medicare card. The ones that do ... may have three or four Medicare cards.' (Workforce Agency, interviewee)

This comment indicated a lack of awareness of the MSOAP-ICD guidelines by this fundholder, or difficulty in applying the guidelines, which provided for additional funding for 'workforce support' for areas where billing Medicare presented a challenge. It was apparent from the Sentinel Sites that some regional and remote host organisations did not have the administrative capacity to determine eligibility requirements for this category of funding, and claim for it. Fundholders were not always able to assist with this.

In some of the Sentinel Sites, Supplementary Services funding was used to bring allied health and specialist services to the site. Local interviewees expressed concerns that this would lead to a distortion in fees charged by health professionals and less willingness to work with MSOAP-ICD as they were fully funded rather than having to generate Medicare income.

'I am worried that with all this money around for specialist services [through CCSS] that what will happen is our existing specialist services through MSOAP or other specialists will up their fees.' (AHS, interviewee)

There were no reports during the evaluation period that fee distortions had influenced supply in this site or in other sites. However, implementation was at a fairly early stage and this may become an issue in the future.

11.3.3. REFERRALS AND PATIENT ATTENDANCE

KEY POINTS

- MSOAP-ICD was perceived to result in improved patient access to widely needed types of specialists in some sites and in relation to some specialities, including endocrinology.
- There were few referrals to MSOAP-ICD services from General Practice. Explanatory factors included: low awareness of available MSOAP-ICD service in General Practice and DGPs; and a perception that referrals from General Practice were not accepted.
- By the final evaluation cycle, DGP-based IHPOs in two regional sites had commenced initiatives to increase referrals from General Practice. In one site, a diabetes educator took responsibility for coordinating MSOAP-ICD services, including eliciting involvement from General Practice.
- Referrals from the AHS sector were limited by reluctance of GPs to change established practice, and by remaining funding gaps, which were a disincentive to refer to MSOAP-ICD health professionals.
- Factors influencing patient attendance at MSOAP-ICD services included:
 - Availability of human resources for coordination at the host organisation and physical space to accommodate service providers as teams
 - Support for patients to attend on the required days, including recall and reminder systems, clinic management, and transport arrangements
 - Funding gaps for procedures and investigations, and the waiting times and costs involved in transport and accommodation if referred to larger centres for these services
 - External events which affected entire communities, such as funerals and severe weather events, and that sometimes resulted in scheduled clinics having no patients.
- There were indications that program data had under-recorded service delivery in some sites, and over-recorded service delivery in others.

Referrals from the General Practice sector

There were few instances identified in the Sentinel Sites of General Practice referring to the MSOAP-ICD. Most referrals, particularly in the earlier evaluation cycles, came from within AHSs. The lack of referrals from General Practice in the early period may reflect perceptions in some sites that the service was only for regular patients of the AHS. In most sites throughout the period of evaluation, GPs and DGPs showed limited awareness of the program and its intent. GPs in both AHSs and in General Practice also reported reluctance to change established referral practices, particularly where these were believed to be satisfactory.

In the third evaluation cycle, the inability of General Practice to refer to the MSOAP-ICD service had been recognised as an issue by stakeholders in at least two of the regional Sentinel Sites. By the final

evaluation cycle, both of these sites had made progress towards ensuring that General Practices were able to refer patients to the MSOAP-ICD. This was achieved in part through the IHPOs based in the DGPs working with the fundholder and the AHS to address this issue. In one of these sites, there was evidence that General Practice were referring to the MSOAP-ICD program by the time of the final evaluation visit. In this site, key to the involvement of General Practice in this site, was the coordination role played by a diabetes educator, who scheduled specialist appointments for referrals from both sectors, was physically located at the General Practice each month to run a diabetes clinic in the practice, and provided a liaison and feedback role between the GPs and specialist. For most other sites, referrals from General Practice remained low or were non-existent.

Referrals from the Aboriginal Health Service sector

Although most patient referrals to the MSOAP-ICD services in the Sentinel Sites originated from the AHSs, in general there were also fairly low numbers of referrals to MSOAP-ICD services from within AHSs. Despite this there was high agreement with the statement that the referral process was well established with 12/14 interviewees strongly or partly agreeing in the final evaluation cycle (Table 11.1). There appears to be an increasing trend over time in agreement with this statement, though it must be interpreted with some caution due to small numbers.

Some GPs based in host organisations described feeling compelled to refer to the MSOAP-ICD specialist in order to keep the service operating. These GPs also described having satisfactory arrangements in place that predated MSOAP-ICD, which suggested that the service was not being supplied in accordance with needs assessments, or that the needs assessment was not attuned to local needs.

'Specialists funded under MSOAP-ICD are locked in but I don't want to refer them - but then you refer to them only to keep the funding – there is limited value and no point to get service that needs surgical follow-up but it is consult only. There is nowhere for the specialists to operate even if they wanted to. It then becomes up to the GPs and it is billed as our responsibility to keep the program going by ensuring referrals. We actually need organisational support to make it run.' (AHS, GP)

Also illustrated by the quotation above, is the important need for greater attention to system-wide and organisational support in order for the program to work effectively. For this interviewee, the kinds of support required included funding for surgical follow-up and facilities and equipment to deliver the full scope of care.

Patient attendance and perceptions of MSOAP-ICD

There was a wide range in the number of patient attendances per health professional visit, and a wide range in number of visits by health professionals per annum. In the period July 2011 to June 2012, there were 72 operational MSOAP-ICD services across the Sentinel Sites and, of these, around 70% (51/72) reported an average of 10 or fewer patients attending per health professional visit.

For the period July 2011 to June 2012, the frequency of visits to the host organisation varied with some health professionals visiting only once or twice in this period (14/72) and the most frequent visiting weekly or more often. Around a quarter of the services (19/72) visited monthly or more frequently during this period.

There was wide variation in patient attendance between the different sites - sites reported between 0 and 183 patients seen by health professionals per year during the period July 2011 to June 2012. Some of the wide variation in patient numbers may have been due to different criteria applied in reporting of

services in different sites, and by different health professionals. For example, in one remote location a diabetes educator and an exercise physiologist reportedly saw 970 and 1,475 patients for the year. This equated to an average of 35 and 97 people per visit in a community that has a population of around 500-600 people. Discussions with DoHA in relation to this site revealed that these numbers reflected the number of patient attendances, including repeat attendances by the same patients, whereas for some of the other sites, numbers of patients rather than numbers of visits were recorded. Where outliers were known to be related to differences in reporting, they have been excluded from averages and ranges presented in this chapter.

Some of the services appeared to have difficulties producing accurate reports. Six of the MSOAP-ICD services recorded zero patients attending for the services, across all visits. Two of those services were in the early stages of commencing, and it was possible that no patients were seen by these services. However, the other four services were hosted by four separate AHSs across two of the Sentinel Sites. During the same period these host organisations reported large numbers of visits to AHWs but no patients recorded for these other services for this period. This appeared to reflect recording and reporting difficulties.

Overall, it was difficult to make an assessment of patient attendance based on program data. Interview data suggested that patient attendance following referrals was not optimal. Barriers to patient attendance that were identified in the Sentinel Sites are outlined below.

Factors influencing patient attendance

For several AHSs, physical space constraints resulted in providers attending on different days rather than as a team. This meant that patients required multiple visits to the clinic in order to consult with the different team members. Patients were sometimes unable to manage multiple visits, or were unmotivated to do so, and this was identified as a contributor to lower patient attendance for some services. Related to this, were difficulties faced by patients in accessing transport to health care. In regard to transport, community focus group members in regional sites highlighted that transport to attend services (in general, not MSOAP-ICD specific) was difficult to obtain, and posed a significant cost barrier. Although the provision of the outreach service in the AHS removed some of the need for transport – since patients did not have to travel as far for the consultation – travelling to the AHS was still a significant journey for some patients. In several sites the OWs based in AHSs were reported to play a pivotal role in facilitating patient access to MSOAP-ICD appointments, assisting with transport and in coordination of service provider visits and patients more generally. This did not happen in all sites, and was influenced by the extent to which OWs received adequate support and management in time poor environments. For patients who were enrolled in the care coordination program, the Supplementary Services funding was sometimes accessed to assist with transport costs. However this was not available to all patients.

For referring GPs, and for patients, a lack of funding for specialist procedures and investigations was noted to be a disincentive for referral and attendance at MSOAP-ICD. From the GP perspective, several GPs noted that they did not want to start the patient on a journey that they could not complete – they were concerned the patient would be unable to access follow-up care that would be required. From the patient perspective, referrals for follow-up that involved investigations or procedures ordered by specialists, were believed to involve high costs and long wait times and for regional and remote patients, often involved travel to a larger centre. Community focus group members reported that where AHSs assisted with transport, this was valued. In many cases, community members felt they needed to be accompanied or guided by a family member when accessing care in larger centres, and

were concerned that associated additional transport and accommodation costs could not be met through available resources.

11.3.4. COORDINATED AND TEAM BASED APPROACHES

KEY POINTS

- Owing to physical space constraints, poor development of clinical information systems, and systems for recall and reminders, host organisations in general struggled with capacity to manage coordination requirements.
- Host organisations needed to: ensure adequate physical space was available; manage patient bookings; facilitate patient attendance including transport; and facilitate communication about patient care between health professionals, and with other members of the primary health care team.
- Coordination needed to take into account visiting service providers from different outreach and service delivery programs, other than MSOAP-ICD.
- Designating the coordination function to a specific individual in the host organisation was a key success factor across a number of sites. Elements of successful approaches included the ability of the individual to work across programs, not just MSOAP-ICD, and their ability to act as a conduit between the GPs and health professionals for relevant clinical information.
- Funding to support coordination was accessed not often owing to lack of staff to provide the coordination function, and lack of administrative capacity to invoice for the function. In one site, with the support of the DGP intermediary organisation, this funding was accessed to back fill time for an AHW to accompany patients to MSOAP-ICD specialists who had arranged to provide care in private rooms.
- There were no examples identified of building the capacity of host organisations to better manage coordination. Some fundholders were reportedly exploring alternate models to support coordination, but their sustainability and the extent to which they were building on existing networks and relationships was unclear.
- Good communication and sharing of information about care requirements was enabled where MSOAP-ICD health professionals were provided access to host organisation clinical information systems, and used the system appropriately. Not all health professionals were granted access to these systems and some were unwilling or lacked capacity to use them.

The lack of effective coordination of service providers at site level was consistently identified by interviewees as a barrier to more effective local use of MSOAP-ICD funded services. Despite this interviewees commonly agreed that there is good coordination of care between local service providers and MSOAP-ICD health professionals, with 12/14 interviewees strongly or partly agreeing in the final evaluation cycle (Table 11.1). There appears to be an increasing trend over time in agreement with this statement, though it must be interpreted with some caution due to small numbers.

The multidisciplinary approach of this initiative requires coordination of service providers, and coordination or case management of individuals to ensure they receive the scope of care. These two aspects of coordination are inter-related, and are included in the discussion below.

Role of the host organisation

From the host organisation perspective, interviewees highlighted that the MSOAP-ICD outreach services were just one amongst a number of outreach services potentially visiting the host organisation, and therefore coordination by the host organisation, rather than coordination at a more central level, was critical.

Host organisation roles that were identified in the Sentinel Sites in relation to coordination and team-based approaches for MSOAP-ICD, included: ensuring adequate physical space was available, facilitating patient attendance, and facilitating communication about patient care between specialists and other members of the primary health care team.

In one site, the AHS hosting the MSOAP-ICD service was struggling with coordination needs of diverse specialists. With the assistance of the DGP, the AHS was able to set up two of the MSOAP-ICD specialists to provide services from private rooms, alleviating the coordination burden. The way in which this worked at this site is outlined in the Vignette below.

Vignette – problem solving approaches to lack of capacity for coordination of health professionals in a regional site

In one regional site, an AHS host organisation receives MSOAP-ICD services from a cardiologist, a respiratory physician, and an endocrinologist. Patients were not using the services optimally, and the AHS was struggling to ensure that physical space and coordination needs were met for the service. GPs reported already having established referral patterns which they were reluctant to change, and a number of GPs were sessional, and were not always aware of the service, which was provided as monthly clinics. Specialists felt that the value of their time was not appreciated - with one instance of a specialist being locked out of the AHS, with a booked appointment for 8.30am, and someone arriving to open the building only at 8.45am.

The DGP, who is an intermediary organisation in this site, has assisted with setting up a consulting model whereby the service providers can work from private rooms. The AHS manages patient appointments, and assists with transport. An AHW from the AHS accompanies the patients to the rooms, and their time is refunded through the MSOAP-ICD session coordination funding. Although one of the providers continues to work from the AHS, the other two use the private rooms. Patients and the AHS are happy with the new arrangement. Remaining challenges include developing systems that will allow effective team-based approaches to care, since the providers are unable to link up as a team, and there is no face-to-face contact with referring GPs.

Designating the coordination function to a specific individual in the host organisation was a key success factor across a number of sites. For example, in two sites where the MSOAP-ICD services were being used to fund a range of services for diabetes patients, different people were initially 'coordinating the visits' for the different visiting services. When this was identified as an issue and rectified, the potential of the diabetes clinics was realised more effectively.

In some sites, host organisations were using Outreach Workers funded at the AHS to coordinate all visiting specialists. In one site, the OW compiled patient lists and conducted follow-up and this role was viewed as vital to the success of the specialist outreach service in this site.

In another site, the coordination role was taken on by a diabetes educator and her local diabetes education team (who were state funded).

‘Communication and coordination between the practice and the endocrinologist has been excellent. This has been due to the effective facilitation by the Diabetes Educator who schedules the appointments in consultation with the GP practices and [name of AHS]. She makes sure to make phone calls and sending letters to patients to remind them of the appointment on specific intervals. Diabetes Educator also come and sits at the [name of General Practice] to run diabetes clinic once a month. She also brings back feedback to the GPs from the specialists which are helpful.’ (General Practice, GP)

Also evident in this quotation, is the involvement of both AHS and General Practice in the MSOAP-ICD program in this site, and the pivotal role of strong coordination in achieving this involvement. As indicated in section 11.3.3, it was generally uncommon in the Sentinel Sites for General Practice to refer to the MSOAP-ICD.

Whilst the MSOAP-ICD program provides funding for backfilling of staff, or for session based payments to support coordination by the host organisation, there were few host organisations accessing this funding.

‘This is not working, as you are trying to back fill already busy people. They may take the [sessional coordination] money but ... Health Services are generally just too busy and don’t have the extra capacity ... We are pulling on stretched staff already – there are no extra people ... The sessional rate is well intended but not working and problematic.’ (Workforce Agency, interviewee)

Two factors were identified as influencing the ability of host organisations to take up the program funding available for coordination. These were lack of staff to provide the coordination service, and limited capacity to invoice for the coordination service.

In some cases where host organisations struggled with capacity for coordination, fundholders took on a more active role. However as shown below, this was not always successful. There were no good examples of building the capacity of host organisations for coordination of service providers and patients identified in the Sentinel Sites. In many instances, the systems to support coordination functions at the host organisations, such as clinical information systems, and systems for patient recall and reminders, were not well developed (Appendix E).

Clinical information systems

Consistent use of clinical information systems in the host organisations was an important influence on the extent to which coordination and team based approaches were successful. In the final evaluation cycle seven of the eight interviewees strongly or partly agreed that there was good communication of relevant patient information (Table 11.1). There were some examples identified of host organisations and MSOAP-ICD health professionals working together on the same clinical information system, with the health professionals having access and using the system at the AHS.

‘We receive letters from the specialists, the endocrinologist writes into Communicare and provides letters, we receive these about two weeks after service.’ (AHS, GP)

Where this happened, this was noted to facilitate good communication and sharing of information about care requirements.

Where health professionals were not using the AHS clinical information system, this was sometimes due to the host organisation having not provided the health professional with access to the system. In

other cases, the health professional had been granted access but was unfamiliar with the system or was unwilling to use it. From the perspective of the Health Services/host organisations inconsistent use of information systems resulted in delays in feedback (which compromised quality of care) and poor flow of information between the relevant service providers.

'One specialist who comes and works at [AHS] is not good at using Communicare which is difficult. The Diabetes Educator and dietitian are good at using Communicare so they can look at it and figure out what's going on. If good at the information system the patients' notes can be shared easily and the specialists can address those issues.' (AHS, GP)

'We use Communicare so if they use that there is potential for good communication. But if they don't enter information into Communicare it's at least a week before they send a letter back to us and more if you factor in administration time, so there are delays in finding out what the patients need.' (AHS, GP)

Role of the fundholder

Fundholders took on varying roles in relation to coordination, including coordination of visits by health professionals, and in one case, coordination of patient lists.

Most commonly, health professionals funded under MSOAP-ICD visited host organisations as individual providers. Although there were some examples in the Sentinel Sites of visits by teams of service providers, this was not always feasible. Interviewees from workforce agencies indicated that even where host organisations were able to accommodate a team, ensuring that outreach teams come together and travel on the same day was difficult.

'Trying to get service providers together is like aligning stars to visit at the same time. Generally, if there is a team of four [we are] only ever able to get three out of four to visit together to the region.' (Workforce Agency, interviewee)

In relation to remote sites specifically, other fundholders reported that they had committed to ensuring that remote health centre facilities and staff would not be overwhelmed by concurrent visits by services.

'One of commitments we gave to clinics was that we would do everything in our power to minimise multiple [health professional] presentations at a clinic. As the workforce agency we try to coordinate visits so this does not occur – unless it makes sense that they go together.' (Workforce Agency, interviewee)

The challenges of physical space constraints were amplified in remote sites, but were still evident to some extent in regional sites.

One fundholder had established their own coordination unit to assist with coordination of MSOAP-ICD services. The fundholder reported they hoped in this way to lessen the administrative burden on the host organisations.

'Often they don't want to be bothered doing the invoices. This is why we have set up a coordinated administration unit so we can actually take control of that as much as possible.' (Workforce Agency, interviewee)

The work of this unit was described positively by the fundholder as fulfilling the following functions:

- planning visits to avoid multiple concurrent visits by different service providers to the same site, unless there was capacity to accommodate them
- saving costs on charter flights through people travelling together, balancing cost savings with the need to ensure adequate infrastructure and staff to support visiting teams
- coordinating appointment lists and sending these to the host organisation.

Interviewees noted that, from the host organisation perspective, the model did not work effectively. They described how they were not given sufficient lead time to plan for hosting the services, with teams arriving at short notice. They also felt uninformed about what support was going to be required on the ground, and therefore did not know how to prepare for visits. Host organisations also in general would not have information about other visiting specialists, and would be unable to easily factor these in to planning. Effective coordination clearly required a collaborative approach between the fundholder and the host organisation.

In some instances, arranging visits was left to the service provider, who contacted the host organisation directly to make a mutually convenient time. The success of this approach depended on the sensitivity of the health professional, and the assertiveness and administrative capacity of the host organisation. For example, in one remote site, the host organisation described how an allied health professional had contacted the service directly, indicating that they had received funding and would be doing a fly-in-fly-out visit of approximately four hours the following week. From the host organisations perspective, this did not allow adequate time for the service to facilitate attendance by those patients who needed the service, but they felt they needed to ‘grab what they could get’, and so agreed to the visit.

Another fundholder reported that they had commenced discussions with DoHA regarding developing new models to support coordination of MSOAP-ICD teams. One proposed solution was a tiered model of regional coordination for remote areas, with a coordinator position in a regional service centre and ‘sub-coordinators’ in small communities. The model would involve having communities support community members to get to appointments.

‘There has been a lot of development of models as this won’t necessarily be a one size fits all approach. Having a coordinator won’t completely fix the problem of people not turning up but will come to improving a solution. Each location works differently.’ (Workforce Agency, interviewee)

It was unclear how this proposed model would differ from what host organisations already do in relation to supporting community members to get to appointments, for example, through the work of OWs and existing staff. There were no systematic approaches identified in the Sentinel Sites to strengthen existing systems within AHSs to improve coordination, including MSOAP-ICD teams and other outreach services. It may be that some local approaches and models have been developed, for example, by regional support organisations, but if these have emerged, they do not appear to be clearly documented or disseminated.

In general, as illustrated in the Vignette below, the multiple funding sources and programs involved makes it challenging to deliver coordinated care for patients at local level.

Vignette – Lack of coordination and awareness of services provided through MSOAP-ICD

Site X is a remote site in which Rural Primary Health Care funding, held by the AHS, is being used to fund podiatry, dietitian, occupational therapy, physiotherapy, diabetes education and nutrition services. MSOAP-ICD services funding is held by a jurisdiction-wide specialist outreach service. The two funding sources are regarded as complementary, but do not appear to be coordinated.

A relevant manager in the AHS was, until very recently, not aware of the scope of services available, nor the MSOAP-ICD funded services reported to be delivered in the site. The manager expressed concern that the potential of the funding to be utilised in the site is limited by lack of capacity to offer administrative support, lack of transport available to support service delivery and space constraints in consult areas at the AHS. Another concern was that allied health professionals in a large town in the neighbouring site were not the 'first port of call' to provide outreach services.

Case conferencing, tele-health and building GP capacity

Although MSOAP-ICD funding provides for support for tele-health, case conferencing, and for specialists to provide training to GPs on-site, there was little evidence of these types of activities receiving support from MSOAP-ICD in the Sentinel Sites. None of the fundholders interviewed indicated that health professionals under MSOAP-ICD were using case conferencing facilities or claiming these types of Medicare item numbers. These aspects of the program are potentially highly relevant to greater coordination of patient care, and also could potentially alleviate some of the challenges in coordination of service provider visits through lessening demands on physical space.

Several interviewees in the Sentinel Sites were enthusiastic about the possibilities of tele-health, and a number of sites were actively exploring how to make tele-health work for them. One fundholder indicated that they were commencing a trial of a tele-health process for follow-up of surgical procedures. This was not part of the MSOAP or MSOAP-ICD arrangements. During the evaluation period, Medicare announced new item numbers for tele-health.¹⁴¹

'This is early stages and we have been advocating to have tele-health consultations under Medicare for about 15 years, and we see some real opportunities to deliver services remotely with good systems like this.' (Workforce Agency, interviewee)

It seemed that models for how these types of activities would work in practice were still being worked out, as described below.

'As they are salaried they can't bill under Medicare, however some of them do have rights to private practices, and some services have been set up to utilise their private practice and we will buy back the service and they can bill. We have to be vigilant to know who can bill and who can't. Through e-health we are already using our full-time public hospital doctors and again, can't bill. This has actually posed a problem that we are trying to get addressed.' (Workforce Agency, interviewee)

¹⁴¹ Medicare Australia <<http://www.medicareaustralia.gov.au/provider/incentives/telehealth.jsp>> (accessed 18 November 2011).

While coordination of service providers and of patients remained challenging, there were indications that coordination improved to some extent over the period of evaluation. Interviewees across evaluation cycles were asked whether or not they agreed with various statements about the MSOAP-ICD service (Table 11.1). Although numbers of interviewees were small, there was a general trend of increase in positive responses with respect to coordination under this initiative, possibly suggesting that strategies to improve coordination have been at least partially successful or systems are being developed in some areas.

11.3.5. PROGRAM MONITORING AND REPORTING

KEY POINTS

- Program data under-recorded service delivery in some sites. Varying capacity of individual specialists and service organisations to complete reports and perceived inappropriateness or misunderstanding of some indicators influenced reporting accuracy.
- Some stakeholders were eager to demonstrate outcomes in their reporting. To some extent their suggestions in this regard appeared to be driven by availability of data rather than indicators that reflect critical measures of service quality based on a clear program logic. There are in general few data sources that provide timely information about quality of primary health care for Aboriginal and Torres Strait Islander people, including access to coordinated, multidisciplinary team care through the primary health care system.
- Process indicators were in general not well defined. Fundholders recognised the importance of reporting on progress towards achieving improved access to specialist care, but appeared uncertain about how to do this. This may have reflected a lack of appropriate process indicators in reporting frameworks.

While non-attendance by patients was consistently reported as a particular challenge by fundholders, host organisations and health professionals, it seemed that the program data may underestimate service delivery in some sites. When shown the data provided by DoHA, interviewees in one site indicated that they had seen significantly more patients than reported in the data. This may have been due to differing capacity among Health Services and health professionals in relation to recording and reporting services delivered.

In some sites, host organisations appeared to require greater clarity about what to record and report. For example, some fundholders and service providers were unclear whether the number of sessions or the number of session participants should be recorded in the case of group-consultations, and as indicated earlier, some host organisations reported numbers of patients seen by health professionals, whereas other reported numbers of patient visits, including repeat visits by the same patients.

Indicators and processes

There were some underlying concerns evident in the Sentinel Sites regarding meaningful indicators and processes for program reporting of MSOAP-ICD.

Host organisations generally had responsibility for reporting the program outputs (such as numbers of services delivered, and patients seen) to the workforce agencies, who then collated the information and reported to DoHA regional offices. It was evident from the Sentinel Sites that host organisations did not

always have capacity to track and report on the indicators that were requested. As shown below, some interviewees felt that the problem lay with the indicators, which they felt were inappropriate and not feasible to report on.

When shown data that had been reported to DoHA, an MSOAP-ICD funded health professional in one of the Sentinel Sites indicated that the data were an under-count and that this was most likely due to lack of reporting capacity in the host organisation. In another location, the workforce agency negotiated for the health professional providing the service to take responsibility for reporting. This was a response to the perception that the host organisation had limited capacity to meet the necessary reporting requirements. It was unclear whether or not the data provided by the health professional were verified in any way by either the host organisation, or the workforce agency.

The focus of reporting on outputs rather than outcomes of the service was questioned by several interviewees in workforce agencies and in host organisations. These interviewees noted that reporting on number of patients seen by health professionals did not provide a true indication of the impact of the service on health outcomes.

‘From the way we report there is no indication as to whether health outcomes are being improved. We could see 1,000 people and have absolutely no impact whatsoever, or we could see 50 and change a whole community environment.’ (Workforce Agency, interviewee)

It was also noted, that the emphasis on quantitative indicators in reporting frameworks meant that the influence of external factors were not taken into account when considering program performance. Interviewees discussed the range of contextual factors that may influence service delivery – including factors that affect a large proportion of the community, such as a death in the community, or extreme weather events - and their relevance to interpreting the numbers provided in reports. Staff of some fund holding organisations held the opinion that DoHA staff did not appear to understand the challenges of providing the service and that progress in overcoming challenges was not well reflected in current reporting frameworks, making it appear that nothing had been done.

‘There really is quite a disconnect between the understanding in Canberra of what happens and often the challenge of delivering services. For example, you think you are going to see thirty patients and you see one. You go to a community and there has been a death and the whole town is empty. This is the reality of what we do and sometimes it happens when we don’t have time to change or move things. Feedback we get from DoHA is that the DNA [‘did not attend’ rate] is the fault of the fundholders and/ or the service providers and they think we are not delivering, so I think there is a ... poor understanding. There is a lot of lip service given that they understand. They just see [small] numbers of patients and then think we are not delivering. Lack of attendance is often due to factors outside of our control. The way it is set up how we report, our data is number focused.’ (Workforce Agency, interviewee)

Also illustrated in this quotation is the concern expressed by fundholding organisations about how reported data might be interpreted and used.

In general, fundholders were enthusiastic to find ways to report on the program that went beyond activity- or output-based reporting. One fundholder suggested using indicators such as ‘transport out of the community for hospitalisation’ as a clinically relevant outcome. In this site, the development of a new health information system (at the fundholder level), which was intended to improve robustness of data on patient movement, was seen to have potential to provide data relevant to tracking MSOAP-ICD outcomes.

'This is a challenge ... but there are things we could look at immediately. For example, has there been a reduction in the need for transport out of a particular community for hospitalisation over a 12 month period? If you start delivering a service into a community and you reduce the transport out this is a very real health outcome. We recognise that the robustness of the data that we have ... about patient movement is not great under the current system ... but with the new electronic system it should be a lot more robust. We should be able to report on trends and we will be able to very clearly demonstrate if we have got reductions in movement of patients. We are hoping in the next 6 to 12 months we are able to increase our ability to report on health outcomes.' (Workforce Agency, interviewee)

This quotation also highlighted a challenge faced by DoHA in developing a common reporting framework. Not all areas will have access to the same data, or find the same indicators meaningful and useful to them. It also raised the more general issue of how the scope of the program, and its performance, is measured in relation to the other programs also aiming to increase access to specialists and allied health professionals. It is potentially misleading to view the program in isolation, since it is intended to be complementary to state and other initiatives. There are in general few data sources that provide timely information about quality of primary health care for Aboriginal and Torres Strait Islander people, including access to coordinated, multidisciplinary team care through the primary health care system. This information would be important for understanding the effectiveness of the range of initiatives with similar aims, not just MSOAP-ICD.

In general the above discussion reflects a need for indicators and a reporting framework that is based on a clear program logic for how specialist outreach is intended to provide benefits to people at the local level.

11.3.6. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the MSOAP-ICD would result in enhanced access to specialist and allied health services for Aboriginal and Torres Strait Islander people with chronic disease through the primary health care system, with appropriate referrals, use of these services and improved chronic disease management.
- The program worked through: achievement of a practical and workable program design at site level – through problem-solving and development of local solutions; establishment of arrangements with host organisations and service providers and, where relevant, intermediary organisations; improved accessibility and appropriateness of specialist and allied health care; and complementarity and linkages with other ICDP funded activities
- These mechanisms were found to be influenced by a range of factors – including the extent to which decision-making was devolved to local level; application of problem-solving, rather than solution-driven approaches; support from a well networked fundholder; and shared expectations about how arrangements would work practically, and a shared and realistic understanding of the access barriers faced by Aboriginal and Torres Strait Islander patients with chronic disease and living in regional or remote locations.

Effective implementation of this measure would result in access to specialist services for Aboriginal and Torres Strait Islander people through the primary health care system, with increased cultural appropriateness of these services, and improved chronic disease management in primary health care. This chapter has identified a range of enablers and constraints that influence the extent to which effective implementation was achieved at local level. These are shown in Figure 11.1 and discussed below with examples from the Sentinel Sites.

Our analysis has identified four broad mechanisms of change identified for effective implementation of the MSOAP-ICD (Figure 11.1). Constraints and enablers specific to each of the mechanisms are outlined below.

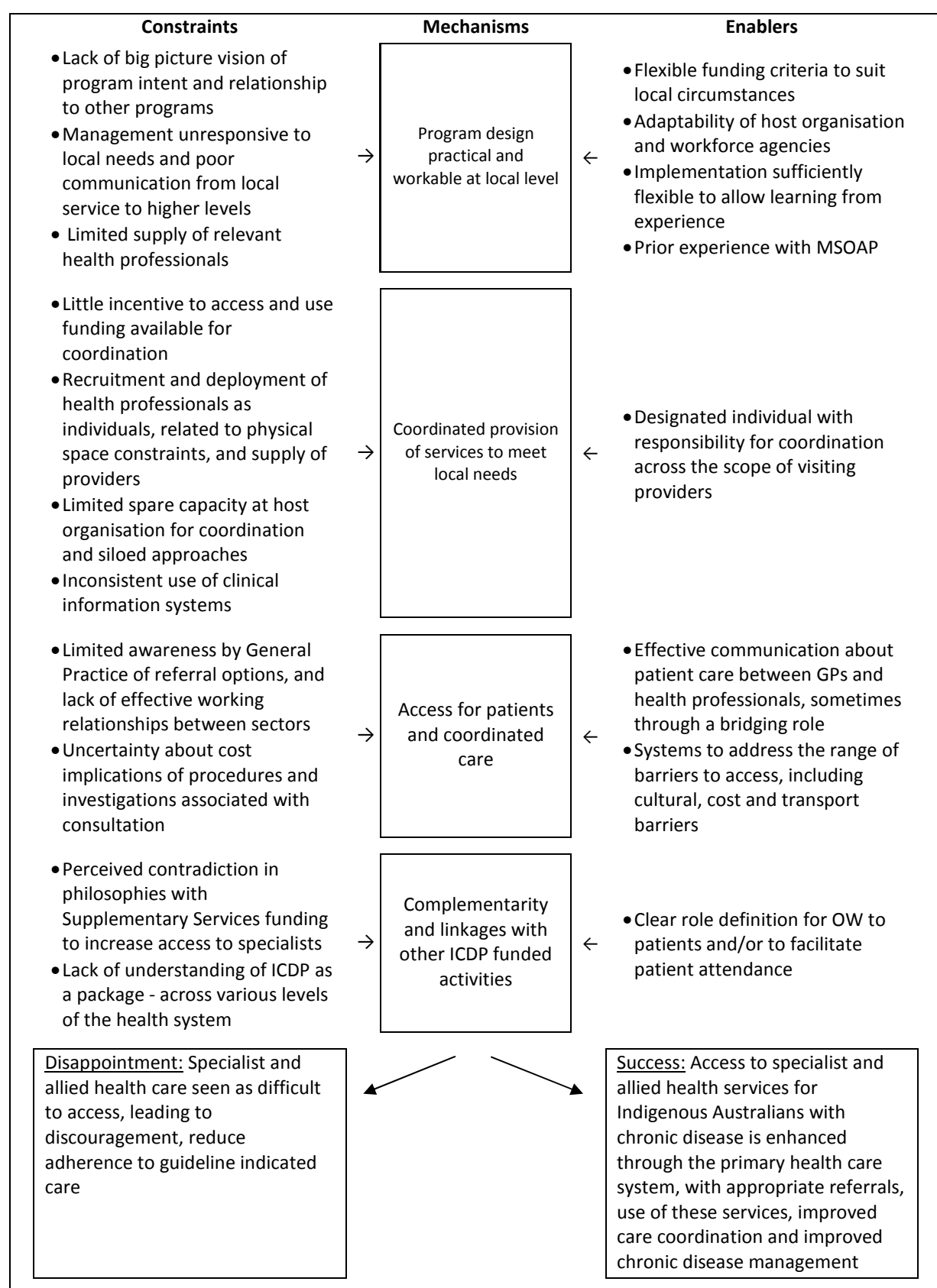


Figure 11.1: Enablers and constraints to effective implementation of the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease measure

Practical and workable program design

The extent to which the MSOAP-ICD was able to achieve (or failed to achieve) a practical and workable program design at site-level was a key mechanism through which the program achieved its effects. A workable and practical design would be apparent if MSOAP-ICD health professionals were integrated into the local primary health care teams, were a resource to them through enhancing their service delivery capacity, and were valued and used effectively and efficiently, along with other health professionals funded through other programs.

It was evident from the Sentinel Sites, that whilst MSOAP-ICD aimed to increase access to a range of specialist and allied health services, and promote team-based approaches, it was not the only program aiming to do this. To some extent, being a relatively new program, it was used to 'plug the gaps' at site level, rather than taking responsibility for leadership in ensuring meaningful outcomes. A lack of clear understanding amongst implementers about what the program could realistically achieve, and how it related to other programs in contributing to achieving desired outcomes, constrained the development of a practical and workable design at site level in some sites.

Conversely, host organisations and fundholders with a shared vision of the program intent, coupled with flexibility in using the funding to suit local circumstances, was identified as a key enabler for the development of practical and workable designs at site level. Where sites were able to increase accessibility to needed specialist and/or allied health services through expanding the contracts of existing providers, workable designs were more likely to be developed. Conversely, where fundholders felt that contracting local health professionals would contravene the guidelines, and where their understanding was not underpinned by a clear understanding of the program scope and intent, they rejected requests for this use of the funding. In some cases, this led to cost-inefficient arrangements of transporting health professionals from major centres whilst health professionals living in the local area who may have been similarly or better qualified, were unable to participate in the program.

Adaptability and willingness to learn from experience also appeared to enable the development of a practical and workable design at site level. For example, some sites changed specialists contracts where these were no longer needed, and adjusted their expectations. Some fundholders demonstrated a pragmatic approach through exploring alternative approaches. For example, if the requested specialist physician was not available, or it was infeasible to provide the requested service, the potential to use a General Physician, or a specialised nurse with tele-health support, was explored.

Prior experience with MSOAP also appeared to be an enabler of this mechanism, possibly through the previous experience in contract negotiations and the established relationships with service providers through this program. In general, MSOAP-ICD fundholders were also fundholders for MSOAP, and in some of these cases, MSOAP-ICD funding was used to expand existing outreach services.

Strong management, including facilitating communication and information flows enabled the development of workable program design. In some host organisations, interviewees reported feeling unheard and described programs that were not workable for them, and that did not fit with local needs. In these contexts, it was perceived by local stakeholders that service provision was driven by ideological, not practical clinical need. This perception appeared to be related to limited communication between service providers, and management, with limited opportunities for workers at the 'coal face' to provide feedback to management, and for this to flow through to the workforce agencies.

Limited supply of required health professionals appeared to constrain the development of workable models in some sites. In some cases this was related to health professionals, particularly allied health

professionals, not being oriented to Medicare billing, and this limiting their participation. In other cases, there was an absolute lack of the required professionals willing to work in the program. The constraining effects of limited supply of professionals were lessened where Health Services were able to problem-solve, and find workable solutions – these did not always involve the use of MSOAP-ICD funding.

Coordinated provision of services to meet local needs

For the program to be effective, MSOAP-ICD service providers needed to be well integrated into existing and evolving systems of care. If this mechanism was operating, this would mean that the right mix of skills would be available at an optimal time, relevant to the disease burden of the patient population, and service provider visits would occur at times and in the manner most likely to work for the primary health care centre, and for patients.

The program design recognised the need for resources for coordination, through provision of funding for this purpose. Whilst the funding provided for coordination (remuneration at a specified level for hours equivalent to the hours spent in service delivery by providers), may have been appreciated by those who accessed it, some fundholders noted that the coordination money was seldom accessed due to administrative requirements, and that if it was accessed, it was not necessarily used as intended by the measure design. There appeared to be relatively little attention by host organisations to develop systems for improving service coordination.

A key enabler for the coordinated provision of services identified in the Sentinel Sites, was a designated person at the host organisation who worked across the various outreach services, not only the MSOAP-ICD. In some contexts, OWs took on coordination roles across the scope of visiting outreach health professionals, and where this happened, this was considered critical to the success of the MSOAP-ICD program.

Coordination efforts that were siloed by source of funding constrained coordinated provision of services to meet local needs. In many sites, MSOAP-ICD providers tended to be recruited and deliver services in much the same way as an individual provider might. In a few sites, the ‘team’ available for team-based chronic illness care, was predominantly made up of MSOAP-ICD funded providers, but in many instances, team members were funded from different programs. This put additional burden on the host organisation to coordinate the services provided, and to promote the team-based approaches that were envisaged in the measure design.

Related to this constraint, was the limited capacity in some host organisations to fulfil the coordination functions that were required by various health professionals visiting at different times, and with different levels of preparedness for their role. Clinical information systems would potentially support communication between different health professionals at the point of care, but in general these were not consistently used. In some cases, this had to do with visiting health professionals not being granted access to these systems. There may be a need for protocol development in this area. In other cases, the health professionals, including MSOAP-ICD professionals, were reluctant to use information systems that differed from those they were used to. In some cases, the clinical information systems may have not been well set up to provide relevant information for coordination. This was countered to some extent by people able to ‘translate’ / bridge between the clinical information system and service providers, and ensure all relevant providers were kept informed.

Access for patients and coordinated care

The MSOAP-ICD was able to achieve some of its effects through providing access for patients and coordinated care. For this to happen, GPs needed to refer to the MSOAP-ICD health professionals in the area, patients needed to attend for appointments, and information about patient care needed to be shared between team members. Enablers and constraints to these three aspects of access for patients and coordinated care were inter-linked, and are discussed below.

The extent to which GPs felt confident about receiving feedback and information about their patients after referral, was identified as critical influence on whether or not referrals were made into the program. In the Sentinel Sites, there were few referrals from General Practice. Although GPs in General Practice tended to be aware of MSOAP-ICD, they in general were not aware that MSOAP-ICD health professionals would accept referrals from General Practice. This was in some instances related to the historical lack of collaboration between the sectors, with associated low expectation that patient information would be shared.

As noted above for the previous mechanism, the presence of a 'bridging' staff member, who took responsibility for coordination and worked with both sectors, was a key enabler for improved access for patients. In contexts where there was good communication about patient care between GPs and the outreach health professionals, access for patients and coordinated care was enabled. GPs from both sectors highlighted the importance of relationships and communication with health professionals in determining their referral patterns. In some instances, reluctance to change established referral patterns was noted as a barrier to greater referrals to MSOAP-ICD health professionals, but this was countered where there was greater communication about patient care. For example, in one regional site, there were initially no referrals from General Practice into the MSOAP-ICD program, but this changed during the evaluation period. This change was attributed to a number of developments: the coordination and 'bridging' role of a designated person who worked across both sectors, to the work of the IHPO in advocating for the service to be available to regular patients of General Practices, and to the role played by a state-government funded diabetes educator in facilitating referrals from General Practice. In this site, the bridging role that this individual played was valued. She acted as a conduit of information between GPs from both sectors, and the MSOAP-ICD health professional. Also valued, was the leadership she provided in relation to the practical aspects of coordination. This included setting up appointments and patient lists and developing processes to facilitate patient attendance.

Patient attendance was influenced to some extent by the situation in which health professionals visited as individuals. This was partly dictated by space constraints at the host organisation. Patients would have to return several times for consultations with the various members of the team, rather than being able to go from one to the other on the same day. This was a significant constraint on patient attendance, particularly where patients lived some distance from the AHS. It also placed additional demands on the AHS to facilitate attendance multiple times. Access was enabled by OWs who were given responsibility, resources and management support to facilitate attendance, including arranging transport.

Whilst access to specialist and allied health professional consultations was valued by many in the Sentinel Sites, the uncertainty about cost of procedures or other interventions that may be ordered as a result of the consultation, constrained patient access in some contexts. Some GPs noted that this uncertainty and the potential cost implications stopped them referring to the program, and some patients noted that this factor made them less willing to attend.

Complementarity and linkages with other ICDP funded activities

Some of the ways in which other ICDP funded activities were complementary to and supported the establishment of the MSOAP-ICD have been outlined above in relation to the previous mechanisms. There was evidence of considerable local level efforts to ensure that the OW and IHPO roles were supporting the services provided under MSOAP-ICD. The extent to which this worked varied between sites. In one of the sites, the IHPO played a role in increasing referrals to MSOAP-ICD from General Practice. This was the result of discussions between local level stakeholders committed to improving the program.

Some stakeholders were concerned that the Supplementary Services funding through the CCSS program had the potential to create ‘bidding wars’ for services of specialists to provide care to Aboriginal and Torres Strait Islander people with complex care needs, and potential to drive costs up. Although there was no evidence that this had occurred in the Sentinel Sites, the perception that the programs were not synergistic, pointed to the need to more clearly identify the scope of each measure and their common vision.

11.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 11.3). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

Although the USOAP and MSOAP-ICD were collapsed into one funding stream at the end of 2012, (Medical Outreach), it is still useful to reflect on the findings from the Sentinel Sites for each of the measures separately. We noted that some different implementation challenges were identified for urban, compared to regional and remote locations - and these may have implications for future development, including the development of a monitoring and evaluation framework for the combined program.

11.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 11.3: Summary of key findings in relation to the program logic –Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease measure

	Summary of key findings
Outputs for year 1 and beyond	
Effective fundholding arrangements in place	As for USOAP, fundholding arrangements were effective at the local level where they were responsive to local needs and took a problem-solving approach to gaps in service provision and adjusted services on the basis of lessons learned from experience. This was evident in several sites. In other sites, fundholding arrangements were considered ineffective at local level. This appeared to be where the arrangements were bureaucratic, did not use problem-solving approaches and where decision-makers did not have a comprehensive understanding of access barriers.
Aboriginal and Torres Strait Islander people utilise and value services.	Some community members were using and valuing the MSOAP-ICD services. Transport to attend appointments was highly valued by community members, as was assistance provided by AHSs to attend follow-up. Serial visits by a range of different providers, rather than team-based visits, constrained access for some patients who then had to visit on multiple days. Patients and GPs were concerned about financial implications of follow-up procedures and investigations, and this was a disincentive for some to participate in the program.
Specialists demonstrate cultural awareness	Orientation of specialists to the service delivery environment of AHSs was reportedly not optimal. Specifically, needs were identified in relation to developing shared expectations about the service, and defining the respective roles and responsibilities of health professionals and the host organisation.
Expected early results for years 2-4	
Increased specialist and allied health services.	It was generally perceived that the MSOAP-ICD had led to increased provision of specialist and allied health services for Aboriginal and Torres Strait Islander patients with chronic conditions. The lack of good quality data on provision of specialist outreach and allied health services (historically and over the period covered by the SSE) is a serious limitation on ability to assess change over time in access to and quality of care.
Expected medium term results for years 4+	
Care coordination is improved.	There was no evidence over the course of the SSE of systematic efforts to improve care coordination through MSOAP-ICD identified, and little or no evidence of MSOAP-ICD funding being used for this purpose. There were no apparent synergies evident with GPMP/TCAs and use of the follow-up item numbers by allied health professionals, with MSOAP-ICD specialists not necessarily participating in these arrangements. There were some isolated pockets of improved care coordination evident. Where this happened, local stakeholders were committed to improve the service, and a designated person acted as a conduit of information between MSOAP-ICD specialists and other health professionals involved in care, and set up systems to facilitate patient access.

11.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease measure.

Fundholding and emerging models of service provision

Most eligible sites were accessing program funding by the final evaluation cycle, although implementation was at a fairly early stage. The most typical service delivery model was the ‘outreach model’ whereby service provision was provided to communities by health professionals travelling to locations from a larger town. There were some differing perceptions among fundholders and local stakeholders about what constituted outreach, with implications for who could be contracted under MSOAP-ICD funding. AHSs hosted the program in the majority of the participating sites. This may be different from models of program implementation in the rest of regional and remote Australia.

Effectiveness of planning processes in ensuring local needs were addressed was variable, partly owing to limited supply of relevant specialists and partly owing to limitations in consultation processes and fundholder responsiveness to local needs. Program set up and implementation were enabled by participants’ prior experience with complementary programs, flexibility and willingness to learn from experience. In a number of sites it appeared that there should have been more attention to the development of shared expectations and clearer delineation of roles and responsibilities of the health professional and the host organisation prior to commencement of service delivery.

The level of uptake and effectiveness of cultural awareness training among MSOAP-ICD service providers was not clear. However, orientation of providers to the AHS service environments appeared to need more attention in a number of sites.

Recruitment and engagement of health professionals

Recruitment and engagement of specialists was shared between the fundholder and host organisation, and was largely complete at the time of the final evaluation visits. Different approaches to recruitment had been used, influenced by fundholder understanding of eligibility criteria, and prior experience. It was in general easier to promote outreach work in regional and remote locations for MSOAP-ICD than for urban areas for USOAP.

Some recruitment strategies put in place by workforce agencies were perceived by AHS interviewees to be overly driven by the availability and interest of health professionals, and were not necessarily responsive to local needs for service delivery. Lack of familiarity with billing Medicare was considered a barrier to recruitment of health professionals.

Health professionals had commenced service delivery in a half of eligible sites by June 2011 (8/16), and in the majority of eligible sites by June 2012 (12/16), with between 1 and 10 types of services provided per site. At site level, health professionals were seldom engaged as teams – this left greater coordination responsibility to the host organisation.

The retention difficulties evident in USOAP were not as apparent in MSOAP-ICD.

Referrals and patient attendance

MSOAP-ICD was perceived by site stakeholders in some sites as having resulted in improved patient access to widely needed types of specialists. However, efficiency was questioned, with low numbers of referrals and low patient attendance for many services. There appeared to be wide variation in number

of service visits per health professional, and in numbers of patients seen per visit (this is discussed further under Program monitoring and reporting below).

Patient attendance at MSOAP-ICD services was influenced by availability of human resources for coordination at the host organisation; support for patients to attend on the required days (including recall and reminder systems, clinic management, and transport arrangements); funding gaps for procedures and investigations, and the waiting times and costs involved in transport and accommodation if referred to larger centres for these services. External events that affected entire communities, such as funerals and severe weather events, were also reported as a reason for poor attendance at some scheduled clinics.

Remaining funding gaps for follow-up procedures and investigations were seen as ongoing barriers to access to appropriate care that were not adequately addressed through MSOAP-ICD.

There were few referrals to MSOAP-ICD services from General Practice. In the one example identified in which General Practice became engaged in referrals, a dedicated person acted as a conduit for information between specialists and GPs in both sectors, and led development of systems to facilitate patient attendance.

Coordinated and team based approaches

Owing to physical space constraints, poor development of clinical information systems (including systems for recall and reminders), host organisations in general struggled with capacity to manage coordination of visiting service providers. Coordination needed to take into account visiting service providers from various outreach and service delivery programs other than MSOAP-ICD.

Designating the coordination function to a specific individual in the host organisation contributed to more effective operation of MSOAP-ICD in a number of sites. Elements of successful approaches included the ability of the person responsible for coordination to work across programs, not just MSOAP-ICD, and their ability to act as a conduit between the GPs and health professionals.

Funding to support coordination was not often used owing to lack of staff to provide the coordination function, and lack of administrative capacity to invoice for the function. In one site, with the support of the DGP intermediary organisation, this funding was accessed to back-fill time for an AHW to accompany patients to MSOAP-ICD specialists who had arranged to provide care in private rooms.

Some fundholders were reportedly exploring alternative models to support coordination, but their sustainability and the extent to which they were building on existing networks and relationships was unclear.

Communication and sharing of information about care requirements was enabled where MSOAP-ICD health professionals were provided access to the host organisation clinical information systems, and were able to use the system appropriately. Not all health professionals were granted access to these systems and some were unwilling or lacked capacity to use them.

Program monitoring and reporting

There were some discrepancies apparent between the program data received from DoHA and the information received from the Sentinel Sites. There were indications that program data had under-recorded service delivery in some sites, and over-recorded service delivery in others. While low patient volume was evident in DoHA program data and in interview data in the Sentinel Sites, the data on referrals, patient attendance and numbers of specialist visits was generally of limited quality. Inconsistency in reporting between providers and sites complicated the interpretation of the data.

There appeared to be varying capacity of individual specialists and service organisations to complete reports, and quality of reports was influenced in some sites by misunderstanding of reporting requirements or perceptions that some indicators were inappropriate.

Some stakeholders were eager to demonstrate outcomes in their reporting, and to some extent their suggestions for indicators in this regard appeared to be driven by availability of data rather than an interest in reporting indicators that reflected measures that were based on the logic of how the MSOAP-ICD could provide benefits to people in the community. Process indicators were in general not well defined. Fundholders recognised the importance of reporting on progress towards achieving improved access to specialist care, but appeared uncertain about how to do this. This may have reflected a lack of appropriate process indicators in reporting requirements. There are in general few data sources that provide timely information about quality of primary health care for Aboriginal and Torres Strait Islander people, including access to coordinated, multidisciplinary team care through the primary health care system.

11.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Work with stakeholders to develop a clear understanding of the range of barriers to access, and how the program can address these. Clarify the definition of 'outreach', and consider if this is the most appropriate term for a program that could be designed to address a range of access barriers (not only distance). Ensure that program design (including monitoring and evaluation and performance reporting) is sufficiently flexible to encourage problem-solving, not solution-driven approaches to program set up.
- b) Support systematic efforts to strengthen the capacity of host organisations to better manage coordination across the scope of outreach programs. Consider the potential to build on existing networks and resources rather than setting up parallel systems.
- c) Consider the best ways to align with other ICDP initiatives that aim to foster multi-disciplinary team care (for example, greater use of MBS follow-up items, GPMPs and TCAs). Consider how to strengthen links with the CCSS program, and of the role of IHPO in raising awareness and availability of MSOAP-ICD.
- d) Work with stakeholders to develop clearer specification of how the program may contribute to increasing skills of the primary health care team.
- e) Consider ways to support communication and feedback about patient care between GPs and outreach staff.
- f) Ensure that cultural awareness training includes a specific focus on culture of Aboriginal primary health care organisations and is well integrated into a systematic orientation process for specialists and allied health professionals. Explore synergies with other cultural awareness training that has been developed. Include consideration of the evidence relating to differing access barriers faced by Aboriginal and Torres Strait Islander communities in urban, regional and remote locations and in different settings.

- g) Consider working with stakeholders to develop a shared understanding of how visiting services can best provide benefit to local communities and community-based services, and then to develop a corresponding monitoring and evaluation framework for such programs. In this process, consider the role of MSOAP-ICD alongside other relevant programs, and identify indicators that provide a meaningful reflection of the progress towards providing benefit to people in the local community.

12. WORKFORCE SUPPORT, EDUCATION AND TRAINING (MEASURE C1)

12.1. Description of measure

This measure aims to increase the capacity of Aboriginal Health Services and General Practice to provide care for Aboriginal and Torres Strait Islander people with chronic and complex health conditions through provision of orientation and training for the ICDP workforce (OWs employed in both AHSs and DGPs), and through expansion of existing training and professional development opportunities in AHSs for nurses, student nurses and GP registrars.¹⁴²

Key elements of the measure include:

- **Orientation for OWs employed in AHSs (through measure C2) and in DGPs (through measure C3).** Whilst the employing organisation was responsible for on-the-job orientation, this element of measure C1 provides funding for the development of jurisdictionally-specific orientation that was intended for OWs employed in both AHSs and DGPs in each jurisdiction. The intention of the measure was to provide this mandatory orientation within six months of employment. NACCHO affiliates in each jurisdiction were funded to develop and provide the orientation, with the support of NACCHO to ensure coordination, networking and some consistency between jurisdictions.
- **A funding program to support ongoing training needs of OWs (referred to hereafter as ‘OW individualised training’).** The employing organisations were responsible for developing training plans together with the OWs, identifying relevant training courses, and applying to either the NACCHO affiliate or SBO for funding to undertake the training. Initially, NACCHO affiliates were required to coordinate training for all OWs. Later in the evaluation, SBOs took responsibility for coordinating training for DGP-based OWs. To be eligible for support, the training needed to be nationally-accredited health-related competency based training in the vocational education and training sector. The original design of the measure allowed funding for training up to Certificate Level II, consistent with the expectation that OWs would be entry level recruits. During the evaluation period this changed to allowing OWs to have access to Certificate III and IV qualifications if employers considered it beneficial. This change allowed OWs more flexibility to develop career paths in the health sector, by undertaking more advanced training such as that for AHW or enrolled nursing. Initial communications in March 2011 referred to Certificate II training being available to OWs. The expansion of available training was communicated in April 2011.
- **Additional training positions available in AHSs for medical graduates intending to seek specialist registration as a GP with the Medical Board of Australia (GP registrar training posts).** Measure C1 expanded the existing GP registrar program through provision of funding for an additional 38 GP registrar training posts within AHSs. Special registrar salary funding

¹⁴² DoHA, Workforce, Education and Training – Fact Sheet, <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/workforce-education/\\$file/Copy%20of%20DHA6136%20C1%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/workforce-education/$file/Copy%20of%20DHA6136%20C1%20Factsheet.pdf)> (accessed 10 December 2012).

arrangements were available to support these posts. This funding was managed by General Practitioner Education and Training (GPET).¹⁴³

- **Additional professional development scholarship opportunities for Enrolled Nurses, Registered Nurses and Midwives working in AHSs (the Continuing Professional Development Scholarships for nurses working in an Aboriginal Health Service).** These scholarship opportunities were managed by the Royal College of Nursing Australia (RCNA) and included under the Nursing and Allied Health Scholarship and Support Scheme. These scholarships provided \$15 000 per successful applicant in support of professional development at an Australian university or registered training organisation. Advertised on the RCNA website, the six week application rounds opened twice per year (around March and August) and fifty scholarships were offered annually under measure C1.¹⁴⁴
- **A funding program to support clinical placements of nursing and midwifery students in AHSs (Aboriginal Medical Services Clinical Placement Scholarships).** Similar to the professional development scholarship opportunities for nurses, this funding program was administered by the RCNA, with twice yearly applications. This was subsequently amended to be applied for all year. Scholarships were worth up to \$11 000.¹⁴⁵ The money supported placement costs for the student (e.g. living, accommodation) and provided the organisation with \$500 per week to cover supervisory and other costs. Clinical placements were usually organised through the educational institution.

12.2. State of implementation – national context

The main achievements of this measure at a national level at the time of the final evaluation cycle and of relevance to the SSE are summarised below. This information was extracted from information supplied by DoHA throughout the evaluation period. The national-level achievements are described separately for those elements of the measure that relate to the new workforce (orientation and OW individualised training) and those elements that relate to expanding training opportunities for GPs and nurses.

12.2.1. ORIENTATION AND OUTREACH WORKER INDIVIDUALISED TRAINING

Over the period of evaluation there were a number of significant developments at the national level in relation to orientation and OW individualised training.

Orientation

Funding agreements between DoHA and the NACCHO affiliates were put in place in each jurisdiction for the development of jurisdictionally relevant orientation packages, with timing of these agreements differing between different jurisdictions. By November 2010, WA, SA, Vic and NSW had agreements in place, followed by Qld and then NT by June 2011. Negotiations were underway for Tasmania in July 2012, but the funding agreement had yet to be reached at last report.

¹⁴³ Australian General Practice Training [website] <<http://www.gpet.com.au/AGPTtheProgram/AGPTHandbook/>> (accessed 15 December, 2012).

¹⁴⁴ Royal College of Nursing Australia [website] <<http://www.rcna.org.au/wcm/default.aspx>> (accessed 17 December 2012).

¹⁴⁵ Royal College of Nursing Australia [website], op cit.

Components of orientation packages in each jurisdiction and requirements for implementation and ongoing training and development had been identified through jurisdictional workshops (workshops coordinated by NACCHO). These were held in WA, SA, NSW, Vic, Qld and the NT during the period March 2010 - June 2010.^{146,147}

By the final evaluation period, orientation packages had been delivered in all jurisdictions with the exception of Tasmania; delivery commenced in NSW and WA in March 2011 followed by the other jurisdictions. Development of the orientation package in Queensland lagged behind, with OW orientation delivery commencing after November 2011.

By the end of the evaluation period, 134 OWs had been recruited in both AHSs and DGP/Medicare Locals nationally. This represented recruitment of around 119 FTE out of an allocation of around 144 FTE. DoHA reported that from commencement of orientation delivery in 2010/2011 to August 2012, 130 individual people in OW positions had attended orientation. No data, however, were received to indicate the rate of attrition from those roles and the current number of recruits operating without having attended orientation. No orientation sessions had been reported between March and August 2012.

Some variation in delivery of orientation was evident in different jurisdictions as shown in Table 12.1. The program logic states that by June 2011 the aim was for 166 OWs to be oriented. From program data, by that time, there were 107 OWs recruited, and 84 orientations had been completed. Fewer orientations were completed in the following quarters - addressed in the next point.

Table 12.1 Number of Outreach Workers that completed orientation by quarter, and jurisdiction, 2011-2012

Quarter	Jurisdiction	Number of OWs that had undertaken orientation
31 March 2011 ^a	NSW, WA	35
30 June 2011	Vic (including ACT), WA	49
30 September 2011	SA	10
31 December 2011	NT	8
31 March 2012	Qld	28
30 June 2012	-	0
Total		130

^a This period may also include the previous quarter.

Source: DoHA, Workforce Support, Education and Training.

Staggered recruitment of OWs and insufficient numbers of OWs to convene orientation workshops were noted as barriers to timely delivery in some areas. Communication from DoHA indicated that where there were insufficient numbers of OWs to conduct group orientation, the orientation providers

¹⁴⁶ DoHA, COAG Workforce Expansion Jurisdictional workshops: National summary report November 2010.

¹⁴⁷ DoHA, Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report on the Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes - November 2010 <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-gp-kit-annual-progress-report-toc~ctg-gp-kit-annual-progress-report-Implementation-Progress>> (accessed 20 December 2012).

were willing to deliver the orientation for smaller OW groups. It was the employers' responsibility to inform the NACCHO affiliate of new recruits. DoHA reported that other influences on uptake included the accessibility of the orientation for regional and remote staff to main centres, the costs associated with the travel and the time off work.

Outreach Worker individualised training

Uptake of funding for individualised training for OWs was fairly low nationally - as of September 2012, 46 OWs (or approximately one third of the number currently employed) had been provided with funding support to undertake nationally-accredited health-related competency based training in the vocational education and training sector.

Some adaptation of individualised training models emerged in the different jurisdictions – Qld and NT had submitted training proposals to DoHA as of July 2012. The NT proposal was not restricted to OW training, but included the whole NT ICDP workforce. DoHA reported that they anticipated proposals from NSW and Victoria, with Victoria's proposal expected to include OWs in Tasmania.

In WA an accredited module was specifically developed for OWS and eleven 11 OWs enrolled in the Certificate III Unit - Facilitate Communication between Clients and Service Providers. In the final evaluation period, nine OWs from Tasmania were provided funding to undertake the Certificate III in Aboriginal and Torres Strait Islander Primary Health Care.

The availability of DoHA funding support for individualised accredited training was promoted at a NACCHO-organised Aboriginal and Torres Strait Islander Outreach Worker National Workshop in Sydney in June 2011. A further national workshop was being planned for 2013. Although these workshops were not funded under measure C1, the first workshop reportedly provided an important networking opportunity for OWs at a time when the orientation was just commencing.

Further information about ongoing activities in OW orientation and training was communicated at the Workforce Information Policy Officers Network meeting June 2012 and via teleconference to the IHPOs national network meeting in September 2012.

12.2.2. EXPANSION OF TRAINING OPPORTUNITIES AND POSITIONS FOR GPS AND NURSES IN AHSS

GP registrar training posts in Aboriginal Health Services

- The ICDP component of the GP training program was a small portion of the program delivered by GPET.
- Prior to implementation of this measure there were approximately 101 AHS GP training posts funded. The measure provided an additional 38 training posts in AHSs. The way in which data were reported meant it was not possible to identify specific Sentinel Sites where the 38 ICDP funded GP registrar posts were located.
- Overall, 147 and 138 registrars had taken up a training post in AHSs in the 2010 and 2011 calendar years respectively, including those funded through the ICDP.

Continuing Professional Development (CPD) Scholarships for nurses working in an Aboriginal Medical Service

- At the time of the final evaluation cycle there had been six successive rounds of advertisements for scholarships for AHS employed nurses. In 2010 and 2011 respectively, 50 and 43 scholarships were allocated. A total of 75 CPD scholarships had been awarded as of 31 August 2012, with one more allocation round to complete.
- The annual target of 50 CPD scholarships has been exceeded in 2012. This was due to two reasons. Firstly, many of the scholarship recipients did not require the full amount of funding for their activities, so the administrators were able to award more than the target 50 scholarships. Secondly, the annual funding committed under the ICDP for the scholarships exceeded the amount of money required to meet the target number, allowing additional scholarships to be funded.

Aboriginal Health Services Clinical Placement Scholarships

- The 2010 year demonstrated full allocation of the scholarships with 50 awarded. However, in 2011 only 22 clinical placement scholarships were taken up. By 31 August 2012, 61 clinical placement scholarships had been awarded to nursing students undertaking placement in AHSs, with further allocation expected over the rest of 2012. The annual target of 50 clinical placement scholarships was exceeded in 2012, due to the same reasons described above for the CPD scholarships.
- A mismatch between scholarship application timeframes and universities' clinical placements schedules was identified as a barrier to greater uptake. In response, the RCNA changed the AHS clinical placement scholarships application and assessment processes in March 2012, to enable applications to be lodged at any time and assessed monthly.
- During the evaluation period, DoHA worked with the nursing scholarships Administrator and with NACCHO to determine and implement strategies to increase demand for the nursing scholarships in AHSs. An updated strategy for promotion and communication of the scholarships was implemented in late 2011. NACCHO sent letters and promotional material to all AHS CEOs; and the RCNA sent letters to universities and held a trade booth at the November 2011 NACCHO annual general meeting and conference held in Sydney.
- An AHS needs to undergo training accreditation before hosting clinical placements - DoHA reported an increase in the number of accredited AHSs over the evaluation period.
- As a result of the above strategies, it was reported by DoHA that demand for these scholarships had increased during 2012.

12.3. Findings from Sentinel Sites – orientation and Outreach Worker individualised training

12.3.1. DEVELOPMENT AND UPTAKE OF OUTREACH WORKER ORIENTATION

KEY POINTS

- Online surveys, review of job descriptions, and consultations with OWs and their employing organisations were used by some NACCHO affiliates in the jurisdictions in developing relevant orientation packages. Interviewees in the Sentinel Sites held different perceptions of the comprehensiveness of consultation.
- In some sites, inadequate consultation about what was needed from orientation was perceived to have resulted in inappropriate orientation for DGP-based OWs, and for those in remote sites.
- There were some successful models identified where orientation appeared to work well for both sectors.
- Attendance of OWs from remote sites at orientation was low, and orientation packages generally not considered appropriate for them (owing to low literacy and different work expectations in remote sites).
- A regionalised model to support orientation and to coordinate individualised training was used in one site. Although considered effective by some, participation by remote-based OWs in the regional events was low, owing to reluctance to travel.
- Models of orientation that included other members of the ICDP workforce were generally preferred at local level, owing to opportunities to develop collaborative working relationships between different team members. These models were also considered to be better suited to situations in which there was considerable mobility of workers between positions (for example – between OWs, TAWs and HLWs).
- Whilst some workshops convened at national and jurisdictional level fulfilled an orientation role, the extent to which generic competencies for the ICDP workforce, and specific competencies for OWs (and other workers) had been defined, and orientation (and individualised training) designed to address these, was unclear.
- The delay in roll out of orientation packages led to opportunities for transfer of learning from more experienced OWs to new workers, and reports of Outreach Workers training themselves ('learning by doing').
- Workforce changes, in particular, the establishment of the ICDP Care Coordinator role, and the transition to Medicare Locals, led to the evolution of OW roles. This required flexibility in the design and delivery of orientation over time.

Process of development of orientation

The process of development of the orientation was the responsibility of the NACCHO affiliates in each jurisdiction. In broad terms, the intention was to develop specific orientation in each jurisdiction in consultation with local service providers including AHSs, DGPs and possibly other stakeholders.

It was evident from interview data in the Sentinel Sites that there were divergent perceptions about the effectiveness of consultation processes, with some interviewees satisfied with the consultation, and others believing that it had been inadequate or ineffective in achieving an orientation package design relevant to their needs.

Where meaningful consultation was perceived to have occurred, stakeholders in the sites valued the outcomes. For example, in one jurisdiction, the SBO reported adequate opportunity to provide input into the development of the orientation package, and that the package that was developed aligned well with other relevant activities. This positive process included for example: joint planning meetings between the SBO and the NACCHO affiliate; an online survey of OWs in the jurisdiction to identify orientation needs and; a review of all OW position descriptions across the jurisdiction, including consultation with some of the host organisations (specifically including DGPs), about how actual roles aligned with position descriptions, and to identify any need for refinement of position descriptions.

In contrast, for other interviewees from DGPs, the orientation was considered inappropriate for DGP-based OWs and this appeared to be partly due to a lack of effective communication between the sectors and possibly a lack of understanding of the different roles required of OWs depending on their sector of employment.

'[We] ended up with a manual more suited to the ACCHS sector. The sectors are so different, which means that the OW employed in the AHS has a very different role to the OW employed in the DGP sector. The orientation was more about being inducted into a clinical setting and therefore there were sessions on hand washing, OH&S. We did our best to try and manage that, but at the end of the day we had little influence.' (SBO, program manager)

Also indicated in the quotation above, was a sense of frustration at the perceived unresponsiveness to feedback about the orientation. This interviewee explained that three consecutive sessions were held, in each case, with more DGP-based OWs attending than OWs from the AHS sector – but despite feedback, no changes or adaptations were made to the content of the orientation.

'... At the orientation they had three OWs from AHSs and eight from the DGP sector. It certainly did not meet the needs of the OWs in the DGPs as it was so focused on the AHS sector. It was so focused on this that they were showing examples of reporting templates from the AHS and this caused untold confusion for the DGP staff. In the ACCHO sector the OW is working often more as an Aboriginal Health Worker and so the orientation was very much about how an AHW may interact in an AHS in a solo setting, rather than how to support a myriad of practices and the operating environment of these practices. There was not a good grasp of the role of the OW in the DGP.' (SBO, program manager)

Different models of development of orientation were evident in the different jurisdictions in which Sentinel Sites were located. In one of the remote sites, the NACCHO affiliate located in the capital city took a strong regional approach to orientation, including taking a lead role in planning of orientation for different categories of ICDP workers. This meant that there was greater potential for coordination between different members of the ICDP workforce. In this site, this person also had a lead role in developing both orientation and individualised training plans for OWs in the region. This also had the potential to improve continuity between orientation, training needs that may be identified during orientation, and the individualised training plans. Whilst this regionalised model may have been successful in some contexts, it did not appear to be a workable model for the OW based in the remote Sentinel Site within this region. This OW did not attend the joint orientation that was held in the capital city. Interviewees from this site indicated that this was a strategic decision, based on the need for orientation activities for this OW to be tailored to his/her literacy level and capacity to travel. However,

it was also apparent in this site that the OW was largely unsupported, as clinicians were absorbed in acute care needs, and moving between different clinics. This illustrates some of the difficulties in designing orientation to suit different contexts. These issues are discussed further at a later point in the chapter.

The potential advantages of developing a generic orientation package for all ICDP workers, rather than separate orientations for each workforce type, were identified by interviewees. Advantages that were identified included: being more cost-effective; promoting collaborative working relationships between different members of the team; and being better suited to situations in which there was considerable mobility of workers – for example – between OWs, TAWs and HLWs. Worker mobility was particularly pronounced in remote and regional sites, which were also more likely to have experienced difficulties recruiting OWs compared to urban sites.

Timing of orientation

It was intended that orientation would be delivered within six months of OW employment. For the reasons outlined in more detail below, this intent was difficult to achieve. Staggered recruitment of OWs in different sites and the state of development of the jurisdictionally-relevant orientation packages in relation to OW recruitment made it difficult to deliver the orientation at the appropriate time for each worker.

Some OWs had been in positions for more than a year before orientation became available in their jurisdiction. This delay in the availability of the jurisdictional orientation was an issue for some organisations, but in others interviewees indicated that employing organisations had developed their own orientation (with the jurisdictional orientation regarded more as a networking opportunity).

By the final evaluation cycle, at least one OW from six out of the eight case study sites had attended orientation. There was generally more than one OW employed per site, and not all had received orientation. As a proportion of OWs recruited, just over one half of OWs interviewed in the case study sites indicated that they had attended orientation by the time of the final evaluation cycle. This was slightly more than the national average of around one third. In the Sentinel Sites, some of the OWs who had not attended orientation reported that they had been appointed after the orientation package had been delivered for their area. Other OWs, particularly those based in regional and remote locations, reported that they had been offered orientation but had not attended, owing to constraints on ability to travel.

Remote sites experienced the most significant delays in accessing OW orientation, and interviewees expressed the greatest dissatisfaction with the type of orientation available under the measure. There were many different reasons for delays and perceived lack of appropriateness in remote sites. These are discussed below.

In some cases a positive unintended consequence of the staggered recruitment (and delays in orientation for some OWs and not others), was that the more experienced OWs were able to provide mentoring and support to those who were less experienced.

‘There were new OWs who had just come on board who found the orientation more beneficial as they were able to link in with OWs that had been on board a long time and find detailed information from Medicare and other parts of the package.’ (NACCHO affiliate, program manager)

'This orientation was 12 months after the OWs were employed. It helped them to meet other OWs and see what other areas were doing but as far as orientation [went], they did their own 'see as you go' [learning].' (AHS, program manager)

Whilst interviewees from both DGPs and AHSs expressed frustration that orientation had not been available at the time it was intended, it was also recognised that it had taken some time for organisations to develop an understanding of how the OW role could fit into the work of the organisation – and it was recognised by some of the interviewees that this evolving understanding was important in informing the content and approach to orientation.

'First [orientation and training design] tasks should ideally have been done before OWs were recruited rather than 18 months down the track. Though in saying that, we now have insight into what we now need, but ... we have left them in very vulnerable positions with no training. The roll out ... is quite delayed and it has impacted in particular on the Outreach Worker positions as they are ... often people employed with no qualifications or minimal [qualifications].' (SBO, program manager)

Meeting the needs of both sectors

Across the evaluation cycles, interviewees noted that joint orientation had been largely unsuccessful in meeting the needs of the General Practice sector, and as outlined earlier, in relation to consultation processes, in some cases, DGPs felt they had not been adequately consulted. However, it was also apparent that in general, DGPs had more to learn about the OW role, and had greater need for organisational support in understanding how to integrate and work effectively with an Aboriginal workforce.

'We are learning that the Outreach Worker roles are a lot more complex than what guidelines state.' (DGP, program manager)

This situation changed over the evaluation period, with greater confidence evident, as roles and expectations became more established. As greater numbers of workers were appointed and gained experience, the OWs in DGPs became more established in their role, with greater understanding developing about the role in some DGPs.

'The new OWs that are coming on board are in a better position to be supported by the existing OWs as there is a vast knowledge within the existing workforce. The [DGP name] OW demonstrates useful leadership within the network. Other OWs do call on him for support when required.' (SBO, program manager)

There was one site in which orientation was considered valuable by the DGP. This was a remote site, and the OW orientation had been conducted in the capital city, some distance from the site. Interviewees were enthusiastic about this orientation, noting the opportunities provided for networking and sharing experiences.

'They really learnt a great deal ... ongoing support is also important ... sitting in an isolated position in that role ... it is really important to work with other OWs so that you can share experiences.' (DGP, program manager)

It is possible that distance between the orientation training location and the day-to-day service delivery environments, and a greater critical mass achieved when OWs came together, contributed to successful learning and networking outcomes in this situation. This interpretation was supported by the relative

success of the joint national and state-wide workshops, facilitated by NACCHO and SBOs. Whilst these workshops were not billed as orientation, it was evident that they also fulfilled a valued orientation function. Interviewees described the value of generating a 'bottom-up' definition of the OW role, drawing on a broad range of perspectives and experience, and of having a skilled facilitator providing strategic direction using the DoHA guidelines.

'Both sectors were workshopping and being asked real everyday questions that may arise from both sectors. There was plenty of time to have discussions about the roles in both sectors and how to shape them. It kept on bringing the workers back to the guidelines of the funding, which was helpful.' (SBO, program manager)

Whilst national and state-wide meetings appeared to be effective in meeting orientation needs for some, we also noted the constraints on the ability of many OWs to travel to large cities or interstate. This was due to a range of reasons, including community connections and general low levels of literacy and inability to navigate unfamiliar urban centres.

Evolution of roles

OW roles were noted to have evolved over the period of evaluation. This was in response to a number of factors including lessons learned through practical experience, changes in the workforce (for example, recruitment of new types of positions, such as the ICDP Care Coordinators) and organisational changes, (such as the transition to Medicare Locals). This presented some challenges to design of the orientation – which was already underway at the time of some of these changes. It is not surprising therefore that even when orientation had been accessed there was a perception that some OWs were still unclear of their roles.

Relevance of orientation for OWs in remote locations

Across all evaluation cycles, OWs in remote locations were less likely to participate in orientation packages compared to OWs in urban and regional locations. Lower uptake of orientation may have been partially due to perceived lack of relevance of the orientation to these workers – this in turn may have been due to differing roles in remote locations, language issues and generally lower levels of formal education. Other explanations for low uptake of orientation in these settings included constraints on the ability of the OW to be away from family and home, and the logistical and practical support required from managers in order to successfully manage travel to city or central towns (for example, in conducting transactions without credit cards, negotiating transport and accommodation requirements). Although commonly mentioned in remote sites, constraints on the ability to travel were also mentioned in some regional locations.

'Access to orientation has not happened. The OW needs a lot of support to attend something off community - for example [they] often don't know how to check into accommodation, [about needing] a credit card on check in, or about travel allowance.' (AHS, program manager)

Across all evaluation cycles, it was felt that a jurisdiction-wide 'one size fits all' approach to orientation could not meet the particular needs of the remote workforce, with suggestions that on-the-job training tailored to context would be more appropriate.

'The OW did not attend orientation as this is not relevant in a remote setting. You don't send a remote traditional person to national orientation training - it's irrelevant. If you want training or orientation to be effective the government need to invest in on-the-job training where you have people coming out to the workplace and doing that training in their community and in their

health centres and then it becomes real and relevant. We need training pathways - not training packages - in remote. It puts remote employees with huge literacy and numeracy challenges often with English as a second language at a great disadvantage.' (AHS, program manager)

12.3.2. OUTREACH WORKER INDIVIDUALISED TRAINING

KEY POINTS

- Low overall uptake of funding for individualised training was evident in all Sentinel Sites across the evaluation period. Contributing factors included:
 - limited awareness of the funding and confusion over eligibility
 - lack of capacity to identify training needs and match these to training opportunities
 - preference for using other resources for training, partly due to preference for joint training with other members of the organisation or primary health care team, and/or to unfamiliarity with administrative requirements for accessing support through the OW individualised training funding
 - uncertainty over ongoing funding for OW employment and contract dates expiring, limiting the duration of training considered appropriate.
- Types and levels of training accessed through the measure varied widely and were influenced by capacity of host organisations, geographic location and type of training available.
- Differing perceptions of the SBO and NACCHO affiliate role in relation to coordination and support of OW training were evident. In early evaluation cycles, some SBOs felt hindered in fulfilling their support role, since the way the program was set up initially meant that they did not receive timely information about individual applications for training.
- By the final evaluation cycle, different approaches to implementing individualised training (such as identifying common training needs across a jurisdiction and planning at jurisdictional level) had been considered by at least one SBO, with support from DoHA and changes in national guidelines allocated SBOs responsibility for coordination of individualised training for OWs based in DGPs.
- There was in general, no evidence identified in the Sentinel Sites of standardised core competencies for OWs being defined, or reflected on, to inform the development of individualised training plans.

Overall uptake of available training funds

Uptake of funding for individualised training was remarkably low within the Sentinel Sites and nationally. Five of the thirteen OWs in case study sites in the final evaluation cycle indicated that they were currently accessing DoHA allocated training funds to support individualised training.

Although awareness of the funding increased amongst all interviewees over the period of the evaluation, uptake remained low overall, and particularly low in remote sites.

Consistent with difficulties in accessing orientation, remote OWs also experienced difficulties accessing individualised training. OWs recruited from the local community in remote Sentinel Sites appeared particularly disadvantaged in terms of access to, and relevance of, training offered under the current model. In at least one instance, an OW in a remote site accessed no individualised training due to

limited English literacy and constraints on the ability to leave the community. This was in contrast to some OWs in urban and regional sites, who participated in several accredited training initiatives under this measure during the evaluation period. A number of other factors influencing uptake of this funding source were identified during the evaluation – these are outlined below.

Type and duration of training

The program design specified support under this measure for OWs to access training to Certificate II Level. This specification was revised during the period of the evaluation to support access to Level III and IV to enable OWs with higher-level qualifications to seek training support under this measure. This change initially led to some confusion about funding eligibility. However, by the final evaluation cycle, levels of understanding about the scope of what could be funded had substantially improved. Lack of awareness of the type of training that could be funded did not appear to be a significant barrier to uptake of training.

In later stages of the evaluation, as contracts for some OWs were coming to an end, the anticipation of termination of employment (or uncertainty about how employment could be continued), appeared to have influenced OWs ability and willingness to access individualised training, and also, as outlined below, the type of training that their employing organisations considered suitable for them.

In theory, OWs could access training funds for courses of varying durations, including short-term courses of a few days or weeks duration, to coursework leading to degree qualifications of three to four years duration. In general, in the Sentinel Sites, training courses undertaken by OWs and funded under this measure were for shorter-term training. By the end of the evaluation period there were an increasing number of OWs undertaking certificate level or diploma training in either Aboriginal Primary Health Care or AHW training. Some interviewees noted that a number of training support requests were for courses that extended beyond contract periods – and implied that for this reason, they would discourage OWs from applying or enrolling. This issue particularly emerged during the third and fourth evaluation cycles, in relation to OWs employed in DGPs.

‘There are some tensions as the funding is only to June 2013 and this will come quickly. By the time we train this person ... the funded position [will have] come to an end and we may not see directly the investment in time we have committed [coming] back to the organisation.’ (SBO, program manager)

‘So now they have done the orientation we are to develop a training plan and in [site name], the OW is an entry level person which means no qualifications and has decided to become a trainee Aboriginal Health Worker. This entry level position training being undertaken is in blocks and means the worker is away for quite some time during year.’ (DGP, program manager)

In general, DGPs in the Sentinel Sites appeared to be less willing than AHSs to support training beyond contract periods. This may be a reflection of generally greater experience amongst AHSs in dealing with the complexity of short-term funding arrangements, their greater familiarity with employing an Aboriginal and Torres Strait Islander workforce with similar roles, and DGP and SBO involvement in the transition to Medicare Locals, with some uncertainty during the evaluation period about ongoing funding for positions and roles and responsibilities for workforce support under these new arrangement.

Team-based training and use of other funding sources

Both AHS and DGP interviewees noted that they often preferred to use their own internal training budgets or other sources of funding to support training of OWs. For some organisations, particularly those in which there was a large Aboriginal health team, it seemed important that training was team-based, rather than individual-based. This may have reflected an organisational culture that favoured collective learning, or other factors. Interviewees also noted that it was less burdensome to complete administrative requirements for the whole team, and use core funds, than to have to meet separate administrative requirements for each type of worker. Other organisations had access to state and DGP funded training and preferred to send OWs on these known training courses, at no cost to the organisation. For these organisations, OWs participation in these training courses was seen as a higher priority than accessing individualised training, again possibly because of the accessibility and relevance of this training for the whole team.

‘There was no need for individualised training money at the moment as the [jurisdiction] government is organising access to Certificate IV in Population Health and our team are doing this therefore do not need to access ICDP funded training.’ (Feedback from enhanced tracking site)

‘The OW accesses training funded through the DGP which is not funded by DoHA and therefore would not be showing up in data.’ (DGP, IHPO)

Systems to support coordinated access to training

In the original program design, employing organisations were required to take the lead in identifying training needs in collaboration with OWs, reaching agreement on individualised training plans in relation to availability of courses with registered training organisations, and submitting individual applications to the NACCHO affiliates for approval. The SBOs, DGPs and the NACCHO affiliates also had roles in supporting the OW workforce.

It appeared that a greater coordination and support role by SBOs and NACCHO affiliates would be of value to many host organisations and facilitate greater equity of training access. Several interviewees suggested that the ability to access funding for individualised training was dependent on the capacity of the employing organisation to identify appropriate training opportunities and to apply to DoHA for this funding – the administrative and coordination requirement was seen to be a barrier, particularly for smaller, less well staffed organisations that lacked well developed administrative capacity and networks. OWs in organisations with established networks and capacity were more successful in applying for and using the funding. For example, one OW based in an AHS had undertaken several relevant training courses including an Indigenous Leadership Course, Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice), Quality Use of Medicine in Hypertension, Quality Use of Medicines in Asthma and, during the evaluation period, was engaged in a Diploma of Aboriginal Primary Health Care. In contrast, several of the OWs in Sentinel Sites, had not accessed any individualised training through the measure; some accessed training through other sources, but others, particularly those in remote locations, appeared to have few or no suitable training opportunities.

In the early evaluation cycles, SBO interviewees indicated that the system, based on individual applications, made it difficult for them to support coordination of training, or to identify common training needs that might have been addressed in a coordinated way for improved efficiency. This was coupled with a perception that this was a ‘hidden aspect of the package and not well publicised’. Some SBOs believed this to be a ‘new component’ of the ICDP, and were unclear about how to participate. Interviewees from SBOs highlighted that while their organisations were contracted to support the

workforce in their respective sectors, they were unable to properly influence work, and were often unaware of program activity. They reported that this underlying issue limited their ability to ensure that training needs were met. SBO interviewees reported receiving information to inform their support role from networking sessions and reports from DGPs. This situation was compared unfavourably with the CCSS program, in which the SBO was both the fundholder and responsible for workforce support.

'This has been frustrating as we are uncertain how to effectively support when we do not always know the program of activity. It's working better with CCSS funding as we are the fundholders and support agency.' (SBO, program manager)

Towards the end of the evaluation period, it was noted that some SBOs had requested that they manage their organisations' training applications directly. They wanted more flexibility for meeting individual training needs, including (where appropriate) the implementation of training across the jurisdiction by both sectors. This request was supported by a DoHA decision towards the end of the evaluation period, allocating responsibility for coordination of training for DGP-based OWs to the SBOs. During the evaluation period, interviewees from the SBOs and the NACCHO affiliates indicated differing levels of awareness and differing perceptions of their role in relation to enabling OW access to individualised training. Some interviewees believed (erroneously) that OWs were unable to access funding for individualised training until they had completed the orientation. Since the orientation was delivered by the NACCHO affiliates, some DGPs in one jurisdiction felt that OWs in DGPs somehow had less access to this orientation, and therefore less access to the individualised training funding. In this jurisdiction, SBO interviewees believed that they were providing information on the availability of funding to DGPs, who otherwise would not be informed about it, and that they had spent significant time and energy negotiating with the NACCHO affiliate to enable access for the DGP funded workers to attend the training offered through the affiliate. In one specific instance, the training identified in an OW's training plan was not accessible through the NACCHO affiliate and the DGP felt that their requests for collaboration on training had been rebuffed by the affiliate. By contrast, in several other Sentinel Sites, DGP-based OWs accessed training through the NACCHO affiliate, including for example, Certificate III in Aboriginal and Torres Strait Islander Primary Health Care, formal AHW training and other accredited courses. This negative instance described above may have been an isolated occurrence. However, it may also indicate a need for a more systematic and sustainable cross-jurisdictional model.

Overall, it was apparent that the numbers of OWs that accessed individualised training funding was not a reliable indicator of training gaps, since there were many other sources of access to training. Also apparent from the findings was a general lack of a systematic approach to defining competencies required of OWs, identification of gaps, and designing of individualised training plans to address these.

12.3.3. CHALLENGES FOR BOTH ORIENTATION AND INDIVIDUALISED TRAINING

KEY POINTS

- Design of standardised orientation and developing systems to support individualised training was made challenging by the diversity of people recruited to the OW position – some were entry level recruits, with low literacy levels, and others were qualified and experienced professionals such as registered nurses and AHWs.
- Greater involvement of some OWs in supporting patients with complex health conditions than had been anticipated (for example, through evolving roles in supporting the CCSS program), led to concerns by some interviewees that the skills of some recruits were not well matched to job requirements, and that this mismatch was not easily addressed by provision of training.
- Differing roles of OWs in different settings, and differing community characteristics and their needs in relation to accessing Health Services complicated the development of a shared understanding about competencies required of the position and the design of standardised orientation packages.
- Roles identified and understood by OWs during jurisdictional orientation did not always match up to the employing organisations understanding of roles and this may have presented challenges to design of individualised training plans, and the management and support provided.

Several issues were identified as presenting challenges to the implementation of both orientation packages and individualised training. These included attributes of the OWs, including their skills, experience and expectations, and attributes of employing organisations, including their understanding of the OW role, and how OWs worked with other members of the team, including Care Coordinators. These are discussed below. The difference in roles in DGP compared to AHS and the range of barriers to access of training for OWs in remote locations was also relevant to the implementation of both orientation packages and individualised training, but as these have been discussed separately in the preceding sections, they are not repeated here.

Skills, experience and expectations of Outreach Workers

Whilst OW positions were originally intended to be 'entry level' positions, in practice, OWs brought a wide range and variety of skills and qualifications to the role – some OWs, particularly those in remote locations, had limited formal education, whereas others were well qualified and experienced professionals, for example, registered nurses or qualified and experienced AHWs.

Some interviewees from both sectors felt that the roles that OWs were being asked to perform were not appropriate to an entry level position. This was identified as a concern in urban, regional and remote sites. For example, SBO interviewees identified the need for basic health worker skills, necessary for dealing with patient health emergencies. The NACCHO affiliate interviewees in addition raised the need for a professional approach to privacy and confidentiality issues. It is notable that, for these interviewees, availability of orientation and individualised training for the OW did not sufficiently resolve the issue – it was not a simple matter of sending OWs to the relevant course for them to gain the skills.

'These people who have come in as Outreach Workers often don't have any health worker qualifications and what they are being confronted with is things that require these qualifications. [The] Outreach Worker's role is to facilitate access to health care services and this is done in a number of ways; through supporting community members to get from point a to point b, but what can happen in between point a and point b in this transport role is a myriad of things. People being transported obviously are people who need to access Health Services and therefore at times can be quite unwell, and people have had turns in cars and Outreach Workers have no idea what to do, so they are left to care without any knowledge of what to do.' (SBO, program manager)

A further factor impacting on expectations and evolving OW roles was the relationship that OWs developed with the CCSS program. Those OWs who developed close working relationships with the CCSS program tended to have greater involvement with patients with complex chronic care needs, compared to other OWs. As mentioned earlier, this complicated the development of orientation and training. Some DGP interviewees were concerned that OWs had not been recruited with this kind of work in mind, as this relationship had not been planned for.

'As SBOs have workshops with all the ICDP workforce (IHPO, OW and Care Coordinator) this discussion about a role of the OW is emerging in supporting the care coordination worker and this is creating some expectations amongst the workforce that they will be able to broaden their role. We are finding we need to work with the managers, CEOs and OW in the DGPs to come to an arrangement how you manage the expectation of the workforce.' (SBO, program manager)

There were expectations of complementarity between OW and Care Coordinator roles. Care Coordinators appeared to be seeking support from OWs (with SBOs encouraging this), and OWs anticipated working more closely with the Care Coordinators to facilitate access to care coordination services, including Supplementary Services funding. Ramifications for orientation packages and training included difficulties in describing to OWs their roles as part of the health system, when some OWs would be expected to work closely with Care Coordinators, for example, to identify vulnerable patients and accompany them to appointments, while others would be more involved with GPs through a DGP network, working with an IHPO, or as part of a larger Aboriginal health workforce.

Employing organisations had different expectations of what they wanted OWs to do. This was partly related to the nature of the community: requirements for improved connection between Health Services and communities differed between contexts, and this impacted on the OW role.

'This has been difficult to develop a standard approach as the roles the OWs are playing are so diverse from DGP to DGP. They all have a varying skill set on employment and also each community requires a different approach ... [it] has been a challenge because the nature of their role is unique to their areas, reflective of what communities are about and driven by organisations' own understandings of what the OW is doing ...- how management at DGP have conceptualised the OW role.' (SBO, program manager)

Softer skills, such as communication skills, knowledge of people and community, and confidence to feel comfortable going into people's homes with health messages, were identified by OWs, and by some of their employing organisations, as key to the effectiveness of the role. The extent to which these and other skills were addressed through available training was not clear.

Organisational understanding of the role and capacity for support

Over the evaluation period, it became apparent that orientation and individualised training which targeted individual OWs was of limited value if the organisation lacked understanding of how to use the role, and how to provide OWs with adequate organisational and management support. Interviewees identified that in organisations where there were divergent understandings about the OW role, it was difficult for entry level OWs to assert their understanding, or to work effectively. For example, some OWs reported returning to their organisations after orientation and finding that their managers did not share the vision of the OW role outlined in the orientation. Some interviewees suggested that capacity development activities targeting OWs needed to be supported by broader capacity development efforts targeting employing organisations if the objective of equipping OWs to work effectively was to be achieved. For example, some interviewees suggested training was needed for managers of the OWs within DGPs and, to a lesser extent, AHSs in how best to support the OWs to carry out the required program of work.

'There needs to be training for the people who are expected to support the OW in how to support the position.' (AHS, GP)

In general, whilst the OW role was valued, there was a lack of a clearly articulated vision of the core competencies required for OWs to effectively fulfil their roles, and how training could be systematically developed and coordinated to address the required competencies. There appeared to be a need for systematic assessment of the kind of support and mentoring needed by OWs, and of the organisational capacity required to provide this. This was evident in relation to the Outreach Worker orientation and training, but was a more general cross-cutting theme relevant to the workforce capacity and support of the whole of the ICDP, and is discussed further in Chapter 17.

The World Health Organisation (WHO) has identified a set of five basic competencies that health workers need in order to improve outcomes for patients with chronic conditions. These are: patient centred care; partnering; quality improvement; information and communication technology, and a public health perspective. Implications of these competencies for workforce support and training are shown in the box below.¹⁴⁸

Box 1: What healthcare workers should do as part of training to make core competencies for chronic illness care a reality¹⁴⁹

- Learn how to move from reactive care to proactive, planned, and preventive care
- Learn how to negotiate individualised care plans with patients, taking into account their needs, values, and preferences
- Learn how to support patients' efforts at self-management
- Learn how to organise and implement group medical visits for patients who share common health problems
- Care for a defined group of patients over time
- Work as a member of a healthcare team

¹⁴⁸ Pruitt, S, Epping-Jordan JE. Preparing the 21st century global healthcare workforce. BMJ 2005;330:63.

¹⁴⁹ Ibid.

- Work in a community based setting
- Design and participate in quality improvement projects
- Develop information systems (for example, patient registries) and use available technology and communication systems to exchange information on patients
- Learn to think beyond caring for one patient at a time to a 'population' perspective
- Develop a broad perspective of care of patients across the continuum from clinical prevention to palliative care

12.4. Findings from Sentinel Sites – training opportunities in AHSs for GPs and nurses

12.4.1. ADDITIONAL GP REGISTRAR TRAINING POSITIONS

KEY POINTS

- Uptake of the ICDP funded GP registrar positions in Sentinel Sites appeared to be low overall. However, awareness of these positions was high, and accreditation requirements were not perceived to be a barrier to greater uptake.
- There were more posts available than AHSs with capacity to supervise them, and GP registrars to fill them.
- Salary top-ups funded through GP registrar billing to Medicare were sometimes used to incentivise GP registrars to take up positions.
- For some AHSs, hosting a GP registrar placement was seen as an investment in future capacity of the workforce in Aboriginal and Torres Strait Islander health, rather than being an immediate benefit to the service. Others noted the potential of positions to alleviate workforce shortages in AHSs and to generate income through Medicare.
- Participation by AHSs in the GP registrar program was limited by:
 - A premium on physical space in many AHSs, amplified by the influx of new workforce and visiting health professionals under different programs.
 - Limited supervisory capacity, related to low numbers of vocationally registered GPs working in AHSs, high staff turnover, a large proportion of part-time GP appointments, and reduced time available for supervision due to high patient load and high proportion of patients with complex care needs.
- Broader-ranging refinements to the measure, such as establishing alternative 'roaming' models of supervision, additional funding for infrastructure to accommodate trainees, and support for AHSs to coordinate trainee positions and their supervision requirements were proposed by interviewees.

Uptake of funding for positions

All AHSs in the Sentinel Sites would have been eligible for one or more GP registrar positions, provided they met accreditation requirements.

At the time of the final evaluation cycle, about half (20/37) of interviewees (similar to the fourth evaluation cycle) indicated that they were aware that the Health Service had a GP registrar in the service either currently or in the past. This was not necessarily an ICDP funded position. Interviewees in urban areas were most likely to have reported that they were aware of their organisation having hosted a GP registrar, followed by interviewees in regional and then in remote sites.

There appeared to be generally low uptake of the ICDP funded GP registrar positions. The accreditation requirements were not reported as a barrier to greater uptake of these positions. Awareness of available GP registrar training posts was generally high in AHSs in the Sentinel Sites; this is unsurprising as the GP registrar subcomponent was an expansion of a longstanding existing opportunity for GPs in AHSs, managed by the same organisation (General Practice Education and Training). Across the Sentinel Sites, none of the interviewees from AHSs indicated that they had specifically taken up ICDP funding for a GP registrar training post.

There were no indications from any of the Sentinel Sites that AHSs felt they had enough GPs (including registrars) relative to their patient load or needs for services. Where organisations did not have a GP registrar position, or where the position was unfilled, the reasons for this primarily related to lack of ability to accommodate and/or supervise such positions and, to some extent, difficulty filling available positions. The ways in which these factors were evident in different contexts are outlined in the sub-sections below.

Recruitment and interest in positions

Interviewees in the majority of AHSs in the Sentinel Sites indicated that they had pre-existing GP registrar positions that they had been consistently unable to fill due to a limited supply of GP registrars willing to work in these sites. Some indicated that their organisations remunerated GP registrars at a higher level than comparable training positions in the General Practice sector, owing to difficulties in finding registrars willing to work with them. Some AHSs regarded GP registrar appointments as an important means of alleviating workforce shortages. Registrars were able to generate Medicare funding for the AHS, and interviewees indicated that salary top-ups provided to the registrars were subsidised by the Medicare generated funding. It was unclear from the SSE whether planned changes to reimbursement systems for GP registrar positions will impact on the ability of AHSs to top up registrar salaries to the same extent in the future.

Some interviewees from AHSs valued GP registrar training posts, not for what they could add to the service during training, but rather in an altruistic sense - that provision of training opportunities would potentially encourage GP registrars to consider a longer-term commitment to working in Aboriginal and Torres Strait Islander health.

'It's crucial to have Aboriginal health training posts to encourage exposure to Aboriginal health.'
(AHS, GP)

Several AHSs provided examples of GP registrars undertaking placements and going on to provide a service at the same AHS when qualified. Other sites witnessed GP registrars moving on to other positions in Aboriginal and Torres Strait Islander health.

'The last two placements have returned to remote clinics. Most of the GP registrar placements have an interest in Aboriginal Health.' (AHS, practice manager)

However, for the purpose of encouraging interest in Aboriginal and Torres Strait Islander health, a number of interviewees indicated that earlier exposure, at the level of the undergraduate medical student, may be more powerful as this is when many individuals developed career interests they would later pursue. This kind of exposure would require greater input from AHSs in orientation and supervision, with less (or no) immediate benefit to the service.

Physical infrastructure, management and supervision requirements

The lack of physical space, primarily consulting room space, was identified as a constraint to participation by AHSs in the GP registrar program, and to expansion of numbers of registrars. Some interviewees indicated that demands on available rooms had increased due to large numbers of visiting specialists and allied health professionals, and that this meant that they were unable to accommodate more trainee positions.

Lack of supervisory capacity was also a key constraint on ability of AHSs to participate, or expand their participation in the GP registrar program. Several AHSs in the Sentinel Sites indicated that they had made a strategic decision to only recruit Advanced Rural Skills Training Post Registrars as these GP registrars are in final years of training and require less supervision. Some AHSs (two in urban sites and one in a remote site), indicated that they would be unable to expand the numbers of posts due to both limited supervisory capacity and insufficient physical space.

'The funding does encourage AHSs to take [GP registrars] but you need an experienced GP as a supervisor. We don't have capacity to increase number at moment in terms of supervision capacity and rooms.' (AHS, GP)

Interviewees highlighted that the AHS sector generally had too few GPs able to supervise GP registrars. This was borne out by data from the 2009 Australian Institute of Health Workforce surveys,¹⁵⁰ which showed that only 214 vocationally registered GPs, 92 GP registrars and 27 other medical practitioners indicated an AHS as their primary place of work across Australia. This represented the total pool of GPs able to supervise students in AHSs (students may be medical students and/or registrars), compared with 18 837 GPs who listed General Practice as their primary place of work.¹⁵¹

Supervisory capacity of vocationally registered GPs in AHSs was limited by:

- A large proportion of part-time GP appointments.
- Perception of a high patient load and complex care needs of patients reducing the time available for supervision.
- High staff turnover and difficulty filling GP positions in some areas, associated with concerns that some AHSs may not be able to fulfil the supervisory obligations for GP registrars.

¹⁵⁰ AIHW, Medical Labour Workforce 2009 [website] <<http://aihw.gov.au/publication-detail/?id=10737419680&tab=3>> (accessed 21 September 2012).

¹⁵¹ Ibid.

12.4.2. NURSING SCHOLARSHIPS FOR PROFESSIONAL DEVELOPMENT OF NURSES IN ABORIGINAL HEALTH SERVICES AND SCHOLARSHIPS FOR NURSES UNDERTAKING A CLINICAL PLACEMENT IN AN ABORIGINAL HEALTH SERVICE

KEY POINTS

- There was little evidence from the Sentinel Sites that the ICDP funded scholarships had created opportunities not previously available to support training for nurses.
- Some interviewees felt that these scholarships were unnecessary as there were already many existing training opportunities. Others expressed strong views about a need for better communication about these, implying that poor dissemination of information was the main barrier to better uptake. The reasons for these divergent views were not clear. Uptake of scholarships increased following implementation of communication and other strategies.
- There were no clear linkages identified in the Sentinel Sites between defined competencies for chronic illness care and the professional development scholarships.
- AHS capacity to host clinical placements for nursing students was possibly already reaching saturation prior to the ICDP. Accommodation for student nurses was a barrier to greater participation in hosting student placements in remote sites.

Uptake of nursing scholarships for professional development of nurses in Aboriginal Health Services

Program data available from DoHA indicated that for 2012 there had been up to eight professional development scholarships offered in Sentinel Sites, an increase from one in 2011.

In the final evaluation cycle, half (19/38) of interviewees in case study sites indicated that they were aware of the new ICDP funded scholarships for nurses working in AHSs to undertake professional development. This was an increase from the fourth evaluation cycle where one third (12/33) indicated awareness. Awareness in the final cycle was highest in urban sites followed by regional and remote sites. When probed further it was evident that interviewees generally were aware not of the ICDP funded scholarships, but existing scholarships for ongoing training. Many interviewees expressed uncertainty about how to access information about the scholarships. Responding to requests for information, the SSE team showed interviewees' web links to the relevant RCNA webpages following interviews. In the final evaluation cycle, a nurse in a remote site indicated that, following sharing of information during a previous SSE site visit, an application had been submitted and a scholarship awarded. Dissemination of information about scholarship opportunities seemed to vary within different AHSs; some AHSs had well developed internal communication systems for this purpose, others did not. Some AHSs felt the responsibility for better communication lay with DoHA.

'[The nursing scholarship] ... is poorly communicated. I'm not sure how this is communicated now, even a couple of fact sheets and letters would be sufficient ... email is received from different sources but not all emails get looked at ... ideally the information should be forwarded to the HR managers of the Health Services because they are generally responsible for coordinating the training within the organisation.' (AHS, CEO)

Other interviewees indicated that individual staff members were more proactive in seeking opportunities from sources other than DoHA. For example, in one site a nurse indicated that an AHS

colleague had applied for one of the ICDP funded scholarships after seeking information by email directly from the NACCHO affiliate.

In contrast to perceptions of lack of communication outlined above, other interviewees reported that many training opportunities were available through various sources, and that there was little need for additional scholarships.

'Most nurses currently working in an AHS are already fully involved in continued education. They often can't take on any more activity.' (AHS, practice manager)

Also indicated by the quotations above, was that there did not appear to be any particular incentive for nurses to take up the ICDP funded scholarships in preference to other scholarships. The ICDP scholarships did not appear to have a greater monetary value than other scholarships, or be linked to a clear training pathway for nurses in chronic illness care.

Scholarships for nurses undertaking a clinical placement in an Aboriginal Health Service

Program data from DoHA showed that in 2012, six clinical placement scholarships enabling students to work in Sentinel Sites had been awarded. This represented a small increase from 2011 allocations, and was approximately one-tenth of the national allocation.

In the final evaluation cycle over half (22/38) of interviewees indicated that they were aware of the ICDP funded scholarships for nursing clinical placements. Awareness was higher in urban sites, followed by regional and remote sites.

For some of the AHSs in the Sentinel Sites, hosting a student nurse was perceived to add to supervisory and administrative requirements, with little benefit to the organisation, in an environment that was already constrained in these areas. Similar to the issues outlined for GP registrar placements, there was also concern about lack of supervision capabilities of existing staff at AHSs, which would impact on their ability to supervise student nurses. In a number of remote sites, accommodation for nursing placements was raised as a barrier to services hosting these placements. Interviewees from AHSs noted that they were not involved in promoting the placements – but that it was generally the responsibility of the students to identify a relevant organisation, and approach them with a request for a placement.

'It's up to individuals [undergraduate nurse] if they would link with the AHS for a placement. It is not the AHSs who will go out and actively promote the clinical placement.' (AHS, CEO)

Students were supported in finding placements by university placement officers. Interviewees from AHSs in the Sentinel Sites noted that they often already had established links with these placement officers and with nursing schools, and would accept requests for placements, if they had the capacity to do so. These arrangements pre-dated the ICDP, and some AHSs indicated that their capacity to accommodate placements was already saturated through regular requests from these existing contacts.

12.4.3. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION OF OUTREACH WORKER ORIENTATION AND INDIVIDUALISED TRAINING

KEY POINTS

- Effective implementation of the OW orientation and individualised training required the design of orientation and individualised training models to meet the needs of both the AHS and the General Practice sector, to fit with the establishment of the OW role in the organisation, and for staff development to be linked to identified capacity gaps.
- At site level, constraining factors included the evolving nature of the OW role during the evaluation period, the staggered recruitment of OWs (which meant that orientation was not timely for many) and changing roles over the period of delivery of orientation packages, and short term funding cycles.
- Shared understanding of common training needs; a critical mass of OWs, employers and skilled facilitators engaged in defining roles; and flexible and supportive regional or jurisdictional support to organisations in coordination of training were important determinants of the extent to which the orientation and training met the needs of both sectors.
- OW roles needed to be established within organisations, particularly DGPs, which tended to have little prior experience with similar positions. This was enabled where there was strong organisational and management capacity, and good networks between the employer and training organisations. Characteristics of OWs, particularly their experience and connection and credibility with community were also key influences of the extent to which the role could be established successfully.
- A key constraint on the development of OWs linked to identified capacity gaps, was the general lack of understanding of competencies required for the role, including generic competencies shared by OWs across sectors, generic competencies shared by other ICDP workforce, and competencies specific to the position within an AHS or DGP/Medicare Local. Diverse sources of funding for training, and the lack of a definition of what was required, made it difficult to ascertain remaining needs for support.
- Delivery of joint orientation with different ICDP workers enabled collaborative working relationships with other ICDP team members in some sites. Difficulty defining the OW role, and unrealistic expectations of role in general and specifically with regard to potential for population coverage may have constrained greater complementarity between measures.

Effective implementation of this measure as envisaged in the program logic would result in a greater number of people working in the health workforce who are trained to provide quality of care to Aboriginal and Torres Strait Islander people, value and benefit from the training received, intend to remain in the workforce, and that primary care services improve capacity to identify and provide care for Indigenous Australians with or at risk of chronic disease. This chapter has identified a range of enablers and constraints that influenced the extent to which effective implementation could be achieved at the local level.

Following the presentation of the findings on the different elements of the measure, the sections below discuss enablers and constraints separately for those elements of the measure targeting Outreach Workers (orientation and individualised training), and the elements targeting nurses and GPs (GP

registrar positions, continuing professional development scholarships for nurses, and student nurse clinical placements).

Our analysis identified four main mechanisms through which the orientation and individualised training elements of the measure appeared to achieve change in different contexts. As is evident through the analysis presented above, the orientation packages and models for delivery of individualised training models were still in relatively early stages of implementation in the Sentinel Sites at the time of the final evaluation cycle. Nonetheless, orientation packages and training had been implemented differently in different jurisdictions, and in different organisations within Sentinel Sites, with different outcomes. The analysis presented in this section is based on consideration of the evidence related to these differences. It aims to identify the mechanisms through which effective implementation can be achieved at the local level, and the influences that enable and constrain each of these mechanisms. The mechanisms identified are shown in the central boxes in Figure 12.1.

Constraints		Mechanisms		Enablers
• Evolving roles of OWs in DGPs • Short term funding cycles and uncertainty in fundholding • Staggered recruitment of OWs	→	Orientation and individualised training models that meet DGP and AHS service needs	←	• Shared understanding of common training needs and sector-specific training needs • ‘Learning by doing’ and critical mass of OWs and employers participating in role definition • Flexible regional and/or jurisdictional support for coordinating training needs
• Limited management and supervisory capacity • Lack of experience with Aboriginal and Torres Strait Islander workforce in some DGPs • Difficulty defining boundaries of role in AHSs with similar roles, and mobility between positions • Restricted staff complement and/or workforce mobility • Lack of community connection	→	OW role established in organisation	←	• Strong organisational capacity, including good management and supervision of OWs • Organisational cultural awareness and existing Aboriginal and Torres Strait Islander teams • Good networks between organisation and training providers • Networking opportunities for OWs • OWs with good community connection and knowledge and trust of service environment
• Lack of workable training models suitable for remote context • Perceptions of inflexibility of funding and burdensome administrative requirements • High staff turnover, job mobility and need for cross-over roles • Training extending beyond period of staff contracts • Lack of clearly defined competencies required and training to address these	→	Staff development linked to identified capacity gaps	←	• Employing organisations with good networks and capacity to identify relevant training • Regional/jurisdictional systems to support organisations in identifying and addressing training needs
• Training delivery (whether specific to OWs, ICDP workforce, or whole of PHC team) determined by ease of administration, not strategic choice • Unrealistic expectations of role and ICDP coverage • Lack of understanding of ICDP as a package – across various levels of the health system	→	Complementary linkages with other ICDP funded activities established	←	• Vision for training as team-building and good fit between vision and strategy • Joint orientation training with other ICDP funded positions • Ongoing consultation between sectors, support organisations and employing organisations • Co-location and secondments

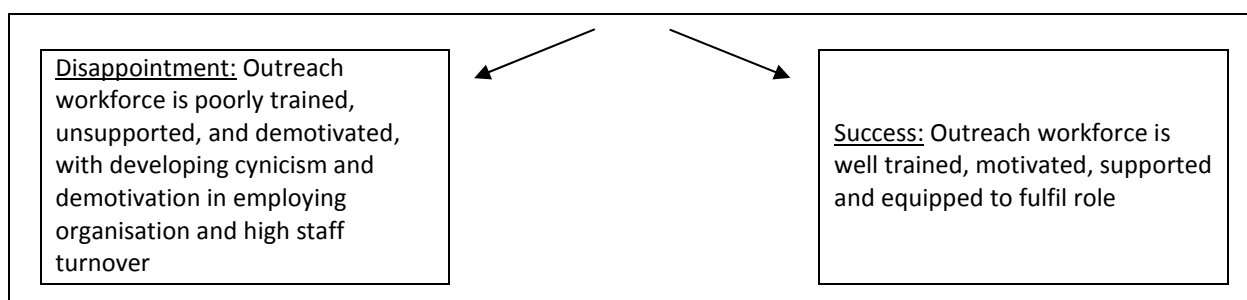


Figure 12.1: Enablers and constraints to effective implementation of the orientation and individualised training for Outreach Workers measure

Establishment of orientation and training models that meet both DGP and AHS service needs

One of the requirements of the OW orientation and individualised training was that jurisdictionally relevant orientation packages were to be developed that met the orientation needs of OWs working in DGPs and in AHSs, and that individualised training plans were developed for OWs to enable them to fulfil their roles effectively. Key factors that appeared to influence the effective establishment of models that met needs of both sectors at site level are outlined below.

A shared understanding between the sectors, and with training providers, about common and sector-specific orientation and training requirements enabled the establishment of effective models that met both DGP and AHS service needs. Since the OW role was a new role for DGPs (in contrast to AHSs that had experience with similar roles) some DGPs noted initial uncertainty about how the role would work in their context. This undoubtedly would have impacted on their ability to participate on an equal footing with AHSs in early consultative processes about what orientation needed to include. In the sites in which shared understanding was considered to have developed, this was not always part of an early consultative process as envisaged in the design of the orientation, but came later, through ‘learning by doing’. For example, DGP interviewees described a large state-wide gathering as fulfilling a key orientation role, through getting a critical mass of OWs and employing organisations in the same venue and determining the specifics of the role in different contexts.

The success of state-wide and national OW conferences and meetings in achieving orientation goals appeared to be related to their ability to direct focus to the bigger picture and to draw on a wide range of OW experience in different organisational settings to inform discussion about the OW role and how it played out in each sector.

Constraining factors included short term funding cycles and uncertainty regarding ongoing funding, leading to malaise about training, as its future utility was unclear. This appeared to affect the DGP sector to a greater extent than the AHS sector, possibly because of the additional uncertainties introduced by the transition to Medicare Locals, and the greater experience of the AHS sector in working with an Aboriginal and Torres Strait Islander workforce in this way.

Regional support for training needs, coupled with flexibility in implementation to suit local context, was an important enabler for this mechanism, and also a cross-cutting theme influencing effective implementation across many aspects of the ICDP. For example, whilst it had initially been intended that employing organisations (in consultation with training organisations and NACCHO affiliates/DGPs) were to take responsibility for driving individualised training, in some jurisdictions, SBOs and/or NACCHO affiliates took a greater leadership role in identifying common individualised training needs and coordinating training in accordance with these common needs. This greater leadership role at

jurisdictional and/or regional level was in response to limited organisational capacity at the local level and developed over time. In at least one jurisdiction, common training for the whole of the ICDP workforce was being considered, as this was the model that the jurisdictional stakeholders believed to be most appropriate in supporting the intent of the measure.

Staggered recruitment of OWs, whilst part of the implementation plan, appeared to constrain the design of appropriate orientation, due to the delay in clarification of expectations regarding the background and skills of the OWs, and which organisations they would be based in. It also made it difficult to deliver orientation at the appropriate time in relation to individual appointments, and difficult to achieve a critical mass necessary for networking and discussion about roles.

Establishment of the OW role within the employing organisation

The establishment of the OW role within the organisation was a key mechanism through which the OW orientation and individualised training could achieve the goal of improved capacity within primary health care services. Where this worked, we would anticipate the OW to be a valued member of the primary health care team, and fulfilling roles consistent with the intention of the position. In the Sentinel Sites, it was apparent that establishment of the OW role within employing organisations was not straightforward, and was influenced by a number of factors - some of these were related to the capacity of the organisation to absorb and support the new position, and others had to do with the characteristics of the OWs employed and with the way in which the orientation and training was delivered in different settings.

Organisations that were well networked with training providers and had a broad knowledge of resources and training available, and their strengths and limitations, were better able to apply for and use individualised training funds, recognise the OW contribution, and embed the role within the organisation structures. This was often coupled with good supervisory and management capacity. OWs employed in organisations with strong capacity to supervise, manage and support them in their role, were more likely to be able to apply their knowledge and skills gained through orientation and training opportunities, along with other skills that the incumbent brought to the role. Where management and supervisory capacity were weak, OWs were unable to use the skills and knowledge gained through orientation and training, and were either relatively unproductive in relation to their core responsibilities, in some instances because they were drawn into activities that differed from what they had been led to expect, through orientation, to be their intended role. We did not identify any arrangements in the Sentinel Sites in which employing organisations were supported in respect of their capacity to manage and supervise OWs.

In establishing the OW role, both AHSs and DGPs experienced challenges related to limited management and supervisory capacity. For many DGPs, there was the additional dimension of capacity required to integrate an Aboriginal and Torres Strait Islander workforce into a non-Indigenous working environment. For these organisations, the establishment of the role was both enabled by, and enabled learning about, cultural appropriateness and cultural safety and the support needs of an Aboriginal and Torres Strait Islander worker in this environment. Conversely, where there was already an Aboriginal and Torres Strait Islander team established in the DGP, for example, through other funding sources and historical commitment to Aboriginal and Torres Strait Islander health, the establishment of the OW role was enabled. For AHSs, one of the key challenges in establishing the OW role seemed to be about defining role boundaries, particularly in environments where there was considerable mobility of the Aboriginal and Torres Strait Islander health workforce – some OWs had previously been employed for many years as, for example, nutrition workers or AHWs, or other roles that had some similarity with the OW role, but also had important differences. For organisations sharing the context of workforce

mobility, ability to establish the specific OW role (and to access appropriate training, or attend orientation) was constrained. Similarly, in organisations where there was a restricted staff complement, OWs were noted to have to perform generalist roles, or adapt their role to what was required at any particular time, further constraining the establishment of the role as envisaged by the program design.

Factors related to the characteristics of OWs that constrained the establishment of the OW role, included limited supply of the 'ideal' candidate - some OWs, despite high education levels, and a good skills set, were still unable to perform the role as envisaged if they lacked, for example, a good connection with community. In some sites, there appeared to be a general under-estimation of the complexity of cultural relationships, and what was required from the OW for the role to be effective.

Trusting relationships with both community and with the employing organisation were both necessary for establishment of the role. For example, where OWs were employed who were relatively 'senior' and had robust linkages with the community, along with the ability to influence the ways of working in their employing organisation where necessary, the establishment of the role was enhanced.

Staff development linked to identified capacity gaps

Developing the capacity of OWs in relevant areas was identified as a key mechanism through which this measure was able to achieve change. This happened to varying extents in the Sentinel Sites – where it worked well, OWs were accessing training resources (whether through the ICDP funding, or through other sources), and had opportunity to apply the skills that they had gained.

The capacity of employing organisations to identify relevant training opportunities, and to meet the necessary administrative requirements to access funding, and facilitate OW participation was a key enabler of this mechanism for some Health Services. In response to capacity gaps at the organisation level, some regional/jurisdictional systems had been developed to support organisations in identifying and addressing training needs, and to achieve greater efficiency in use of resources, for example through setting up specific training to address common needs. This was an enabler for staff development in some contexts. However whilst there was a clear need for support for employing organisations, the evolving models of support did not work for everyone. In particular, it was apparent from evaluation visits to remote Sentinel Sites, that these general regional- or jurisdictional approaches had not yet been developed in a way that was suitable for some of the remote-based OWs. This was either because of travel requirements to attend training in larger towns, and OW reluctance to travel, or because employers felt that the training was unsuitable for their context. In general, there appeared to be a lack of formal training models and opportunities appropriate for the remote-based OWs.

Other constraints to the operation of this mechanism included perceptions of inflexibility in funding criteria and/or limited awareness of the funding, perceptions that administrative hurdles were not worth the effort of accessing the funding, and utilisation of other funding sources, such as core funds. Some organisations valued team-based approaches over individualised training, constraining uptake of individualised training.

Instability of the OW workforce, and perceptions that OWs may be deployed elsewhere, or that contracts would end before training was completed, also constrained uptake of individualised training, particularly longer-term courses.

An overarching consideration that appeared to constrain the effective development of staff according to identified capacity gaps, was the general lack of clear and comprehensive identification of core competencies required by OWs (including competencies shared by other members of the ICDP workforce, and those specific to the OW role), and development of orientation and individualised

training plans with reference to these competencies. There were no instances in the evaluation site visits in which stakeholders referred to clearly defined competencies and how OW training and staff development was aligned with required competencies of the role.

Complementary linkages with other ICDP funded activities established

The workforce support, education and training measure provided a potentially critical linkage between OWs based in DGPs and OWs based in AHSs (measures C2 and C3) through the design and delivery of shared orientation packages for OWs from the two sectors. Where the needs of both sectors were addressed through the orientation, and/or where consultative processes were effective, complementary linkages between these two measure areas were strengthened. Conversely, there were no specific examples identified in the Sentinel Sites of individualised training funding being used specifically to enhance linkages between sectors (for example, to facilitate or fund secondments of OWs between AHSs and DGPs), suggesting that the potential of the measure to promote inter-sectoral collaboration was not fully realised.

Roles of OWs in DGPs and AHSs (see Chapters 13 and 14 respectively), included descriptions of complementary linkages between OWs and almost all of the other ICDP measures. The extent to which these complementary linkages were reflected in and supported by the orientation packages, and the individualised training, was unclear. Where joint orientation with other members of the ICDP workforce was conducted, linkages were formed at local level between the different positions, and collaborative approaches to working together were enhanced. For example, expectations were developed about the role OWs could play in supporting Care Coordinators in some areas following joint orientation and training workshops involving these workers. In other instances, joint orientation including HLWs and TAWs reportedly enabled the development of greater complementarity in roles at local level.

Many organisations expressed preferences for joint training of OWs together with the other members of their primary health care teams (for example, AHWs, nurses and others). Underlying this preference for some, appeared to be the recognition that how training was delivered sets the tone for how services are delivered - with a preference to build a strong primary health care team, rather than a siloed or vertical ICDP or outreach program. For others, the relative ease of access in organising training from a common funding pool, rather than separate acquittal from different funding sources, would have explained their preference for 'whole of team' approaches to delivery of training. What appeared to be important was that a strategic approach was taken to the type of training that was accessed – rather than the type of training accessed being predominantly determined by how easy it was to organise.

12.4.4. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION OF CLINICAL TRAINING PLACEMENTS AND SCHOLARSHIPS

KEY POINTS

- Effective implementation of the clinical training placements and scholarships required that implementation was workable and practical for the AHS, that the measure aligned with, or appealed to core values of the AHS, and that complementary linkages with other aspects of the ICDP were developed.
- AHSs were constrained in their ability to participate through lack of supervisory capacity, and lack of physical space to accommodate trainees in the workplace. These constraints often co-existed. A further constraint for remote sites was lack of residential accommodation for trainees.
- The practicality of participation was enabled in contexts in which:
 - Placement candidates were viewed as a valued resource, alleviating workforce shortages; this was linked to GP registrar ability to bill Medicare for services, and to services hosting only those placements that would provide direct benefit to the service.
 - Good supervisory capacity and adequate physical facilities to accommodate trainees, and visiting health professionals available through other programs.
- Leadership in the AHS and championing a core value related to contributing to education, and positive past experience with hosting trainees, enabled the measure to work through aligning with AHS core values. The lack of clear links between the nursing scholarships, and commitment to chronic illness care, may have constrained the operation of this mechanism in relation to uptake of nursing scholarships.
- There is potential for complementarity between the measure and other aspects of the ICDP, but this has not yet been fully realised. Competing demands on physical space, and lack of clear understanding about participation of GP registrars in Medicare billing constrained the development of greater complementarity.

The clinical training placements and scholarships component of this measure, targeting GPs, nurses in AHSs and nursing students can be viewed as a longer-term strategy to increase capacity in the primary care workforce in relation to provision of quality care for Aboriginal and Torres Strait Islander people – and we would not expect to see increased numbers of trained and equipped nurses and GPs working in AHSs at this early stage.

With regards to effective implementation, this component of the measure required that the measure was workable and practical for the AHSs, and that they were motivated and committed to participate. These mechanisms of change, along with the factors that appeared to enable or constrain their activation at local level are shown in the central boxes in Figure 12.2 and described in the text below, with examples from the Sentinel Sites.

Implementation workable and practical for the AHS

For the measure to be effectively implemented, implementation needed to be workable and practical for the AHS. There were some indications in the Sentinel Sites that pre-existing training opportunities had largely saturated existing AHS supervisory capacity prior to introduction of the measure,

contributing to the generally low uptake of ICDP funded training positions. There may have been a 'negative feedback loop' in the system, in which low numbers of supervisors had resulted in lower numbers of trainees, further contributing to longer-term low numbers of supervisors.

Some organisations adopted a strategy in which they offered training positions only to those types of trainees who could work fairly independently, and offered a clear benefit to service delivery, such as GP registrars in their final years of placement. For AHSs with limited supervisory capacity and that otherwise may have been unable to participate in the measure, this strategy was an enabler to implementation being workable and practical for them. Across the Sentinel Sites, several AHSs had adopted this strategy – these were located in urban, regional and remote locations. However, this approach is constrained by the availability of advanced level registrars.

Related to this enabler, it was evident that where the placement candidates were seen as a valued resource by the AHS, this enabled practical and workable implementation. This was relevant to GP registrars, not to student nurse placements. The ability of GP registrars to generate Medicare revenue was important in this context – in some cases Medicare revenue was used to top up GP registrar salaries, to attract them to work at the service, and in other cases, contributed to the general revenue of the AHS. Those AHSs without adequate supervisory capacity (also possibly the ones who had the greatest GP shortages to start with) were less likely to be able to access the additional resources available through GP registrar placements – a parallel to the inverse care law, in which the availability of good medical care varies inversely with the need for it in the population served.

A constraint to practical implementation for some AHSs was a lack of physical space in Health Services to accommodate GP registrars. Limited supervisory capacity and physical space constraints in some cases occurred together, with the less well resourced and lower capacity AHSs, affected by both constraints. In some contexts, pressures on physical space in the AHS were amplified by increased resources available through the ICDP, and other programs, for visits to AHSs by outreach specialists and allied health professionals. Again, these constraints were noted across different geographic locations. Conversely, enabling practical and workable implementation for the AHS, were good supervisory capacity and adequate physical space in which GP registrars and other students could be placed. For remote and outer regional sites, lack of residential accommodation for trainees was a key constraint on their ability to accept both GP registrar placements and student nurse placements.

Measure aligns with core values of AHSs

The extent to which the trainee and scholarship opportunities achieved (or failed to achieve) an appeal to core values of the AHSs was identified as one mechanism through which this aspect of the measure achieved its effects. Where this mechanism was operating, participating organisations had a sense of 'doing good' for the greater benefit of Aboriginal and Torres Strait Islander health, motivating their participation.

The presence of strong leadership in the AHS with a passion and commitment for teaching was identified as a key enabler for this mechanism. For example, in the one urban site where the AHS provided a strong academic environment, interviewees attributed the success of their GP registrar program to the passion for education of a key individual (a senior doctor) who made it his business to support the GP registrar program and ensure its success. This commitment to education, and the role of this key individual, was mentioned over successive evaluation cycles, suggesting a long-term commitment to this core value.

Positive past experience was also identified as an enabler of effective implementation in some contexts. For example, in discussing the value of hosting of GP registrars, and their support of the registrar

program, interviewees mentioned past trainees that they had hosted, and were able to identify where these now qualified professionals were working (in other Aboriginal and Torres Strait Islander primary care settings). This may also have reflected the 'small world' of Aboriginal and Torres Strait Islander primary health care, and the reputational capital that accrued to some AHSs through their hosting of students, reinforcing participation in the program.

Uptake of the nursing scholarships was generally low – as shown earlier, there were no clear advantages noted to participate in these scholarships. The lack of focus on chronic illness care in the nursing scholarships, and that they were not linked to a clear career pathway for nurses, was identified as a constraint on their appeal to core values of nurses working in Aboriginal and Torres Strait Islander primary health care settings.

Ensuring complementarity and linkages with other ICDP funded activities

This aspect of the measure was not linked directly to other aspects of the ICDP, but several measures are likely to be complementary to it. For example, it would be anticipated that the funding available through the ICDP for capital works infrastructure could have alleviated some of the physical space constraints that have been noted in earlier sections of this chapter as constraining greater participation by AHSs in hosting training positions. Similarly, increased revenue available to Health Services through the adult health assessments, and expanded MBS item numbers could in theory have been used to expand supervisory capacity where this was a constraint to greater participation by AHSs. Although these synergies may have occurred, we could not identify any clear examples from the SSE confirming this. The deficiency nationally of qualified supervisors constrained the extent to which funding could provide a short-term solution.

GP registrars played a role in some Health Services in increasing uptake of adult health assessments – this is described further in Chapter 6. In some cases, expectations that registrars perform this role were resisted by registrars, who felt that they were not there to 'make money'. This may have been linked to a lack of clear understanding amongst registrars about the clinical relevance of adult health assessments, and their potential to improve care for their patients if linked into a comprehensive care process. It was also likely to be linked to a more general lack of clarity about Medicare billing arrangements and what was and was not permissible for salaried professionals in terms of billing for services, and how the funds could or should be used.

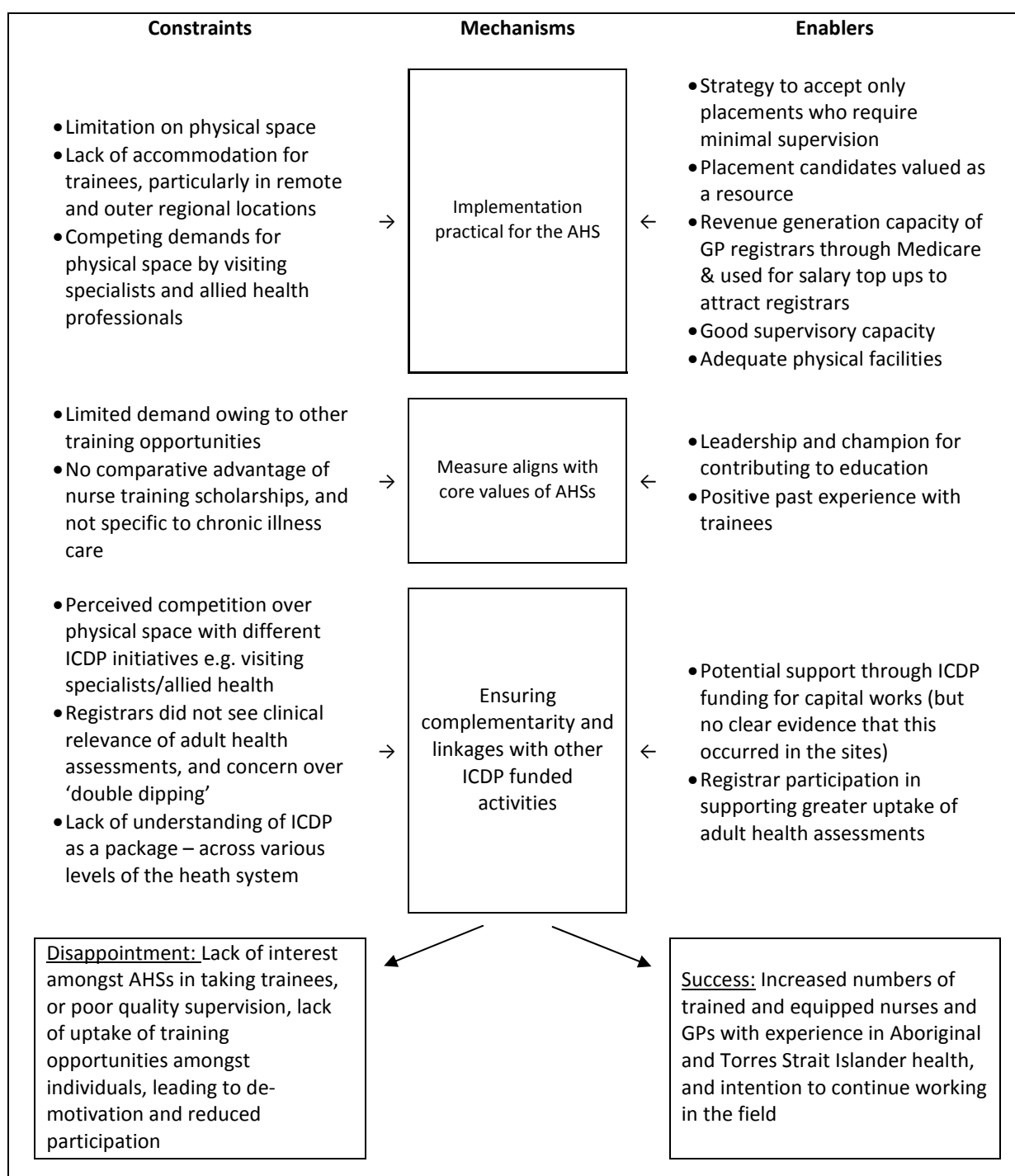


Figure 12.2: Enablers and constraints to effective implementation of the clinical training placements and scholarships measure

12.5. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the SSE in relation to the logic within the National Framework. This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

12.5.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Table 12.2: Summary of key findings in relation to the program logic – Workforce Support, Education and Training measure

	Summary of key findings from SSE
Outputs for year 1 and beyond	
The measure is implemented in accordance with the work-plan.	Orientation was delayed in many sites owing to consultation processes and other factors. Delays in orientation provided opportunities for peer-to-peer learning, including support to new recruits by more experienced OWs. Remote and outer-regional OWs in general had greater difficulties accessing orientation and individualised training than their urban and inner regional counterparts. Orientation packages that were delivered were in general less well suited to DGP-based than to AHS based OWs. Regional/jurisdictional approaches to coordination of individualised training were developed in some sites, but were at a fairly early stage at the time of the final evaluation visits. AHS uptake of GP registrar positions and student nurse placements was generally low.
Expected early results for years 2 – 4	
Participants in C1 activities are effectively oriented, trained and supported to provide quality care to Aboriginal and Torres Strait Islander people.	Effective implementation of orientation and training has been constrained by a number of factors described in this chapter. Of overarching importance is the apparent lack of clear and comprehensive specification of competencies required by OWs evident relevant for guiding development of orientation or individualised training plans. At the local level, support provided to OWs was influenced by the capacity of employing organisations to provide this support, and there were no initiatives identified for development of organisational capacity to provide support to OWs. It may be that such initiatives existed, but were not identified in the evaluation visits.
Participants in C1 activities value and benefit from the training and the placements.	Orientation programs and SBO-organised training were valued for the opportunities provided for networking and peer-to-peer sharing. They were criticised in some instances for not being responsive to the needs of the OWs in DGPs.
Expected medium term results for years 4+	
There are more people working in the health workforce who are trained to provide quality primary health care to Aboriginal and Torres Strait Islander people.	Owing to the range of training opportunities available to OWs, nurses and GP registrars, it was difficult to form an assessment of the extent to which the ICDP funded training opportunities have contributed to expanded capacity of the workforce in relation to providing quality primary health care to Aboriginal and Torres Strait Islander people. Achievement of this result in the future will most likely be dependent on addressing capacity of AHSs to supervise and mentor trainees and outreach workers, and to provide physical space to accommodate trainees.
Participants in C1 activities intend to continue working in primary health care and other services assisting Aboriginal and Torres Strait Islander people.	Positive past experiences in relation to GP registrar positions suggest that this may be achieved. The contribution of orientation and training opportunities for OWs to retention of this workforce appeared to be influenced by the short-duration of contracts, uncertainty over ongoing funding, and in some cases, inadequate management and supervision.

	Summary of key findings from SSE
Primary health care services improve their capacity to identify and provide quality care for Aboriginal and Torres Strait Islander people with or at risk of chronic disease.	Contribution of the measure activities to the achievement of this goal is difficult to ascertain at this relatively early stage of implementation.

12.5.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Workforce Support, Education and Training measure.

This section provides a summary of the key findings in relation to the Workforce Support, Education and Training measure.

Development and uptake of Outreach Worker orientation

Different consultative processes were evident in relation to development of OW orientation. In some sites, inadequate consultation about orientation needs was perceived to have resulted in inappropriate orientation for DGP-based OWs, and/or those in remote sites. There were some successful models where orientation appeared to work well for both sectors, but little or no evidence of successful models of orientation for remote based OWs.

Delays in roll out of orientation packages led to opportunities for transfer of learning from more experienced OWs to new workers, and outreach workers learning on-the-job ('learning by doing'). Workforce changes (in particular, the establishment of the Care Coordinator role) and the transition to Medicare Locals, led to the evolution of OW roles during the evaluation period. This evolution required flexibility in the design and delivery of orientation over time.

Generic orientation for the ICDP workforce was preferred at local level owing to opportunities to develop collaborative working relationships between different team members, and was considered to be better suited to situations in which there was considerable mobility of workers (for example between OW, TAW and HLW positions). There was no evidence to indicate that core competencies for the ICDP workforce, and specific competencies for OWs (and other workers) had been defined, gaps identified, and orientation designed to address these.

Outreach Worker individualised training

Types and levels of training accessed through the measure varied widely. Access to training was influenced by capacity and values of host organisations, geographic location, type of training available, and other training opportunities (through other sources, such as state/territory or program funding).

Commonly identified challenges for individualised training included limited awareness of the funding; lack of capacity to identify training needs and match these to training opportunities; and preference for using other resources for training (partly due to preference for joint training with other members of the organisation or primary health care team, and to unfamiliarity with administrative requirements for accessing support through the OW individualised training funding). Uncertainty over ongoing funding

for OW employment and contract dates expiring also appeared to limit the duration of training that employers considered appropriate, and the extent to which they were prepared to invest effort in organising training.

SBO and NACCHO affiliates had differing expectations regarding their role in coordination and support of OW training. Initially SBOs felt hindered in fulfilling their support role as they felt that they did not have timely access to information about individual applications for training, and therefore they did not know how to support requests. Different approaches to implementing individualised training (such as identifying common training needs across a jurisdiction, and planning at jurisdictional level) were being considered by at least one SBO at the time of the final evaluation cycle, with support from DoHA.

The point made above about lack of clearly defined core competencies in relation to orientation is perhaps even more relevant to informing the development of individualised training plans for the ICDP workforce, including for OWs.

Challenges for both orientation and individualised training

Design of standardised orientation, and developing systems to support individualised training, was made challenging by the diversity of people recruited to the OW positions, and by differing roles of OWs in different settings. In some instances, OWs had greater involvement in supporting patients with complex health conditions than had been anticipated by employers (for example, through evolving roles in supporting the CCSS program). This led to concerns by some interviewees that the skills of some recruits were not well matched to job requirements, and that this mismatch was not easily remedied through training. Differing community characteristics and their needs in relation to accessing Health Services presented challenges for the development of a shared understanding about required competencies, and for the design of standardised orientation packages and individualised training plans that would support development of relevant and transferable knowledge and skills.

Roles identified and understood by OWs during jurisdictional orientation did not always match up to the employing organisations understanding of roles. This may have presented challenges to design of individualised training plans, and the management and support provided to OWs by their employers.

Additional GP registrar training positions

Uptake of the ICDP funded GP registrar positions in Sentinel Sites appeared to be low overall. However, awareness of these positions was high, and accreditation requirements were not perceived to be a barrier to greater uptake. There were more posts available than AHSs with capacity to provide appropriate supervision, and GP registrars to fill them. Salary top-ups funded through GP registrar billing to Medicare were sometimes used to encourage GP registrars to take up positions.

For some AHSs, hosting a GP registrar placement was seen as an investment in future capacity of the workforce in Aboriginal and Torres Strait Islander health, rather than having an immediate benefit to the service, and this was noted to be a motivator for participation. In some organisations, core values of education and expansion of capacity in Aboriginal and Torres Strait Islander health aligned with the measure, and leadership in the organisation ensured that the GP registrar program was actively supported.

Participation by AHSs in the GP registrar program was limited by a premium on physical space in many AHSs, amplified by the influx of new workforce and visiting health professionals under a range of programs, and limited capacity to orientate and supervise trainees. Some AHSs that had periods of high staff turnover reported reluctance to commit to a trainee, in case the supervisor was to leave.

Broader-ranging refinements to the measure, such as establishing alternative ‘roaming’ models of supervision, additional funding for infrastructure to accommodate trainees, and support for AHSs to coordinate trainee positions and their supervision requirements were proposed by interviewees.

Nursing scholarships for professional development of nurses in AHSs and scholarships for nurses undertaking a clinical placement in an AHS

There was little evidence from the Sentinel Sites that the ICDP funded scholarships had created opportunities not previously available to support training for nurses. Some interviewees felt that these scholarships were unnecessary as there were already adequate training opportunities. Others expressed strong views about a need for better communication about these, implying that poor dissemination of information was the main barrier to better uptake.

There were no clear linkages identified in the Sentinel Sites between defined competencies for chronic illness care and the professional development scholarships.

Uptake of clinical placements for nursing students was low, possibly owing to the capacity of AHSs to host student placements. Lack of residential accommodation for student nurses was a barrier to greater participation in hosting student placements in remote sites.

12.5.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) The workforce support, education and training measure has in this early implementation period largely focused on provision of training opportunities. There is now a clear opportunity to develop and support development of capacity that goes beyond the provision of training. For example, development of regionalised models to support mentoring and supervision, of trainee positions, and possibly of OWs, may assist those Health Services struggling with capacity to participate in available opportunities. Clearer identification of generic and job-specific competencies required of the ICDP workforce would assist in identifying the kinds of system support required by employing organisations, by the OWs and trainees, and for training providers.
- b) There is a clear need to address underlying factors constraining greater participation by AHSs in providing trainee placements (including physical space constraints, and supervisory capacity), and factors constraining greater participation by potential trainees (including perceived lack of value-add of ICDP training opportunities compared to other opportunities). This may include greater alignment of training opportunities with career pathways and commitment to chronic illness care in Aboriginal and Torres Strait Islander health.

13. EXPANDING THE OUTREACH AND SERVICE CAPACITY OF ABORIGINAL HEALTH SERVICES (*MEASURE C2*)

13.1. Description of measure

The aims of the measure as outlined in the National Framework were to:

- increase the service capacity of the AHS to provide care for Aboriginal and Torres Strait Islander people with chronic disease
- improve the accessibility of AHSs for the communities they service
- generate interest and encourage more people to work in primary health care services assisting Aboriginal and Torres Strait Islander people.

The activities related to achieving the aims of this measure included.¹⁵²

- *Funding for local Aboriginal and Torres Strait Islander people to work as OWs in AHSs.* The intent was that OWs would encourage and support Aboriginal and Torres Strait Islander people to access primary health care services and to ensure follow-up treatment is accessed. This might include assisting people to travel to and from appointments. OWs were intended to be drawn from the local community, not expected to have existing qualifications and expected to be supported, mentored and supervised by practice managers and AHWs based in AHSs. Strategies to meet role orientation and individual OW training needs were developed, with this aspect managed by another measure area in the DoHA (Chapter 12).
- *Funding for practice managers in AHSs.* The intended use of this funding component was to: maintain systems for individual client records and patient information and recall; ensure people are assisted to access care and follow-up consistently on recommended treatments; establish links with other health organisations to assist local Health Services, hospitals, specialists and allied health professionals to work together effectively in providing continuity of care for patients in accordance with their chronic disease management plans; organise referrals and follow-up appointments for people to access health services as identified in their chronic disease management plans and, in some instances; supervise and support other staff such as Outreach Workers.
- Funding for limited expansion of the current health professional workforce in regional and remote AHSs to help meet the expected increase in demand for services. The additional workforce could include doctors, nurses, allied and Aboriginal Health Workers, as well as medical technicians.
- *Capital infrastructure funding for additional housing and clinic upgrades in AHS to support this workforce.* This funding was limited under this measure. Identification and prioritisation of projects was undertaken internally within DoHA.

Measure C2 is specific to the Aboriginal Community Controlled sector. Separate funding is available to DGPs/Medicare Locals under measure C3 to support Outreach Worker positions based in DGPs/Medicare Locals.

¹⁵² DoHA, Expanding the Outreach and Service Capacity of Indigenous Health Services – Fact Sheet
<<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/expanding-outreach>> (accessed 17 September 2012).

13.2. State of implementation – national context

The workforce allocations associated with this initiative, including OWs, practice managers and additional health professionals, was implemented in a staged approach over separate funding periods between 2009-2010 and 2012-2013 (Table 13.1).

At the time of the final evaluation cycle, information provided by DoHA indicated that at a national level:

- There were allocations for 66 Outreach Workers, 31 practice managers and 25 additional health professionals funded (Table 13.1).
- Recommendations for workforce allocations were agreed by the Indigenous Health Partnership Forums in each jurisdiction, together with DoHA, State and Territory government departments using criteria of organisational capacity to absorb the workforce, need, and population characteristics.
- Overall, implementation has been on track. Completion of funding agreements for the roll-out of new positions was slightly behind due to delayed advice from jurisdictions regarding recommended locations for the new workforce. The 2012-2013 allocation completed the roll-out of positions funded under this initiative. Funding for current positions is considered by DoHA as ongoing.

Table 13.1: Numbers of Outreach Workers, practice managers and additional health professionals funding allocation nationally, by funding allocation period

	2009-2010	2010-2011	2011 - 2012	2012 - 2013	Total
Outreach Worker	22		21	23	66
Practice Manager	8.3		11	12	31.3
Additional Health Professional	6.4		9	10	25.4

Note: Presented as full-time equivalent.

DoHA data did not disaggregate the funding allocations for the SSE in the first two funding rounds.

Source: DoHA, Expanding the Outreach and Service Capacity of Indigenous Health Services, measure update, 15 March 2011 and 5 January 2012.

There had been some concern expressed nationally regarding high turnover of staff in OW positions, in both the DGP and AHS sectors. As reported in September 2011, NACCHO affiliates raised this as a concern in relation to the efficient organisation of orientation workshops. Concerns have been raised about lack of role clarity and differing stakeholder expectations, including those expressed at the June 2011 NACCHO Aboriginal and Torres Strait Islander Outreach Workers National Workshop.¹⁵³ In response, the DoHA engaged the DoHA State and Territory Offices to work directly with funded organisations to ensure consistency in the types of activities and roles performed by OWs, and the way they were reflected in each funded organisation's annual action plans. This work was ongoing at the time of the final evaluation cycle.

¹⁵³ NACCHO, Aboriginal and Torres Strait Islander Outreach Workers National Workshop Report, June 2011.

13.3. Findings from the Sentinel Sites

13.3.1. RECRUITMENT, RETENTION AND AWARENESS OF OUTREACH WORKERS

KEY POINTS

- Around 80% of allocated AHS OW positions were filled at the time of the final evaluation cycle. There were greater challenges to recruitment and retention in remote sites, compared to urban and regional sites. Less workforce stability in remote sites, lower capacity for management and supervision, and general difficulties with recruiting community members to work in an AHS environment, may partly explain this finding.
- Adaptations to OW positions to suit local context included pooling of funding from different sources to support generalist positions; splitting a FTE position into two part-time gender-specific positions; and using OW funding to continue contracts of existing staff with OW roles.
- Recruits to positions varied in their skills and experience. In general remote AHSs tended to recruit entry level people to the position, and regional and urban AHSs were more likely to recruit people with existing qualifications such as AHWs and nurses.
- Moderate levels of awareness of the AHS-based OW positions were evident across both sectors, with lower but increasing awareness in General Practice and amongst community focus group members over the evaluation period.
- Awareness of AHS-based OWs increased over time amongst clinicians in AHSs, and amongst community focus group members – this may indicate an increasing integration of OWs in supporting clinical follow-up and community involvement, or at least potential for this to happen.

Recruitment and retention

By the final evaluation period, the majority of the Sentinel Sites (20/24) had funding allocations to support OWs within AHSs. Most sites had 1 FTE allocated. There was an urban site, a regional site, and two remote sites where more than one FTE (up to 2.0 FTE) had been allocated.

Overall allocation and uptake of positions was reasonably stable between the fourth and fifth evaluation cycles, with 24 positions allocated and around 80% of these allocated positions filled.

In the final evaluation cycle, six urban sites had seven OW positions allocated, with six of them filled; ten regional sites had eleven positions allocated, with ten filled; and four remote sites had six positions allocated with three of these filled (Table 13.2).

Although numbers were small, these data suggested that remote AHSs may have experienced greater difficulty recruiting to and retaining OWs. In the final evaluation period, three of the five vacant positions were due to the incumbent having left the position. One of these vacant positions was in a remote site. The remaining two vacancies, which were both in remote sites, had not been filled since the funding allocation was made.

Table 13.2: Outreach Worker allocation and recruitment in Aboriginal Health Services, over time and by urban, regional and remote locations, March 2011 - October 2012

Evaluation cycle	Two	Three	Four	Five
Number of Sentinel Sites with OW allocation/Number of Sentinel Sites	17/18	18/24	20/24	20/24
Number of OW positions filled / Number of OW positions allocated	18/20 (90%)	19/21 (90%)	19/24 (79%)	19/24 (79%)
Urban	7/7	7/7	7/7	6/7
Regional	7/9	8/10	9/11	10/11
Remote	4/4	4/4	3/6	3/6

Notes: The first evaluation cycle is not included as only stage 1 sites had been engaged (n=8) and no recruitment data were available. In the second evaluation period cycle there were 18 sites established and from the third evaluation cycle onwards all sites had been established (n= 24).

The data are presented as 1.0 position equals 1.0 FTE or less. (e.g. 1.5 FTE recruited is recorded as two positions filled). The intention is to show the investment in a site as positions allocated and recruited, not actual FTE or numbers of people employed (as there can be more than one person per FTE).

All DoHA sources have been updated to reflect site visit findings, up to 4 months after DoHA data source.

Source: DoHA, ICDP workforce tables for periods 15 March 2011, 30 June 2011, 31 December 2011 and 30 June 2012 and interview data (up to October 2012).

The data presented in Table 13.2 were derived from program data supplied by DoHA, and supplemented by data obtained directly from services during evaluation site visits. There were some data discrepancies between these two sources; with some of this explained by the different reporting periods involved. See Appendix C and footnotes to Table 13.2 for further explanation.

Data on the timing of recruitment to the OW positions, recruitment to other ICDP positions, and when positions became vacant, are shown separately for each of the case study and enhanced tracking sites in Appendix B. The Appendix shows ICDP workforce investment in relation to the timing and scale of implementation of other aspects of the ICDP, such as uptake of the PBS Co-payment measure and adult health assessments, and other major service developments in each site.

Interview data confirmed that recruitment was challenging in some remote sites. In one remote site in which the OW position had been recruited to, but was considered to be largely unsupported, interviewees noted that the AHS generally had difficulties in recruiting local people. For example, one interviewee believed that the AHS was employing nursing staff 'on \$100 000 dollars a year' to do cleaning work and reception as the AHS was unable to recruit and retain community people. While the OW position was filled at the time of the evaluation visits to this site, the position did not appear to be optimally effective. Possible reasons identified for this are outlined in subsequent sections of this chapter.

Instability in the AHS workforce appeared to have influenced the ability of some sites to recruit OWs and other staff. In general, remote AHSs experienced greater turnover of managers and health professionals and less stable work environments than urban and regional sites. There was generally less capacity to undertake the work of recruitment, and less motivation to recruit, if there was no assurance of adequate management and supervision being available.

Selection criteria and processes appear to have been defined and applied differently in different sites. Literature on the effectiveness of community health workers (with functions similar to OWs) emphasises several points. Firstly that these workers should be selected with good connections to the community they serve; ideally from their own community. Secondly communities should have a say in the selection process of such workers, or at least in the selection criteria.¹⁵⁴ In one remote site, community consultation about the selection of the candidate was reported to have delayed recruitment to the position. The effectiveness of this process in resulting in an appointment of an appropriate candidate in this site was not known. Consultation with community about the appointment was not evident to the same extent in all sites.

Some AHSs reported that the OW funding had been used to continue or expand contracts of existing workers fulfilling similar roles. Use of this approach in some sites may have contributed to the differing levels of skills and qualifications of OW recruits, and it appeared to often result in successful and effective appointments of trusted and experienced workers. For example, one urban AHS using this approach had employed an OW (a qualified AHW), who had 25 years experience in the organisation.

Local adaptations

OW positions were adapted in some of the AHSs to better fit with service delivery and community needs. Adaptations were more common in remote and regional sites than in the urban sites. Examples of adaptations identified in the Sentinel Sites included:

- not recruiting a designated person, but using the funding to extend existing workforce contracts that were believed to fulfil OW roles, including partial funding for a receptionist and transport positions
- pooling funding for a number of OW and HLW positions and combining roles into ‘family support workers’
- using the allocation of one position to fund two part-time positions for a male and a female OW, in order to enhance culturally appropriate service provision.

Local adaptations to positions contributed to the funding being used in a workable way at site level, but had some implications for management and supervisory requirements and for training and orientation.

Awareness of Outreach Worker positions

In order for OWs to link effectively with other service providers as envisaged in the program logic in the National Framework, it was important that staff in other organisations and community members were aware of the presence and role of these workers in the AHS.

Over the evaluation period, awareness of the AHS-based OWs amongst the stakeholders interviewed in the Sentinel Sites increased reasonably steadily in urban and regional sites (Table 13.3). Awareness in remote sites fluctuated. This was possibly related to some positions being pooled in remote sites, some having been vacated, and others not yet recruited to.

Awareness amongst interviewees from the General Practice sector almost doubled between the third and fourth evaluation cycles. This may indicate greater communication between sectors about outreach work and community needs.

¹⁵⁴ WHO, 2007 ‘Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers.’

Table 13.3: Trends in awareness of Outreach Worker in the Aboriginal Health Service (% who responded 'yes') overall and by sector and geographic location in Sentinel Sites

	Sector/ Geographic location	Evaluation cycle			
		Two	Three	Four	Five
Are you aware of an Outreach Worker based in the AHS in the Sentinel Site? MS, CS, PM ^a	Overall	42% (n=81)	42% (n=84)	53% (n=74)	60% (n= 67)
	AHS	NR	64% (n=39)	66% (n=35)	71% (n=35)
	General Practice	NR	22% (n=45)	41% (n=39)	47% (n= 32)
	Remote	69% (n=16)	68% (n=22)	80% (n=15)	64% (n=14)
	Regional	30% (n=40)	19% (n=31)	31% (n=29)	40% (n=20)
	Urban	44% (n=25)	45% (n=31)	60% (n=30)	70% (n=33)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. NR = not reported.

Aboriginal Health Sector includes: AHS, NACCHO affiliates.

General Practice Sector includes: General Practice, DGP/Medicare Local and SBOs.

Community focus group members indicated increased awareness of these positions and greater understanding of their role. This increase was evident from the third evaluation cycle onwards.

Awareness of the positions amongst clinicians in AHSs initially lagged behind that of practice managers. However by the final evaluation cycle, similar proportions of clinicians and practice managers reported awareness of these positions. This may suggest increasing use of OWs for support of clinical follow-up and coordinating visits and care.

13.3.2. EFFECTIVENESS OF OUTREACH WORKERS

KEY POINTS

- Ways in which AHSs in the Sentinel Sites may have increased service capacity to provide care through the OW positions included:
 - moving an existing worker into the OW position, when other funding sources for the worker were close to expiry
 - employing an additional person in a position that was established in the AHS, shared similar roles to the OW role, and for which demand was clearly apparent – for example, AHW or transport officer
 - back-filling for administrative roles that were not being met through other sources
 - removing the non-clinical outreach work from an existing role, and allocating it to the new OW position.
- Most AHSs were already engaged in efforts to improve their accessibility to communities through various programs. OWs in the Sentinel Sites strengthened these efforts, and improved accessibility to communities through:

- assistance with making transport arrangements to the Health Service and follow-up appointments, or direct provision of transport
 - visiting patients in their homes to inform of abnormal test results, deliver medications from pharmacies and accompanying pharmacists on home medication reviews
 - accompanying patients to specialist appointments
 - promoting the AHS and access to ICDP measures – through community events and participation in events of concern to the community, such as organisation of funerals
 - participation in broader health promotion activities, such as coordination of weekly fruit and vegetable deliveries at reasonable prices.
- To increase accessibility of the AHS to the community it served, the OW appointed needed to be a good ‘fit’ with the needs of both the AHS and the community. For some AHSs this meant splitting the position to employ both male and female OWs, for others a young male OW was noted to encourage access by the youth, and for others, it was important that the OW was a more senior and respected member of the community, with an established reputation in liaising with the Health Service.
 - Relevant stakeholders generally held positive perceptions about the contribution of OWs to intended outcomes.

Use of OW positions to increase service capacity

One of the aims of the measure outlined in the program logic was to increase the service capacity of AHSs. This recognised that AHSs were already engaged in supporting Aboriginal and Torres Strait Islander people to access primary health care services and follow-up treatment (discussed in sub-section below).

The OW role was new within AHSs, although some functions of the OW role were similar to those performed by other positions, including AHWs, and in some settings, by ICDP funded TAW and HLW positions. In a number of the Sentinel Sites, AHSs moved an existing worker into the OW role, to carry on with similar duties to those previously performed. In other sites, OW positions were used to fill gaps in clinic administration and transport to ensure continued smooth running of the service. It was unclear whether or not such arrangements were initially viewed to be temporary and then transitioned into more permanent formal arrangements.

‘The female Outreach Worker has been currently filling the gaps for one of the two administration workers who resigned from the [Health Service name] recently ... she has been multi tasking in her position.’ (AHS, manager)

From the AHS perspective, the new OW role needed to be open to adaptation to fit in with local needs and priorities, existing resources to address those priorities and the types of additional and complementary resources available for new positions.

Improving accessibility of AHSs for communities – facilitating use of the AHS

Across the Sentinel Sites, OWs were engaged in work that addressed a range of barriers to accessibility of the AHSs. This work could be categorised broadly as a) work that facilitated people using the AHS service (including transport arrangements) contributing to cultural safety of the service, and building trust and stronger linkages between community and the service; and b) work that helped patients to

follow through on recommended care, including specialist access, and access and use of prescribed medications.

Not all OWs fulfilled all roles – some focused only on transport, whereas others had a broader involvement across the scope of reducing barriers to access. The implications of this for supervision and management are discussed in section 13.3.3.

Transport as a barrier and a way to demonstrate responsiveness

Transport to attend health appointments was consistently identified in community focus groups as a key barrier to access to Health Services. Existing transport schemes, such as Patient Assistance Transport Scheme, and transport officers engaged by some AHSs were reported to be over-stretched, or there were other barriers to accessing these resources for transport.

Across the evaluation period, and in almost all sites, OWs played a role in addressing transport needs to varying extents. Activities included providing or arranging transport for patients to attend health care appointments and to participate in events organised by the AHS.

The value placed on transport in some AHSs was highlighted by the situation in one remote site in which the funding available for the OW position was used to create a transport officer position. This was in addition to other transport officer positions in the AHS that were not sufficient to meet demand. Clinicians and other staff valued the transport role played by OWs. As indicated in the quotation below, the role in this site was not equivalent to a ‘taxi service’, but involved coordination of appointments, along with transporting the patient to the appointments.

‘We have a patient having a lot of chronic diseases who lives a bit far. [Name of OW] has been fantastic to coordinate all his appointments and actually transporting the patient to make sure the appointments are attended.’ (GP, AHS)

Transport, along with coordination, was understood as playing a large role in achieving more regular attendance at the Health Service by chronically ill patients. Interviewees, including OWs and other stakeholders, generally perceived that people were attending more regularly as a result of the work of the OW (Table 13.4).

‘[Name] picked me up this morning and [she] brings me my medication in a Webster pack.’ (Community focus group)

Cultural safety of Aboriginal Health Services

Lack of cultural safety can be a barrier to accessibility of Health Services in general. Several interviewees noted the role of the OW in increasing cultural security of the AHS by virtue of their presence in the Health Service.

‘The OW does provide some cultural security as they are the first face often at the clinic.’ (AHS, GP)

In other cases OWs worked with clinicians, supporting them to provide more culturally appropriate care. As illustrated by the quotation below, this role was described as an informal, rather than a formal activity.

‘Being a non-Indigenous clinician I have learned a lot from the Outreach Worker working at [name of AHS]. If some patients needed to be attending the clinic the outreach workers will make it happen as soon as possible.’ (AHS, GP)

Perceptions amongst interviewees that the OW had improved cultural safety in the service were generally positive. In the final evaluation cycle 59% (10/17) of interviewees from the AHS sector agreed that *‘The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islander people’* (Table 13.4).

Trust and connection with community

OW positions were intended in the program design to strengthen linkages between community and the AHSs, and in this way to improve accessibility to the AHS.

Several types of activities undertaken by OWs were identified in the Sentinel Sites that contributed to this goal, including building trust and community connection. In one case study site, the OW provided a ‘community service’, for example, assisting with non-clinical work such as organising funerals. This type of community work was viewed very positively by the clinician at the AHS, who had observed that it increased attendance at the clinic through the building of trust and relationships. Involvement in broader health promotion work, such as organising a weekly fruit and vegetable service at reasonable prices, was reported from some of the urban sites, and may have fulfilled a similar function in relation to strengthening community linkages.

In some of the urban sites, clinicians described the value of OWs visiting patients in their homes to inform them of abnormal test results or to arrange appointments when there was no response to follow-up calls. These and other forms of support to individuals (described further below) helped to build the credibility of OWs in the community, and strengthen linkages.

Perceptions about the contribution of AHS-based OWs to developing linkages with communities were generally positive, with around two-thirds (21/32) of interviewees from the AHS sector agreeing that *‘The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander people that were not there previously’* (Table 13.4).

Improving accessibility of Aboriginal Health Services for communities – facilitating follow through on recommended care

Roles of OWs identified in the Sentinel Sites often went beyond improving accessibility of the AHS to communities, to encompass helping patients to follow through on recommended care. Broadly, this included specialist care and medication management.

Specialist – access, coordination and cultural brokerage

OWs based in some of the AHSs played a pivotal role in supporting patients to attend specialist appointments in specialists’ private rooms.

In specialist private rooms, OWs arranged transport and some accompanied patients to the consultation, providing a cultural brokerage service. This role was described by an OW in the quotation below, as having had a positive effect on patients attending their appointments at the recommended intervals.

'I've visited a few specialist appointments now I just sit in with them if the client doesn't get it, they will give me that look 'what are they talking about' so I will ask the specialist to say it again without jargon. I started last year I've got a couple of elder and middle aged clients they hardly went to specialists now they have to go every fortnight, I go to reassure them and be there for support.' (AHS, OW)

They also played a pivotal role in some sites in coordination and facilitation of patient attendance at specialist outreach clinics that were hosted by AHSs. These included specialist clinics funded through the ICDP MSOAP-ICD, USOAP and other programs.

In relation to the specialist outreach clinics at the AHS, specific activities that were reported included: OWs assisting with reminders for attendance; working with the specialists in organising the running sheet for the day; organising with the transport team for patients to be picked up, and; ensuring that any requirement for ongoing and follow-up care (including further specialist/team visits) was documented. While evident to some extent in urban, regional and remote sites, these roles were particularly noted in remote sites where patient access and coordination of visits required high levels of support to facilitate attendance.

Also in relation to increasing access to specialists, there was an emerging role in some areas for OWs in AHSs to support Care Coordinators in their work. Although this was particularly noted in relation to OWs based in DGPs, it also affected OWs based in some AHSs.

Of the eight OWs from both DGPs and AHSs who were interviewed in the evaluation site visits, almost all (8/9) reported that they had a role in taking people to follow-up appointments for recommended care.

Medications – medication delivery, home medication review, and access to the PBS Co-payment measure

Several roles performed by OWs were identified in relation to medications. These included accompanying pharmacists on Home Medication reviews, delivering medication from pharmacies to the patient's home and, systematically following up on prescription renewals.

Where OWs were involved in delivery of medications to a patient's home, opportunities for pharmacists to provide advice and monitoring of medication use would have been more limited than if patients received the medications directly. It is likely that in some contexts, the benefits of having the medication delivered may have outweighed these disadvantages, but in others, where patients may have been more able to access medications personally, this may not have been the best model.

There was some evidence of development of systems to support patient access to medications, with the assistance of OWs. For example, in one urban site, a list was regularly generated by a local pharmacy and supplied to the AHS-based OW, who then followed up on patients who needed prescriptions renewed.

OWs also played roles in promoting awareness of the PIP Indigenous Health Incentive and the PBS Co-payment measure. Activities that were reported relevant to these roles included community visits, networking with organisations and attending and organising community events to promote the PBS Co-payment measure to communities. There was one example identified in an urban site in which the aim of increasing community awareness of the PBS Co-payment measure was included as a formal part of the job description of the OW in this site, and relevant activities included in the work plan and performance reporting for the position.

The Vignette provided below illustrates the range of roles that individual Outreach Workers performed, with different aspects of the role emphasised in different settings.

Vignette – roles of Outreach Workers

The following quotes illustrate the variety of roles that OWs in AHS are performing. The common threads are community engagement and follow-up roles.

'The clinicians would use the Outreach Workers to follow-up people when they are overdue for follow-up care or having an abnormal test result. Used them for urgent follow-up care for example antenatal care. The Outreach Workers are assisting with home medicine reviews and making them appropriate for the pharmacies. Have not started to use the Outreach Workers for reminders such as health checks, may do that in future.' (AHS, GP)

'Couple of things the Outreach Workers will do: i) if having difficulty finding some patients and need to contact them the Outreach Worker would personally go to their home and find them; ii) if need to give some information to the patients the Outreach Worker would do that; iii) if we need to do the medication home review the Outreach Worker would accompany the pharmacist to their home. Also keeping contact with the more elderly people we may need them at the health centre but the Outreach Worker can drop some information to them.' (AHS, nurse)

'Having a vehicle to transport community members to the clinic if necessary ... acting as an in-between to get patients to clinic or clinic staff to visit patients in their homes ... being able to talk to parents and have them take children to clinic for treatment ... checking older community members in their homes ... building relationships with community members in order to deliver programs and to have community members participate in them.' (AHS, OW)

Compatibility between the Outreach Worker recruited, the Aboriginal Health Service and the community

Existing knowledge of the local community and understanding of the associated cultural responsibilities were consistently identified by OWs as critical to them being able to have standing in the community and build trust with the AHS. Interviewees in Sentinel Sites referred to different attributes of OWs in discussing the effectiveness of the role. These attributes differed to an extent in different sites. For example, the gender, and in some cases, the age, of the OW was considered important in increasing access in some sites because of issues of cultural appropriateness. As outlined above, in at least one remote site, the OW position had been split into two positions to allow for the appointment of both a female and a male OW. In other AHSs, where young men were employed as OWs, it was reported that there were a new group of young people attending that may have not attended service previously.

'We have different clients coming in because clients know him.' (AHS, AHW)

In another site, the position of the OW as a respected and senior person was considered by the CEO of the AHS to be key to their effectiveness and credibility in the community.

'The Outreach Worker positions are held by senior health workers who are well known. It's important for these two roles - the people's personality and position within the community.' (AHS, CEO)

Defining the OW role in relation to the roles of other members of the Aboriginal and Torres Strait Islander health workforce was challenging for many AHSs. In some AHSs, the solution was to accept that the roles may at times be quite similar, but that this was not an issue as long as team members each knew what was expected of them and were supported to fulfil their roles.

Perceptions of contribution

The percent of interviewees in Sentinel Sites agreeing with varying statements about the role and contributions of the OW positions over the evaluation cycles is shown in Table 13.4. Some of these indicators have been referred to in earlier parts of the chapter. Comparing perceptions between sectors and between different evaluation cycles provides some insight into how the OW role was understood relative to previous service provision and capacity within the AHS.

Approximately 60-65% of interviewees from AHSs held positive perceptions about the impacts of the OW positions in relation to the statements shown in Table 13.4, and this remained fairly constant across evaluation cycles. By way of comparison, in the final evaluation cycle, more than 75% of DGP interviewees held positive perceptions about the impacts of the DGP-based OW positions in relation to three of the four statements.

Interviewees from the General Practice sector were generally more likely to hold positive perceptions of OWs based in DGPs than interviewees from the AHS sector regarding OWs based in AHSs. This difference between the sectors may have been related to the phrasing of the statements - which asked interviewees to compare the current situation to what had been in place previously – and the relative lack of prior experience of outreach-related roles in DGPs compared to AHSs.

Table 13.4: Trends in perceptions of the role and contributions of Outreach Workers based in AHS and DGP (% who responded 'strongly agree' or 'partly agree'), overall and by sector

	Sector	Evaluation cycle		
		Three	Four	Five
The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander people that was not previously available. MS, CS, PM ^a	Overall	70% (n=79)	67% (n=67)	71% (n=52)
	Aboriginal Health Sector	66% (n=35)	55% (n=31)	61% (n=28)
	General Practice Sector	73% (n=44)	78% (n=36)	83% (n=24)
The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander people that were not there previously. MS, CS, PM, OW ^a	Overall	67% (n=70)	78% (n=78)	75% (n=61)
	Aboriginal Health Sector	56% (n=32)	67% (n=36)	66% (n=32)
	General Practice Sector	76% (n=38)	88% (n=42)	86% (n=29)
Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker. MS, CS, PM, OW ^a	Overall	46% (n=78)	55% (n=79)	59% (n=61)
	Aboriginal Health Sector	40% (n=35)	49% (n=37)	66% (n=32)
	General Practice Sector	51% (n=43)	60% (n=42)	52% (n=29)
The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islander people. CS, PM, OW ^a	Overall	45% (n=36)	68% (n=44)	68% (n=34)
	Aboriginal Health Sector	50% (n=14)	65% (n=20)	59% (n=17)
	General Practice Sector	41% (n=22)	71% (n=24)	76% (n=17)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

Aboriginal Health Sector includes: AHS, NACCHO State and Territory affiliates.

General Practice Sector includes: General Practice, DGP and Division SBOs.

Considering responses only from clinicians and practice managers in each sector, a fairly similar pattern of increase in positive perceptions in the General Practice sector was evident, with less of an increase in positive perceptions in the AHS sector. Two examples are shown below (Figures 13.1-13.2). The proportion of clinicians and practice managers in the Aboriginal Health and the General Practice sector who agreed with the statement that *"The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander people that was not previously available"* increased in recent evaluation cycles for General Practice, but not for AHSs (Figure 13.1). In the final evaluation cycle, around 1/3 of the interviewees in General Practice indicated that they 'didn't know or couldn't say' – with very few interviewees disagreeing with the statement.

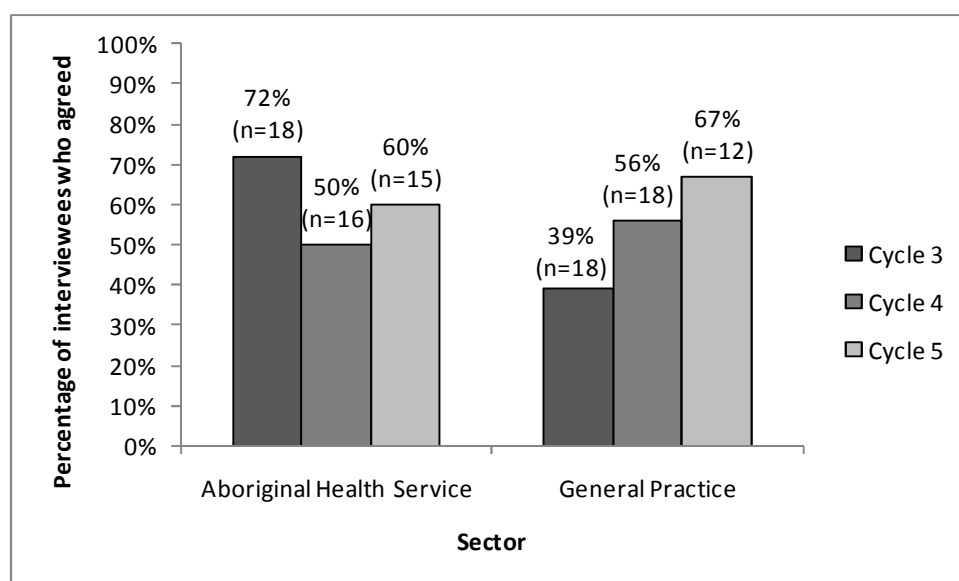


Figure 13.1: Trends in clinicians' and practice managers' responses to the statement 'The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander people that was not previously available' (% who responded 'strongly agree' or 'partly agree'), by sector

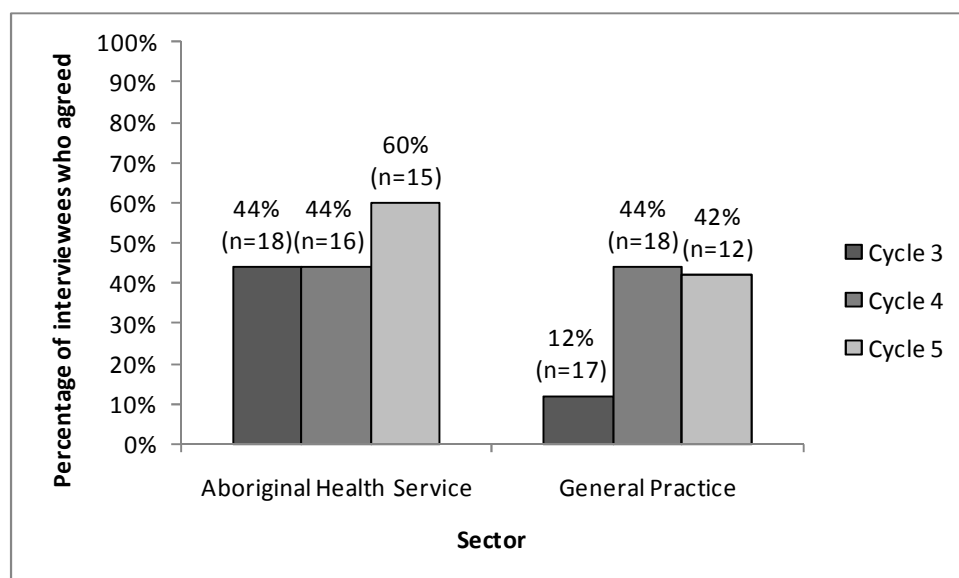


Figure 13.2: Trends in clinicians' and practice managers' responses to the statement 'Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker' (% who responded 'strongly agree' or 'partly agree'), by sector

13.3.3. MANAGEMENT, SUPPORT AND SUPERVISION OF OUTREACH WORKERS

KEY POINTS

- Adequate supervision and support in time poor environments seemed to be a key constraint on the effectiveness of the OW positions in some of the Sentinel Sites, particularly in remote sites.
- Some examples were identified in the Sentinel Sites in which OWs' roles were clearly defined in job descriptions, and this was linked to work plans, performance management and training plans. This effect tended to be in AHSs with strong teams, good capacity for management and supervision, and recruitment of an experienced OW.
- Supervision and mentoring of OWs by ICDP funded practice managers as envisaged in the program design was limited. Within AHSs, capacity to supervise OWs appeared to vary widely, but was generally not well developed.
- Team and peer support were valuable in providing less experienced OWs with direction. This was often enabled by co-location of workers and being part of a team, such as a chronic care team.
- There was little evidence in general of regional bodies providing effective support for OWs. This may be challenging owing to distances involved between regional organisations and AHSs most in need of support for supervision, and other factors.

A key theme that emerged in the SSE was that the success of the outreach role at local level was influenced to a large extent by management, support and supervision provided to the OW in the AHS. The importance of good management, support and supervision for workers with similar roles has consistently been noted in the literature.¹⁵⁵ Meeting supervision needs of such workers may be particularly challenging as they may be on the periphery of organisations, working both in community and in the Health Service, and working with multiple professionals, many of whom may not understand their role, and they may be supervised by professionals who have little experience themselves in conducting outreach work.

As shown below, the extent to which OWs were adequately managed, supported and supervised appeared to be different in different contexts.

Clear and workable role definitions

One of the key functions of management and supervision is to develop clear and workable role definitions for positions in the organisation. Overall, it was apparent that since these were new positions, implemented in environments with widely differing staff complements and community needs, it was necessary to adapt the OW roles to suit local circumstances. However, this did not mean that the roles did not need definition at local level – but rather that there may be different types of roles emphasised in different sites.

In early evaluation cycles, many interviewees were somewhat unclear about the role of the OWs. Many AHSs already had good community linkages, and there was uncertainty over what would be gained

¹⁵⁵ Gilson, L. et al. 'National community health worker programs: how can they be strengthened?' Journal Public Health Policy. 1989 Winter 10(4): 518-32.

from these new positions. Over the period of the evaluation, some AHSs in Sentinel Sites began to more clearly define and articulate the OW role within their own services.

Levels of qualification and skill sets were noted to differ amongst OWs, and community needs and service capacity differed across different sites. These factors influenced the roles that an individual OW would play in a particular AHS. This situation was noted to be not dissimilar to AHWs, whose skills and qualifications also vary, and who work in many different service delivery environments. Some AHSs found it challenging to distinguish between roles of OWs and AHWs.

‘The OW role here is not too dissimilar to how we use AHWs here.’ (AHS, practice manager)

Three types of scenarios were identified in relation to the clarity and workability of role definitions in the Sentinel Sites. First, there were the situations in which funding for OW positions was rolled over into expansion of required service capacity, such as creation of another transport officer position – this did not really require additional role clarification, as these positions were already recognised and probably defined in the organisation.

Second, there were situations in which a general job description was provided, but key stakeholders had concerns about what the role entailed.

In the third scenario, OWs had clearly defined roles, linked to performance management and training plans. This is illustrated in the Vignette below. Also evident in the example provided below, is the broad range of activities that this individual was involved in. Her work included a mix of work within the health centre and in the community. Her work included participation in ‘team’ events, such as quality improvement activities, and individual tasks. It is also notable that skills development (providing information on medication) was consistent with the needs of the tasks she was engaged in.

Vignette – a clearly defined OW role and example of good support and supervision

A well established AHS in a regional city has developed a comprehensive work plan for the OW role. It details the aims of the position, which are to *‘establish links to community and support access to the AHS, and to increase community awareness of the PBS Co-payment and PIP Indigenous Health Incentive measures and the availability of health assessments’*. The work plan includes indicators and measures, with timeframes. A training plan has also been developed and is updated to reflect progress.

The position is non-clinical and focuses on providing practical assistance. It is clear that the Health Service has the capacity to provide the OW with good learning and work support, and that the OW is proactive in developing her role. For example, she is designing a brochure to distribute at community events, medical centres and in the community generally, and to upload on to the AHS website. The brochure will explain the Closing the Gap programs and advertise services available at AHS.

OW tasks include:

- Providing patient transport to the AHS *‘There is a huge patient car park out there and all day it is empty. Transport is needed often.’* The OW also helps patients access other health services, such as specialist access and visits to the pharmacy for medications.
- Supporting the home medications review pharmacist as a ‘cultural broker’ when the pharmacist does home visits. The OW is being up-skilled in providing medication information.
- Working alongside medical staff to assist with patient recalls. The OW uses social networks to

track down patients on the recall list if necessary. *'The community often have no fixed address, no phone or changing numbers or no credit card, so the Outreach Worker [will] go and find that person and get them.'*

- Identifying people who have not had a health check and encouraging them to attend, using opportunities provided at community events and by being part of the community.
- Gathering feedback about issues that may be restricting community access to health services through networking and interagency meetings for community. Taking the feedback to the AHS.
- Participating in CQI activities and internal audits, including a 'patient progress journey' audit.
- Keeping biographical patient data up to date in AHS records (e.g. contact detail).

Supportive teams

Good supervision and support was noted in some of the urban sites, but not to the same extent in remote sites. In two urban case study sites the OWs felt well supported, and this appeared to be largely attributed to support provided by working in a functional team environment. Both sites had two OWs based in the AHS and this created the potential for peer support. In one urban site, the DGP-based OW was seconded to the AHS for a period, and this helped to create a team approach across sectors. One of the OWs spoke about being part of an existing chronic disease team at the AHS, and she found this provided a supportive environment. The OW in the other AHS had worked in the organisation for over 25 years and was a valued member of the service team. This OW brought significant experience, clinical understanding and skills to the position.

The importance of peer support, and mentoring of less experienced OWs by those with more experience, was a valued function of the national and jurisdictional workshops for OWs – described in Chapter 12.

Some of the AHSs did not appear to be able to provide a supportive team environment for the OW, as indicated in the quotation below.

'The OW positions have been entry level community people ... I am not certain about how the OW position is supported. The Chronic Disease Nurse who has since left was providing support to the OW but she was travelling to other communities and the OW was unsupervised for days ... the nurse also was quickly consumed with acute care. The OW often does not know what they are required to do and possibly gets dragged into acute care aspects of delivery in the clinic and all the programs are often calling on the OW.' (AHS, GP)

The quotation also illustrates the undesirable outcomes of lack of team support, coupled with lack of supervisory support. Other interviewees from this same remote site confirmed that local work environment did not provide adequate support for the OW because the busy clinic focused on acute care. Although interviewees in this site were aware that the OW was not adequately supported or supervised, and clearly concerned about it, there did not appear to be any solution found to the issue over successive evaluation cycles – this was possibly because the AHS did not have the capacity to address the issue internally, and regional or other support (or capacity to take this up) was not available – with the AHS being located remotely.

Supervisors equipped to supervise

The program logic for this measure specified a role for practice managers and AHWs to support and mentor the OWs. We found no evidence in the Sentinel Sites that this was occurring effectively. In addition to existing service management capacity, AHSs in some sites were allocated ICDP funding under this measure to employ practice managers. Not all OWs were appointed in AHSs with ICDP funded practice managers – by the final evaluation period, there were 20 sites with OW allocation, and 10 sites with practice manager allocations, two of which did not have OW allocations. In the eight sites with allocation for both OWs and practice managers, practice managers and OWs were not necessarily allocated to the same organisation within the site.

In some sites, OWs were supervised by nursing staff and program managers. In at least one site this presented a problem as the nursing staff were focused on acute work and were also travelling to outer clinics, with the OW being left unsupported.

It was clear that supervision requires committed resources. This is illustrated by a situation where the IHPO based in the NACCHO affiliate was aware of the capacity gaps in supervision at this AHS, but indicated that she found it difficult to provide support to the OW. This was attributed to distance, to low literacy level of the OW (and difficulty this presented to providing support from a distance), and the OWs frequent absence from work (which was probably partly due to lack of support in the role). The IHPO also indicated that she was unable to visit the AHS to provide assistance due to lack of a travel budget to do so.

In general we did not identify many instances of clear strategies and procedures available to supervisors about what was required in supervision of OWs. The quotation below highlights the need for supervisors to be experienced in outreach work themselves, or if not, at least to have an agreed workable framework against which to assess performance and provide supportive supervision in a field that may not be their direct area of expertise.

‘... she won’t accept direction ... part of your job is ongoing mentoring, if you are employed as an expert any direction is seen as criticism.’ (AHS, GP)

The more positive examples of support provided earlier indicate that the solutions are likely to lie in a) support between peers, which can serve to increase intrinsic motivation, and help management support for change, and clarify role, and b) reorientation of Health Services through illustrating change that can be achieved, the value of the OW role.

Logistics and infrastructure

Hand in hand with supportive supervision, are other forms of support, such as infrastructure, reliable provision of supportive transport or transport policies, and other equipment.

The presence (or absence) of infrastructure was often mentioned by OWs and clinic staff. OWs had varying access to cars, and where there was access to a car, this was felt to enable greater effectiveness.

Other types of infrastructure support that were mentioned included systems for good clinical record keeping, so that OWs could develop systematic approaches to clinical outreach work, and regular generation by a pharmacy of a list of people who needed prescription renewals.

13.3.4. RECRUITMENT AND ROLES OF ICDP FUNDED PRACTICE MANAGERS AND ADDITIONAL HEALTH PROFESSIONALS

KEY POINTS

- Just under one half of Sentinel Sites had funding allocation for ICDP practice manager positions; over three-quarters of these positions were filled at the time of the final evaluation cycle.
- Two main categories of appointments were identified – those that dealt primarily with operational aspects of the AHS, including reporting requirements for various programs and managing funding, and those that were more similar to work of chronic disease coordinators, where managing chronic disease registers and ensuring that patients received scheduled care formed the main responsibility.
- There was little evidence of supervision of OWs by practice managers, but there was one instance identified of a practice manager working closely with an AHW in chronic disease care. Many OWs worked in sites and organisations without ICDP practice manager allocation.

Recruitment of practice managers

Table 13.5 shows that by the final evaluation period, practice manager positions had been allocated in 10 of the 24 Sentinel Sites (two urban, six regional sites and two remote sites). The majority of allocated practice manager positions were filled over the whole evaluation period.

The one vacancy in the final evaluation period had been funded in 2011-2012 and was yet to be filled. There was a range in allocated FTE from 0.5 to 1.0, with the majority of positions being full-time.

The composite figures provided in Appendix B illustrate the timing of recruitment to positions for the practice management roles for each of the case study and enhanced tracking sites.

Table 13.5: Practice manager and additional health staff allocation and recruitment in Sentinel Sites, over the evaluation periods, March 2011 - October 2012

Evaluation cycle	Two	Three	Four	Five
Number of practice manager positions filled / number of positions allocated	5/5	7/7	8/10	9/10
Number of additional staff positions filled / number of positions allocated	4/6	7/7	5/9	7/9

Notes: The first evaluation cycle is not included as only stage 1 sites had been engaged (n=8) and no recruitment data were available. In the second evaluation period cycle there were 18 sites established and from the third evaluation cycle onwards all sites had been established (n=24).

The data are presented as 1.0 position equals 1.0 FTE or less. (e.g. 1.5 FTE recruited is recorded as two positions filled). The intention is to show the investment in a site as positions allocated and recruited, not actual FTE or numbers of people employed (as there can be more than one person per FTE).

All DoHA sources have been updated to reflect site visit findings up to four months following the DoHA data source.

Source: DoHA, ICDP workforce tables for periods 15 March 2011, 30 June 2011, 31 December 2011 and 30 June 2012 and interview data (up to October 2012).

Roles of practice managers

Data from the SSE on the roles of ICDP funded practice manager positions are limited to the final evaluation cycle. There were only two case study sites (one remote, one urban) that had funding allocated for such positions. To obtain a more comprehensive understanding, we sought information from some of the enhanced tracking sites and tracking sites where we were able to locate additional ICDP practice manager positions.

It was apparent that there were two main areas ways in which the practice manager funding allocation was used in these sites:

- An administrative and operational type role, as illustrated in a site where practice manager funding was allocated to an AHS that had an existing practice manager position. The ICDP funded position was regarded by the AHS as a welcome addition as it brought increased capacity to manage a large multisite clinic. Interviewees indicated that initially there had been some role confusion, but this had been resolved. The person appointed to the position had previously worked in the local DGP. At the AHS, her roles included: managing operations of the medical clinic, maintaining records as required, administering the reporting requirements for a number of programs including QUMAX and the ICDP funded OW, ensuring compliance with accreditation bodies, managing the quality improvement systems in place at the AHS, managing risk registers, coordinating training, maximising Medicare income and managing grant funding and Occupational Health and Safety requirements. As indicated by this list, this position was largely concerned with supporting the smooth running of the operational aspects of the AHS. Amongst these operational support roles, the practice manager also had responsibility for managing reporting requirements, but the extent to which this involved direct supervision and support for the OW was not clear.
- A role more directly tied in with care planning and chronic disease management. This role was evident in two of the regional sites. These positions were described as chronic disease manager and chronic disease coordinator respectively. In one of the sites, the AHS had topped up the allocated 0.8 position to a full-time position. The Chronic Disease Manager who was appointed using this funding coordinated the management (with other staff) of the approximately 1900 chronic disease patients identified on the chronic disease register through monitoring recalls and follow-ups, facilitating chronic disease networks in the region, ensuring patients were getting scheduled care and keeping data bases updated. This role worked closely with an AHW, who was funded through the additional health professionals funding, which is described below. In the other site, the funding was used for an existing chronic disease coordinator position. The position was a pre-existed funded position and the ICDP funding enabled the other source of funding to be used for a different purpose. This role was also described as one involving more direct support for chronic disease care.

'Their role is to watch the data and ensure patients are getting the required level of care.'

Roles of practice managers in relation to support and supervision of OWs, as envisaged in the program design, were not evident to any great extent in the Sentinel Sites. There were 20 sites with funding allocation for OWs, eight of which had funding allocation for practice managers. An additional two sites had funding allocation for the practice manager role, but not for the OW role. Three sites had funding allocation for OWs, practice managers and additional health professionals (two of these were remote sites and one was a regional site).

In general, across the evaluation period, there was a general increasing emphasis in many Health Services on practice manager roles, responsible for optimising Medicare revenue (not necessarily with a clear view to how this would contribute to improving care). Practice managers in general (not just ICDP practice managers) were noted to bear the bulk of responsibility for administrative requirements related to registration for the PIP Indigenous Health Incentive, with interviewees noting that practice managers were responsible for the paperwork and developing systems to manage the registration process for patients.

Recruitment and roles of additional health professionals

There were six Sentinel Sites with funding allocations for additional health professionals. Three of these were remote, and three were regional. Half of the sites were allocated one position for the site, and the remaining half were allocated more than one position (with the FTE range being 1.5-1.6).

Recruitment to positions in the Sentinel Sites fluctuated over the evaluation period, with 56-100% filled in the different evaluation cycles. Of the nine positions allocated in the final evaluation period, two were vacant at the time of the final evaluation period, one of these being a newly funded service (Table 13.5). Interview data indicated that the funding for these additional health professionals tended to be used for different roles at different times, depending on need, and this could partly explain the fluctuating pattern.

The composite figures in Appendix B present the recruitment to positions for the additional health professional staff in case study and enhanced tracking sites. The site descriptions indicate how services were using this funding.

In those sites with additional health professional funding, it was apparent that the funding was being used to support chronic disease care (for example through the employment of a chronic disease coordinator, an AHW to support the work of a chronic disease coordinator, a diabetes educator or other aspects of chronic disease management).

The examples below are illustrative of the use of the additional health professionals funding:

- In a remote enhanced tracking site the funding was being used to fund a GP to undertake clinic sessions in remote clinics
- In a regional enhanced tracking site the allocation of 1.6 FTE was used to fund a full-time Aboriginal Health Worker whose role was to follow-up patients with chronic disease, ensure they were getting scheduled care and to maintain clinical information systems. This position worked closely with the practice manager funding allocation that was used for a Chronic Disease Manager. The remainder 0.6 allocation was used on an as-needed basis to support the chronic disease management aspects of the clinical service delivery (for example, for funding for a diabetes educator, receptionist and for a GP).
- In a regional site funding used to employ an AHW, dietitian and nurse. The dietitian was also partly funded through other funding sources, including through MSOAP-ICD.
- In one remote site the additional health staff funding was being used to fund positions for short-term registered nurses to undertake chronic disease work. However in this site, it was noted that the placement of nurses was influenced by availability of accommodation. Part of the funding was also used to employ a nurse to support coordination of primary health care services with a focus on chronic disease management.

13.3.5. CAPITAL WORKS INFRASTRUCTURE FUNDING

KEY POINTS

- Within the Sentinel Sites, capital works infrastructure funding had been accessed for major refurbishment of a medical facility building in one case study site, and for building a health administration facility in a tracking site. Both of these were regional sites.
- Although funding was available for both housing and clinic upgrades, there were no housing-related projects using this funding in Sentinel Sites.

There were two funded capital works projects within Sentinel Sites during the evaluation period. These addressed needs for consulting space and for administrative facilities. There were no projects identified that met needs for housing of staff, although this was mentioned consistently as a barrier to providing adequate primary health care service across the evaluation period.

The two funded projects included:

- building a health administration facility for an AHS in a regional site (this reached practical completion in August 2011) and
- refurbishing a building for a medical facility in a regional AHS (this reached practical completion in November 2011).¹⁵⁶

Other funding was available for some sites for capital works. For example, one of the remote sites had been allocated funding through the remote service delivery funding program, and this was being used to construct a new health facility in this site.¹⁵⁷

13.3.6. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- Effective implementation of the 'expanding the outreach and service capacity of Indigenous Health Services' could achieve its effects through enhancing the population health and patient centred care orientation of the AHS, supporting AHS efforts to meet community needs, and enhancing linkages with local service providers and other aspects of the ICDP.
- At the Health Service level, effective implementation was enabled where AHSs had a clear expectation that the new positions were to have a focus on strengthening systems to improve chronic illness care, and where there was already some capacity and organisational support for this role (including for example, well functioning clinical information systems with chronic disease registers, recall and reminder systems).
- Effective functioning of the OW role was enabled where OWs were recruited through community consultation, and recruitment resulted in a satisfactory arrangement for both the AHS and the community; where there was a clear role definition and performance management system;

¹⁵⁶ The main element of 'Practical Completion' is that the facility is 'fit for its designated use'.

¹⁵⁷ FACSIA, Remote Service Delivery [website] <<http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/remote-service-delivery>> (accessed 19 September 2012).

where other members of the primary care team were aware of and valued the role; and where effective management and supervision was in place.

- Recruitment of experienced OWs with good community connection and knowledge of the service environment enabled effective implementation, although this did not fit with the measure guidelines.
- Effective implementation required linkages between local service providers and other aspects of the ICDP which were positively influenced by periods of staff co-location, joint conferences and training opportunities that included workers from both DGP and AHS sectors, recruitment of staff with prior experience in the other sector, clear role definitions and good supervisory and management support.

Effective implementation of this measure as envisaged in the program logic would result in enhanced capacity within AHSs to identify and provide high quality care to Aboriginal and Torres Strait Islander people with or at risk of chronic disease. This was intended to be achieved through greater linkages between community and AHSs and through improved capacity within AHS through enhanced infrastructure, administrative and system support.

It was evident that over the evaluation period that practice manager and administrative roles were being increasingly emphasised within the AHS sector. A key challenge for AHSs in the Sentinel Sites was to ensure that the new ICDP roles, including practice manager roles, and to a lesser extent OW roles, were designed at local level in such a way that they were able to strengthen AHS systems for chronic care illness care. There may have been a tendency in some AHSs to focus on using positions to meet administrative requirements of various funding programs, without addressing the systems within the AHS that would lead to care improvements – for example, not all AHSs in the Sentinel Sites appeared to realise the potential of these positions to establish and run systems for patient recall, follow-up and monitoring of quality of patient care and patient centred care. This was a key overarching consideration that applied across the mechanisms of change that were identified below. Our analysis identified four broad mechanisms of change. These were orientation of the AHS to population health perspectives; orientation to needs of their specific communities; linkages with local providers, and complementary linkages with other ICDP funded activities.

The analysis presented in this section aims to tease out the evidence on the mechanisms through which effective implementation can be achieved and the influences that enable and constrain the operation of these mechanisms. The mechanisms are shown in the central boxes in Figure 13.3. Enablers and constraints related to each of the main mechanisms are also shown in the figure, and described briefly in relation to each of the main mechanisms.

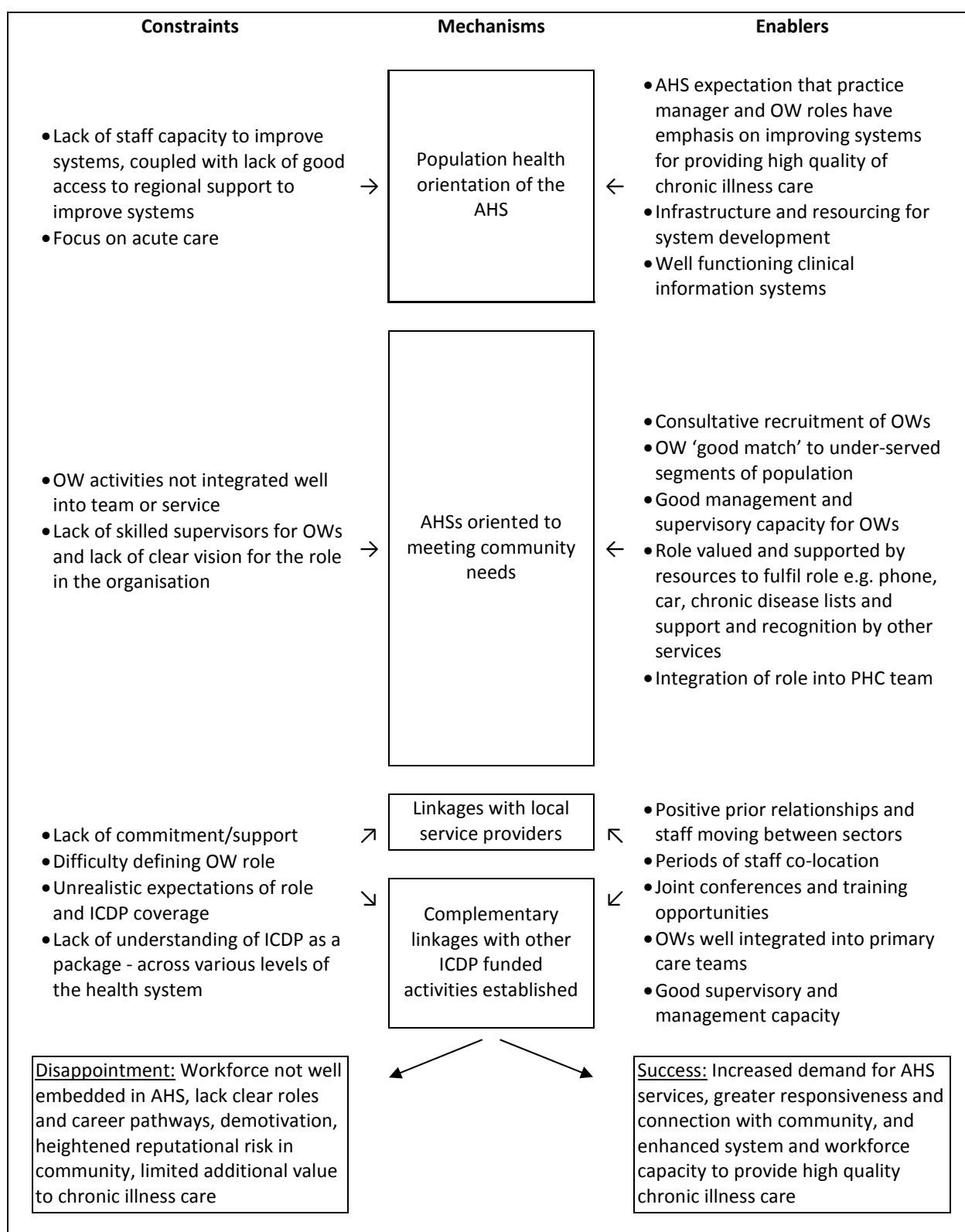


Figure 13.3: Enablers and constraints to effective implementation of the Expanding Outreach and Service Capacity of Aboriginal Health Services measure

Population health orientation

This mechanism proposes that measure C2 may have achieved some of its effects through its ability to assist AHSs to develop a population health orientation. Organisations with a population health orientation are characterised by: provision of population based care, rather than care responsive only to those presenting for treatment; systems thinking; working across the care continuum from clinical prevention to palliative care and; recognition that the system is primary care-led, with effective partnering with secondary and tertiary care.¹⁵⁸ Both ICDP funded practice manager positions and OW positions were relevant resources in activating this mechanism in different contexts, as outlined below.

In those situations where the AHS had a clear vision and expectation that the ICDP practice manager would focus on strengthening systems for delivery of high quality chronic illness care, it seemed that development of a population health orientation was enabled. This was in contrast to other contexts in which the AHS had an expectation that the focus of the role was to develop efficiencies in revenue generation and reporting, or play a more generalist role in strengthening the operations of the organisation more broadly. Examples of these two different areas of emphasis were outlined in Section 13.3.2.

In the Sentinel Sites, it appeared that where AHSs expected the practice manager to focus on improving systems to provide high quality care for patients, this sometimes resulted in a change in the position title from 'practice manager' to 'chronic disease coordinator' or 'chronic disease manager'. These positions were also supported by resources appropriate to a role that focused on improving quality of chronic illness care. For example, the employment of an AHW to work with the practice manager to assist in following up patients as required, and to ensure that chronic disease lists and patient lists were kept up to date and used effectively within the service.

Related to this, it was evident from the examples presented, that development of a population health orientation was enabled by the availability of systems and data that supported population-level or systems planning. For example, a practice manager in a large multisite service worked with an established chronic disease list of almost 2000 patients. In this instance, the chronic disease list predated the appointment of the ICDP practice manager. These kinds of systems and data were important enablers for effective implementation, but there was little evidence from the Sentinel Sites to suggest that resources available through the ICDP had been used to systematically develop these kinds of resources. In other words, they were appreciated when present, but not systematically developed through the ICDP. The extent to which the practice managers would have the capacity and influence to set up systems to enable better and more responsive care, was difficult to ascertain.

The same general observation applied in relation to OWs. For example OWs in some AHSs had a key role in implementing systems in some areas, but on their own, without support, were not engaged in developing systems. OW work in building greater connection with communities, increasing patient attendance at specialist clinics, following up on needs for repeat prescriptions generated regularly from pharmacies, appeared to work where the OW was supported by a higher level commitment from the organisation that these were worthy activities, and resourcing was available to make these work. To work effectively, OWs needed to be employed in an organisation that had a good understanding about what their role entailed, how to operationalise it, and how it supported the broader strategy of the Health Service to improve chronic illness care.

¹⁵⁸ Preparing a health care workforce for the 21st century: the challenge of chronic conditions: World Health Organisation; 2005.

In some cases, AHSs had access to support in the form of regional support organisations (such as the IUIH in SE Queensland), or had access to support for chronic disease management through regionally-based chronic disease coordination. In these cases, OWs were more easily absorbed into teams focusing on chronic illness care, and with this support, a change to population health orientation of the AHS was enabled.

In general, remote sites were less able to access support for system development.

Aboriginal Health Services oriented to meeting community needs

OWs as the ‘eyes and ears’ of the community had an important role in achieving the orientation of the AHS to community needs.

The characteristics of the OWs appointed influenced how well this worked at local level, and this was influenced by selection criteria and recruitment processes. In some sites, it was noted that OWs had been appointed who could identify with underserved patient groups, and this was identified as a key success factor in getting these groups to attend for care. For example, one AHS reported that the appointment of a young man as an OW had resulted in more young people attending the service, and this was identified by interviewees (including GPs), as a valued outcome of the appointment and of the work of this OW.

In the one Health Service in which the OW role was broadly acknowledged to be dysfunctional, the OW had been difficult to recruit to in the first place, and the community did not seem to be motivated to support and sustain the OW role. The community appeared to be dissatisfied with the situation, no visible change was apparent as a result of the work of the OW, and a negative feedback loop ensued.

Where recruits to positions had experience in the AHS or service environment, and good relationships with communities, this enabled an orientation of the AHS to community needs. Effective OW appointments included those who had previously worked in similar roles in the AHS, and one of the effective practice manager appointees had come to the AHS with prior experience in the local DGP, and a good knowledge of the local service environment. In both these types of situations, this prior experience was valued and enabled community needs to be better addressed. In these contexts, the work of the OWs was well integrated into the work of the teams, their role was valued by the organisation.

For OWs in AHSs, who often provided day to day support to patients, it was important that their position was properly resourced (for example with consideration given to communication requirements such as mobile phones, promotional material, and access to vehicles or funding to assist patients with transport).

Linkages with local service providers and complementary linkages with other ICDP funded activities established

Effective linkages between local service providers, and complementary linkages with other ICDP funded activities have potential to contribute to improved access to AHSs and to other Health Services by Aboriginal and Torres Strait Islander people.

Linkages with local service providers were seen to be enabled in the Sentinel Sites through prior relationships and experience. For example, the practice manager in one site had previously been employed in the DGP, and this was noted as enabling her role and greater linkages between service providers in the area.

Relationships and linkages could be established through periods of co-location. For example, in one site, a DGP-based OW who was training to be an AHW, who undertook a clinical placement in the AHS. This OW had been allocated particular responsibilities to gather information about the ICDP implementation and to liaise with stakeholders. Interviewees also noted that this period of co-location helped to build a team environment, contributing to the AHS-based OW feeling supported in her work.

Joint conferences and training opportunities organised by SBOs, and the joint OW orientation under measure C1, were valued for their networking and information sharing function. It appeared that these were likely to have contributed to greater collaboration in service provision at a local level.

OWs played an important role in establishing complementary linkages between ICDP funded activities. For example, though helping to coordinate MSOAP-ICD specialist clinics, accompanying patients to specialist private rooms for appointments, promoting community knowledge and uptake of the PBS Co-payment measure and adult health assessments. This role was enabled in contexts where OWs were well integrated into AHS teams, and were appropriately supervised and supported.

The capital works and infrastructure funding may have expanded ability of AHSs to take on ICDP funded trainees and accommodate visiting health professionals through MSOAP-ICD or USOAP. There were no direct reports of greater use of ICDP funded trainees or other staff as a result of capital works infrastructure funding in the Sentinel Sites. There were no reports of this funding source being accessed to address residential accommodation for staff in remote areas. Lack of accommodation for staff was consistently highlighted as constraining implementation of ICDP measures in remote and some outer regional sites.

13.4. Summary and conclusions

13.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 13.6). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

Table 13.6: Summary of key findings in relation to the program logic - Expanding Outreach and Service Capacity of Aboriginal Health Services measure

	Summary of key findings from SSE
Outputs for year 1 and beyond	
Eighty-six OWs, forty-three practice managers and thirty-three additional health professionals are recruited and retained. Capital infrastructure works relevant to this measure are undertaken.	The targets specified at a national level had not been achieved by the time of the final evaluation cycle of the SSE. However, recruitment and retention of OWs, practice managers and additional health professionals was generally high in the Sentinel Sites. There were some emerging issues with recruitment and retention in remote sites, some of which was explained by lack of clear supervisory and management capacity in AHSs. OWs in remote areas also tended to have less experience and lower literacy than those in urban and regional areas, and therefore needs for day to day supervision may have been greater. Capital infrastructure works were undertaken in several Sentinel Sites. It was difficult to assess the extent to which these contributed to enhancing the capacity of services, or increasing accessibility, but these outcomes would seem plausible. There were no reports of this funding being used to address accommodation needs in remote areas, which was an important constraint on increasing service capacity in remote sites.
Expected early results for years 2 – 4	
Stronger links are forged between AHSs and other health service providers to improve the continuity of care for Aboriginal and Torres Strait Islander people with or at risk of chronic disease.	Roles reported by OWs, including in supporting organisation and delivery of high quality chronic illness care in the AHS, in strengthening linkages with specialists (through accompanying patients to specialist appointments), and with pharmacies (through accompanying pharmacists doing home medication reviews), and systematically following up on patients due for repeat prescriptions, provide evidence of stronger links forged between AHSs and other health service providers.
Aboriginal and Torres Strait Islander people in contact with participating primary health care providers utilise and value the enhanced services.	Community focus group members valued the role of OWs in relation to transport to services. Service providers in AHSs reported effective roles of some OWs in increasing attendance at the health service by previously under-served groups. This depended on the OW being a 'good fit' with the community and AHS needs.
Collaboration is improved between AHSs and other health providers to identify and address barriers to provision of primary health care to Aboriginal and Torres Strait Islander people.	Instances of secondment of OWs from DGPs to AHSs (and possibly vice versa) may have contributed to development of collaborative relationships. Further, OWs may have acted as a conduit of information between AHSs and other health providers, such as specialists. ICDP funded practice managers did not appear to have had a strong role in improving collaboration to identify and address barriers to care.

	Summary of key findings from SSE
Expected medium term results for years 4+	
Access to AHSs for Aboriginal and Torres Strait Islander people with or at risk of a chronic disease is improved.	Provision or arrangement of transport, and cultural brokerage, were likely to have contributed to improving access to AHSs, and to care recommended by AHSs, such as specialist visits and following prescribed medications. Greater use of services by previously under-served groups as a result of the OW appointment was noted in at least one site.
AHSs enhance their system and workforce capacity to respond to increased service demand.	AHSs appreciated the flexible aspect of the funding for additional health professionals, and this was used in different ways locally, with a general focus on increasing clinical capacity for chronic illness care. System capacity for supervision and management of OWs (and other workers with similar roles) had not in general been strengthened by the measure funding. Where strong teams and motivated workforce pre-dated the measure, this enabled effective work of the OW, but where these were absent, there was little evidence of their improvement through the measure.
OWs have established effective links to increase access to AHSs and other Health Services by Aboriginal and Torres Strait Islander people .	There is good evidence to suggest that in most sites OWs were establishing effective links and working practices that would improve access to AHSs and to other health services by Aboriginal and Torres Strait Islander people. OWs were described as the ‘eyes and ears of the community’, and a range of roles were outlined that were relevant to the establishment of effective links. In some cases, strategic linkages were established that were informed by knowledge of communities, and data, and in others, they may have been more ad hoc and opportunistic.

13.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Expanding Outreach and Service Capacity of Aboriginal Health Services measure.

Recruitment, retention and awareness of Outreach Workers

There were high levels of recruitment of OW positions. People recruited to OW positions varied in their skills and experience. In general remote AHSs tended to recruit entry-level people, and regional and urban AHSs were more likely to recruit people with existing qualifications such as AHWs and nurses. There was some evidence of greater challenges experienced in recruitment and retention in remote sites compared to urban and regional sites. Less workforce stability in remote sites, less management and supervision capacity, and general difficulties with recruiting community members to work in an AHS environment, may partly explain this finding.

Moderate levels of awareness of the AHS-based OW positions were evident across both sectors, with relatively lower awareness in General Practice and amongst community focus group members. Awareness of AHS-based OWs increased over time amongst clinicians in AHSs, community focus group members and General Practice interviewees. This increasing awareness may indicate an increasing

integration of OWs in supporting clinical follow-up and community involvement, or at least potential for this to happen.

Effectiveness of Outreach Workers

Service capacity of AHSs to deliver care for people with or at risk of chronic illness was in general increased where OWs were well supervised and supported. Some AHSs used the OW funding to support an existing worker or to employ an additional person into a position that was established in the AHS, shared similar roles to the OW role, and for which demand was clearly apparent (for example, AHW or transport officer). Others used the funding to backfill for key administrative roles that were not being met through other sources or expanding existing outreach capacity.

AHSs were generally already engaged in efforts to improve their accessibility to communities through various programs. OWs in the Sentinel Sites strengthened these efforts, and improved accessibility to communities through involvement in transport arrangements or provision of transport, home visits, delivery and coordination of prescriptions, facilitating specialist visits, and promoting the AHS and access to ICDP measures, through community events and participation in events of concern to the community, such as organisation of funerals. Some were involved in broader health promotion activities, such as coordination of weekly fruit and vegetable deliveries at reasonable prices.

To increase accessibility of the AHS to the community it served, the OW appointed needed to be a good 'fit' with the needs of both the AHS and the community. For some AHSs this meant splitting the position to employ both a male and a female OW, for others, a young male OW was noted to encourage access by younger community members, and for others, it was significant that the OW was a more senior and respected member of the community, with an established reputation in liaising with the health service. Stakeholders generally held positive perceptions about the contribution of OWs to intended outcomes of the OW role.

Management, support and supervision of outreach workers

Clear definition of OW roles, performance monitoring and training plans was evident in some of the sites, but not others. Where these aspects were clearly defined, AHSs were working in strong teams, with good management and supervision, and the OW was relatively experienced.

There was little evidence from the Sentinel Sites of ICDP funded practice managers playing a lead role in supervision and mentoring of OWs. Many OWs worked in sites and organisations without ICDP practice manager allocation. Within AHSs, capacity to supervise OWs varied, with some pockets of good practice identified through the SSE.

Team and peer support were valuable in providing less experienced OWs with direction. Team and peer support was often enabled by co-location of workers, and being part of established teams, such as chronic care teams.

There was little evidence in general of regional bodies providing effective support for OWs in their work environment. Provision of this type of support may be challenging, owing to distances between regional organisations and AHSs most in need of support.

Recruitment and roles of ICDP funded practice managers and additional health professionals

Some ICDP funded practice managers appeared to have a fairly general role in strengthening operational aspects of the AHS, including managing reporting requirements for various programs, and managing funding. Others had roles that were more focused on chronic illness care (similar to chronic disease coordinators), were managing chronic disease registers, and ensuring that patients received scheduled care. There was limited evidence of ICDP funded practice managers setting up systems to improve chronic illness care. In general, if involved in improving quality of chronic illness care, the practice manager had been appointed into an already functioning system - rather than setting up new system, or taking the development of an existing system to a higher level.

Capital works infrastructure funding

Within the Sentinel Sites, capital works infrastructure funding had been accessed for major refurbishment of a medical facility building in one case study site, and for building a health administration facility in a tracking site. Both of these were regional sites.

Although funding was available for both housing and clinic upgrades, there were no housing-related projects using this funding in Sentinel Sites.

13.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Consider how OW roles can be further clarified in a way that allows for flexibility/adaptability to meet priority needs at the local level, and complements or adds value to existing service delivery arrangements.
- b) Consider how policy can more effectively enhance development of capacity for supervision and management of OW type positions across the range of settings in which these positions are located, including strengthening of local team structures, peer support, mentoring, supervisory capacity and networking. Consider how policy in this area can directly address known barriers to high quality supervision and management in the variety of settings.
- c) Consider how policy can enable development of team-work and collaboration in a way that integrates the role of the OW (and practice managers and additional health professionals) with the range of ICDP funded positions as well as existing and other new workers in complementary roles. Consider how structures and processes within DoHA might be used to facilitate greater complementarity between this measure and other closely related measures.
- d) Consider how supervisory and management positions, as well as OW positions can be specified in a way that strengthens core workforce competencies for chronic illness care^{159,160}, while enabling flexibility/adaptability for these positions to address local needs and add value to local service delivery arrangements.

¹⁵⁹ WHO, 2005 'Preparing a health care workforce for the 21st century: the challenge of chronic conditions.'

¹⁶⁰ Pruitt, S, Epping-Jordan JE. Preparing the 21st century global healthcare workforce. BMJ (2005); 330:63.

- e) Consider how practice manager positions, and funding for additional health professionals, can be more clearly focused on strengthening systems to provide high quality chronic illness care in the variety of contexts in which AHSs operate. This is likely to require a high degree of flexibility and adaptability, guided by a clear evidence informed vision of PHC systems designed to support high quality chronic illness care. Consider if ‘practice manager’ is the most appropriate title for these positions. Consider the need for additional resources in this component of the ICDP.
- f) Consider how evidence-informed and internationally accepted models of chronic illness care (such as the Chronic Care Model^{161,162} and the Innovative Care for Chronic Conditions framework¹⁶³) might be used to guide development of high quality systems at the local level, designed to fit with local needs and circumstances.
- g) Consider the need for additional funding and innovative approaches to addressing the common constraint of inadequate infrastructure in terms of clinic facilities as well as residential accommodation for staff.

¹⁶¹ Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. ‘Wagner Evidence On The Chronic Care Model In The New Millennium’ *Health Affairs*, 28, no.1 (2009): 75-85.

¹⁶² E.H. Wagner, B.T. Austin, and M. Von Korff, ‘Organising Care for Patients with Chronic Illness,’ *Milbank Quarterly* 74, no. 4 (1996): 511–544.

¹⁶³ World Health Organisation, *Innovative Care for Chronic Conditions: Building Blocks* [website] <<http://www.who.int/chp/knowledge/publications/iccreport/en/>> (accessed 13 January 2013).

14. ENGAGING DIVISIONS OF GENERAL PRACTICE TO IMPROVE INDIGENOUS ACCESS TO MAINSTREAM PRIMARY CARE (*MEASURE C3*)

14.1. Description of measure

The aim of the Closing the Gap - Improving Indigenous Access to Mainstream Primary Care measure is to contribute to closing the gap in life expectancy by improving access to culturally sensitive primary care services for Aboriginal and Torres Strait Islander people.

The objectives of the measure were to^{164,165}:

- increase access to mainstream primary care services by Aboriginal and Torres Strait Islander people
- improve the capacity of General Practice to deliver culturally sensitive primary care services
- increase the uptake of Aboriginal and Torres Strait Islander specific MBS items including health assessments and follow-up items
- support mainstream primary care services to encourage Aboriginal and Torres Strait Islander people to self-identify
- increase awareness and understanding of Closing the Gap measures relevant to mainstream primary care
- foster collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors.

The DOHA State and Territory Officers were responsible for managing and administering the measure in their jurisdiction. The measure was implemented through selectively identified DGPs with funding transitioned to Medicare Locals as these were established.

The first step in implementation, was that DGPs were required to undertake a needs assessment in order to identify: the service delivery model that would be employed in their area; the process to identify and respond to local needs; existing barriers to Aboriginal and Torres Strait Islander people accessing mainstream primary care; prioritisation of needs; and risk management strategies that address the particular circumstances of the DGP. One of the first tasks of IHPOs under this measure was to lead the development of this needs assessment.¹⁶⁶

The measure comprised the following funding streams and activities:

- **IHPO positions in Division SBOs, NACCHO affiliates and Australian General Practice Network (now the Australian Medicare Local Alliance)** - to lead and coordinate Aboriginal and Torres Strait Islander health activities at the state and national levels. Complementary IHPO positions were funded in both Division SBOs and NACCHO affiliates to provide a similar leadership and

¹⁶⁴ DoHA, Closing the Gap improving Indigenous Access to Mainstream Primary Care, Indigenous Health Project Officers and Outreach Workers. Program Guidelines, Version 1.3, July 2012.

¹⁶⁵ DoHA, Engaging Medicare Locals to improve Indigenous access to mainstream primary care <[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-to-mainstream-primary-health/\\$file/mlprimarycarefs.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-to-mainstream-primary-health/$file/mlprimarycarefs.pdf)> (accessed 12 February 2013).

¹⁶⁶ Ibid.

coordination role within the community controlled sector, and together with the workforce within DGPs (outlined below), to encourage cooperation between the two sectors.

- **IHPOs in DGPs (now Medicare Locals)** - to provide leadership in Aboriginal and Torres Strait Islander health within DGPs, including increasing awareness and understanding of the various ICDP initiatives relevant to General Practice. Funding allocation for IHPO positions was determined by the size of the Aboriginal and Torres Strait Islander population in the DGP. Specifically, IHPOs were mandated to improve the capacity of General Practice to deliver culturally appropriate services to Aboriginal and Torres Strait Islander people (including support for cultural awareness training, quality improvement, health promotion and education and Aboriginal and Torres Strait Islander liaison); to help community members access primary care providers; to work together with AHSs to improve health outcomes for Aboriginal and Torres Strait Islander people; and to support OWs.
- **OW positions in DGPs (now Medicare Locals)** - to assist Aboriginal and Torres Strait Islander people to access primary care, specifically access to the General Practice sector and related follow-up care. The intent was that OWs would be drawn from the local Aboriginal and Torres Strait Islander community and would be entry level positions. Funding allocation for OW positions in DGPs was largely based on the recommendations of the Aboriginal and Torres Strait Islander Health Partnership Forums in each jurisdiction. Funding allocations were to take into account Aboriginal and Torres Strait Islander population, number of PIP registered Health Services in the DGP, and distribution of OWs in the AHS sector (Chapter 13). It was intended that OW positions would only be allocated where an IHPO position had been funded, and recruitment of OWs was to follow recruitment of IHPOs. Required orientation and optional training for this workforce (including the IHPOs) was to be provided through measure C1 (Chapter 12).

14.2. State of implementation – national context

14.2.1. INDIGENOUS HEALTH PROJECT OFFICERS

- Funding agreements for IHPOs in the DGP network were originally offered in October 2009 and continued to June 2012. Ninety-five FTE positions were funded (87 in the DGP and 8 in NACCHO and its affiliates).
- The recruitment of IHPOs in DGPs proceeded smoothly with at least 100 IHPOs recruited as at 31 January 2011. Owing to some part-time and job sharing appointments, the numbers of individuals recruited is greater than the number of FTE positions. Some 45% of IHPOs in DGPs/Medicare Locals identified as Aboriginal or Torres Strait Islander. The most recently available reporting from DoHA (30 June 2012) indicated that DoHA considered the recruitment of IHPOs for DGPs and Medicare Locals to be complete with 100 IHPOs recruited (81.8 FTE).
- As at 31 January 2011, IHPOs had been recruited to NACCHO affiliates in all jurisdictions.

14.2.2. OUTREACH WORKERS

- The OW position allocation was phased over two financial years (2009-10 and 2010-11). The DoHA guidelines stipulate that funding for 43 OW positions was to commence in early 2010 with a further 40 positions from July 2010. DoHA reported that funding agreements were offered to DGPs for 86 OW positions in January and September 2010, continuing until June 2012.¹⁶⁷
- The pace of recruitment to OW positions tended to be slower than recruitment to IHPO positions. There were 67 OWs recruited as of 31 January 2011, all of whom identified as Aboriginal and Torres Strait Islander. Most recently available reporting from DoHA indicated that DoHA considered that by 30 June 2012, DGP/Medicare Local OW recruitment was complete. At this stage there were 94 OWs recruited (81.05 FTE).
- The roles of IHPOs and OWs in DGP/ Medicare Locals have been the subject of some discussion between DGPs and DoHA. A particular area of uncertainty was whether or not OWs and IHPOs were permitted to undertake clinical work. Whilst clinical responsibilities were not part of the role as outlined in the program guidelines, some incumbents to positions had clinical qualifications, such as nurses or AHWs. There had also been a degree of uncertainty over this issue at the NACCHO Aboriginal and Torres Strait Islander OWs National Workshop in June 2011. Written communication from DoHA to AGPN, the SBOs and State and Territory Officers indicated that the roles specified in the program guidelines were to be adhered to, regardless of qualifications.
- In 2009-2010 AGPN was under contract to develop and deliver an orientation package for IHPOs including a national workshop, which was held in Melbourne in April 2010. It was compulsory for DGP and SBOs to attend the orientation workshop. The AGPN were also to manage regular SBO IHPO network meetings and teleconferences, with at least two face-to-face per annum.

¹⁶⁷ DoHA, Closing the Gap improving Indigenous Access to Mainstream Primary Care, Indigenous Health Project Officers and Indigenous outreach workers. Program guidelines, Version 1.0, January 2010.

- The IHPOs in SBOs were contracted to undertake state level leadership by providing support, networking, information and resource dissemination, and coordination for the DGP. They were contracted to organise at least two face-to-face meetings with DGP IHPOs annually and at least one activity with each DGP per annum (face-to-face meeting or teleconference). Evidence of SBO activity has been available on organisational websites over the period of the evaluation. SBOs had their contracts extended to December 2012 to aid with transition to Medicare Locals.¹⁶⁸
- DoHA contracted AGPN to undertake a six month project (April 2011 - September 2011) to provide support to the National Indigenous Health Project Officer role. This project followed on from the National IHPO Orientation Workshop held in 2010 and further supported the work being done by SBOs, DGPs and IHPOs in sharing and connecting with one another in this important role. It included the production of five editions of IHPO communication newsletter, online mentoring, an AGPN central online area for the IHPO role and communication with SBOs and DGPs (via online survey) to identify the key steps and resources used to successfully orientate, commence and support an IHPO.¹⁶⁹

14.2.3. MEDICARE LOCAL TRANSITION

With the Australian Governments National Health Reforms, funding for IHPOs and OWs has been progressively transferred from DGPs to Medicare Locals as they have been established and develop capacity to take on programs. DoHA report that the Central Office was working with State and Territory Officers to ensure transition arrangements will provide continuity of funding and service provision. New contracts for IHPOs and OWs in Medicare Locals commenced on 1 July 2012, and run through to 30 June 2014.

In January 2012 DoHA reported that the AGPN had subcontracted the Australian Mentor Centre to develop a set of resources to facilitate the transition of program funding from Divisions to Medicare Locals.

DoHA reported that the transition process was relatively smooth. In some cases we noted there are interim organisations functioning alongside Medicare Locals and by the time of the final evaluation cycle, funding for the IHPOs and OWs had not yet been transferred. In other instances the program had been outsourced to other organisations.

The guidelines released in January 2010 outlined the roles and responsibilities of the IHPOs and OWs in DGPs, and the IHPOs in the SBOs and AGPN. The IHPO roles for the NACCHO affiliates were funded in recognition of the need for close co-operation between sectors.

¹⁶⁸ DoHA, Closing the Gap improving Indigenous Access to Mainstream Primary Care, Indigenous Health Project Officers and Indigenous Outreach Workers. Program guidelines, Version 1.0, January 2010.

¹⁶⁹ Australian Medicare Local Alliance [website] <<http://amlalliance.com.au/medicare-local-support/Aboriginal-and-Torres-Strait-Islander-health/workforce-support>> (accessed 27 November 2012).

14.3. Findings from the Sentinel Sites

14.3.1. RECRUITMENT, ADAPTATIONS TO IMPLEMENTATION AND IMPACT OF RECRUITMENT ON OTHER ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKFORCE

KEY POINTS

- DGPs were successful in recruiting and, to a large extent, retaining IPHO and OW workforce across urban, regional and remote sites.
- Recruitment of OWs was slower than expected. However, by the final evaluation cycle around 86% of allocated DGP OW positions had been filled and around three in four job incumbents had occupied their positions for at least six months.
- The majority of OWs recruited in Sentinel Sites were qualified professionals or had experience in the health care sector. This differed from the program design, which anticipated that OWs would be entry level positions.
- Funding was intended to be flexible, but in general adaptation to suit local context was limited. Adaptations to OW positions to suit local context included expansion of positions using additional funding sources; splitting a single FTE position into two part-time gender-specific positions, and in one instance, pooling funding between DGPs to increase reach and impact of initiatives.
- Some DGPs made it a selection criterion that IHPOs needed to be Aboriginal and Torres Strait Islander.
- There was no clear evidence from the Sentinel Sites that recruitment of IHPOs and OWs to DGPs had negatively impacted the Aboriginal and Torres Strait Islander health workforce of other programs or sectors.
- The transition to Medicare Locals underway during the evaluation period brought opportunities for a greater focus on Aboriginal and Torres Strait Islander health due to the increased focus on planning for population health needs, but also brought some disruption and uncertainty.
- The work of some IHPOs and OWs in DGPs changed after transition to Medicare Locals. Changes included expectations to provide advice and support across a broader range of programs and larger numbers of staff (which led to concerns for IHPOs and OWs about being spread too thin) and re-deployment to different geographic areas on the basis of perceived need.
- There were indications that the ability provided by Medicare Locals to form larger teams that were focused on Aboriginal and Torres Strait Islander health was valued and added to the effectiveness of the work.

Recruitment of IHPOs and OWs

Table 14.1 shows that 22/24 Sentinel Sites had funding for IHPO and OW positions during the latter three evaluation cycles. These sites included two remote sites, 12 regional sites and eight urban sites. A further two remote sites had IHPO and OW workforce allocation in their DGP, but since the workforce did not intend to work within the Sentinel Site boundaries, these sites were not included in this component of the analysis, or in the Table 14.2. Included in the table, and the discussion below, are two remote sites with IHPO and OW funding allocation. However, we noted that the DGP offices were

outside the boundaries of the sites, with large distances between the DGP offices and the Sentinel Sites, limiting the capacity of this workforce to work within these two sites. This indicates the vast areas covered by some DGPs and subsequently Medicare Locals in remote regions and the challenges for service provision that this presents, particularly for community outreach roles.

Overall there were 51 positions allocated to DGP/Medicare Locals within the Sentinel Sites with 84% of IHPO positions and 88% of OW positions filled at the time of the final evaluation period. Since the third evaluation period there had been a slightly decreasing trend in the proportion of positions filled. The transition to Medicare Locals had an effect on the organisational boundaries covered by ICDP positions, and in some cases funding moved to different organisations as the transitions progressed and priorities were set. There were no major differences in levels of recruitment in urban, regional and remote sites.

Table 14.1 shows IHPO and OW positions allocated and filled at the time of the evaluation visits.

Indigenous Health Project Officer positions in DGPs

At the time of the final evaluation cycle, the majority of sites had at least one filled IHPO position and over two thirds (18/25) of IHPO positions had been filled and stable for more than six months. Of the four vacant positions, all had previously been filled, two had been vacant in the previous evaluation period and two were recent vacancies. One of the sites had both IHPO and OW vacant by the final evaluation period. Five of the 25 IHPO positions were part-time allocations, with the remainder allocated 1.0 FTE. In at least one urban site the 1.0 FTE had more than one worker employed.

Outreach Worker positions in DGPs

Consistent with the measure intention that IHPOs were to be recruited earlier than OWs, recruitment to the OW positions in Sentinel Sites lagged behind that of IHPOs in the first two evaluation periods. In the final evaluation cycle, the majority of positions in Sentinel Sites (23/26) had been filled and the majority (21/26) were stable since the previous evaluation cycle. There were two recent vacancies and one position that had remained vacant over nearly two evaluation cycles (noting that this site had more than one OW position). The majority of sites had been allocated 1.0 FTE OW position per organisation, with exceptions in two urban sites and one regional site with 1.5-2 FTE allocation and one other regional site with 0.8 FTE allocation. Sites with more than 1.0 FTE per organisation indicate that the OWs are required to cover a large region and/or have a need for a male and female role for cultural appropriateness, accounting for the need for more than one position.

Table 14.1: Indigenous Health Project Officer and Outreach Workers allocation and recruitment by evaluation period and by urban, regional and remote Sentinel Sites, February 2011 - October 2012

	Evaluation cycle									
	One		Two		Three		Four		Five	
Number of Sentinel Sites with workforce allocation/ Total number of Sentinel Sites	7/8		17/18		22/24		22/24		22/24	
Overall % IHPO positions filled	7/7		17/17		24/24		22/26)		21/25	
Overall % OW positions filled	5/8		13/20		24/26		24/26		23/26	
	IHPO	OW	IHPO	OW	IHPO	OW	IHPO	OW	IHPO	OW
Urban sites - positions filled/ positions allocated	2/2	2/2	5/5	4/6	10/10	10/10	10/12	9/10	8/10	8/10
Regional sites - positions filled/ positions allocated	4/4	3/5	10/10	7/12	12/12	13/14	10/12	13/14	12/13	13/14
Remote sites - positions filled/ positions allocated	1/1	0/1	2/2	2/2	2/2	1/2	2/2	2/2	1/2	2/2

^a In the fourth evaluation period with Medicare Local formation one site gained an extra allocation of two IHPOs. This funding was transferred to another organisation outside the site by the final evaluation cycle.

Notes: Some sites have more than one IHPO or OW position as was intended with the allocation or, in some sites, there is more than one fundholder. Two urban sites have two DGPs included in the boundaries for the third and fourth evaluation cycle and one site in final evaluation cycle.

The data are presented as 1.0 position equals 1.0 FTE or less (e.g. 1.5 FTE recruited is recorded as two positions filled). The intention is to show the investment in a site as positions allocated and recruited, not FTE or actual numbers of people employed (as there can be more than one person per FTE).

All DoHA sources have been updated to reflect site visit findings up to four months following the DoHA data source.

Source: DoHA, ICDP workforce tables for periods 25 February 2011, 30 June 2011, 31 December 2011 and 30 June 2012 and interview data (up to October 2012).

Table 14.1 presents the allocation and recruitment findings from two sources – DOHA reports and data obtained from sites during evaluation site visits. There were some discrepancies between the data sources, and these are identified in table footnotes and in Appendix C.

In general the IHPOs and OWs employed in DGPs were experienced workers. This was despite the intention that the OW position be an entry level position. The establishment of these new roles in DGPs/Medicare Locals may have been less successful if entry level OWs had been recruited. In several sites roles were described in which OWs were required to influence the organisation and act as change agents, roles which would have been difficult for entry level staff to fulfil effectively. The appointment of more experienced workers than required of the positions was noted by some DGPs/Medicare Locals to have been a strategic decision. This could be seen as an example of an adaptation to the measure design to suit local needs. Unlike the specific local adaptations identified below which varied to suit local context, the appointment of qualified staff was the norm in DGPs in the Sentinel Sites.

Local adaptations

In the Sentinel Sites, the DGPs/Medicare Locals in some cases adapted the IHPO or OW positions to suit local circumstances. Adaptations identified over the evaluation period included:

- Using the funding allocation of one position to fund two part-time positions to allow for a male and a female OW, for reasons of cultural appropriateness.
- Splitting the IHPO position into two part-time positions to enable better geographic coverage of area.
- Supplementing with funding from other sources to fund an additional OW. These additional positions were generally gender-specific, to allow for appointment of both male and female workers.
- Contracting out the IHPO and OW based at the Medicare Local to a different regional coordination and support organisation. The Medicare Local rationale was that the regional support and coordination organisation was better placed to implement the measure, and the Medicare Local saw itself as a contracting organisation.
- Pooling of funding and resources between neighbouring DGPs/Medicare Locals to increase reach and impact of resources. For example, in one regional site, a number of DGPs pooled funding to develop and run television advertisements encouraging Aboriginal and Torres Strait Islander identification at primary health care services.

As indicated by the example provided in the last bullet point above DGPs had flexibility to work with neighbouring DGPs in the delivery of the measure, including through pooling of resources. The single case described above was the only example of cross-DGP implementation that was identified in the Sentinel Sites during the period of the evaluation.

Also evident as a local adaptation was the specification by some organisations that the IHPO position needed to be a designated position for an Aboriginal and Torres Strait Islander person. By the end of the evaluation period IHPOs identified as Aboriginal and Torres Strait Islander in four of the eight urban sites, seven of the 12 regional sites and one of the four remote sites. This was broadly consistent with national data available from DoHA that indicated that 45% IHPOs nationally identified as Aboriginal and Torres Strait Islander.

Impact of recruitment to IHPO and OW related positions on redistribution of the workforce

In the first two evaluation cycles interviewees in Sentinel Sites expressed concerns that the DGPs may recruit from the existing Aboriginal and Torres Strait Islander health workforce, leaving positions vacant in other parts of the system, rather than achieving the measure intention of expanding the workforce. This was related to a perception among some stakeholders that the DGPs would have an emphasis on delivering on contracts, leading them to want to recruit trained and experienced staff, rather than entry level staff. This issue was raised in urban, regional and remote sites.

The SSE team specifically explored this issue over the course of the evaluation, but found little evidence that recruitment had negatively impacted on other programs. In the second evaluation cycle many respondents felt it was too early to comment on the impact of ICDP related positions on the redistribution of the workforce, due to the early stage of implementation. Of those who felt they were able to comment, most believed that the OW and IHPO recruitment had not negatively impacted on other Aboriginal and Torres Strait Islander health programs or workforce groups. Later evaluation cycles

also did not identify that this had been an issue. Some mobility between different employers appears to have contributed to better inter-sectoral working relationships at local level. This has been described in relation to some of the other ICDP funded positions, including practice managers.

Transition to Medicare Locals

For some interviewees, the transition to Medicare Locals that was underway during the evaluation period was seen as an opportunity for greater focus on Aboriginal and Torres Strait Islander health due to the Medicare Local remit to address population health needs. This was viewed as a positive step.

'We always knew that we have XX of the population identifying from Census data but it was not until we had dedicated time and a requirement to turn this percentage into numbers and consider what does this mean for service delivery.' (DGP, program manager)

'We see the change to a Medicare Local as a new opportunity and potential. The way we think about what our core business is has shifted. Previously our remit was to support GPs but now we are identifying needs at a local level and then establishing the programs to meet the local needs of the community.' (DGP, program manager)

'Shift to a Medicare Local will bring benefits ...shift to having a more population health approach.' (AHS, GP)

Other interviewers were concerned that the organisational changes may be disruptive to the ICDP. Informants cited instances of changes of managers, people having to reapply for positions and realignment of boundaries, as factors that were impacting on their ability to progress ICDP work.

'I have had support from IHPO and the OW from the Division through awareness such as posters and education of the item numbers. Had a number of practice visits from the IHPO and OW where they sat and discussed about health assessments. However, this was more focused on last year. Now that the Medicare Local has taken over and reform at the moment there hasn't been too much support from the Medicare Local that the practice has received. But expecting a similar service from these ICDP funded staff. The Division is now at the transition phase: bit of housekeeping is going on. There might be a slight break in getting support from the Division or Medicare Local but I expect to have improved services from the IHPO & OW.' (General Practice, GP)

At the same time, as indicated in the quotation above, it was recognised that the disruptions occurring as a result of organisational changes were likely to be temporary.

For sites on the other side of the transition, some interviewees reported that the new arrangements had resulted in changes to their work. In one site, where the Medicare Local has led to greater ownership and interest in Aboriginal and Torres Strait Islander health, a concern was expressed that this has substantially increased scope of work for the IHPO and the OW. In this site, interviewees noted that the new and larger organisation with interest in their work meant that they were required to advocate and work across many different areas and with a larger range of issues. The IHPO felt that she and the OW were possibly 'spread too thin' as a result, but thought that greater ownership of Aboriginal and Torres Strait Islander health issues across the organisation would be beneficial in the long term.

'Previously in the DGP we all worked in our siloed programs; Aboriginal health here and chronic disease programs here. With the change to a Medicare Local all of a sudden all these programs

want to know about Aboriginal health or we are required to contribute to health planning and consumer engagement above and beyond what we may have previously.’ (DGP, IHPO)

For several sites, the shift to a Medicare Local resulted in changes in how the ICDP funded staff were deployed, with different geographic areas allocated, based on perceived greater need for the services in these areas. This also meant that a critical mass of team members were based together, working on Aboriginal and Torres Strait Islander health issues. The benefit of Aboriginal and Torres Strait Islander health teams is discussed further below.

Lack of certainty about ongoing funding and sustainability of positions was evident in the Sentinel Sites in the fourth evaluation period, but was less of a concern in the final evaluation cycle, possibly owing to communication from DoHA about funding arrangements.

In the fourth evaluation cycle, one of the urban sites indicated that the Medicare Local was exploring options for sustaining the program outcomes if funding from the ICDP was discontinued.

‘CTG won’t go on forever and the way things look at the moment it may stop at end of this year. This has made us look at how is this going to operate without funding and how to make sustainable. The focus of work was previously very GP centric but the main thing we want to do now to ensure sustainability is focus on the Aboriginal community and give them as much information as we can. Make sure they have enough resources and information at hand so that they can advocate in the absence of no one reminding GPs about the service.’ (DGP, IHPO)

In another urban site, the IHPO and OW indicated that they were hoping that their work would continue through the practice support teams in the Medicare Locals. They were distributing contact details for these teams to the General Practices with whom they were working.

14.3.2. AWARENESS OF THE WORKFORCE

KEY POINTS

- High levels of awareness of the DGP-based IHPOs and OWs were evident amongst interviewees in the General Practice sector. As would be expected from interviews with predominantly local site stakeholders, there were lower levels of awareness and less communication with the IHPOs based in SBOs and NACCHO affiliates.
- The urban sites are generally more complex service environments than regional sites (due to the number of Health Services and stakeholders) and this may be a factor in the relatively later increase in awareness in urban compared to regional sites.
- Lower awareness in remote sites appeared to be explained by different types of roles fulfilled by the workforce and limited deployment in these areas, but it is also likely to be at least partly due to the vast geographical areas covered by the DGPs and Medicare Locals in remote areas.

Awareness of Indigenous Health Project Officers

Since the commencement of the evaluation, awareness of the IHPO based in the DGP/Medicare Locals increased steadily in urban and regional sites. At the time of the final evaluation cycle, awareness was highest in regional sites [95% (18/19)], followed by urban [68% (23/34)] and remote sites [21% (3/14)].

Lower awareness of the IHPO in remote sites reflected the tendency of DGPs or Medicare Locals to be less active in remote compared to urban and regional areas, and the vast geographic areas covered by the remote DGPs/Medicare Locals, with the workers not necessarily active in the Sentinel Sites. There are also relatively fewer GPs in General Practice in remote areas, with AHSs playing a relatively greater role in service provision in remote areas.

Interviewees, who were predominantly drawn from local level positions, were in general less aware of those IHPOs who were based in SBOs and NACCHO affiliates, than of those IHPOs based in the DGPs. Interviewees in remote sites were less aware of the IHPO based in the SBO and NACCHO affiliate than their counterparts in urban and regional sites (Table 14.2).

Table 14.2: Awareness of Indigenous Health Project Officer (% who responded 'yes') overall and by urban, regional and remote location

	Rurality	Evaluation cycle				
		One	Two	Three	Four	Five
Are you aware of the IHPO, based in the DGP? CS, MS, PM ^a	Overall	67% (n=39)	73% (n=81)	73% (n=85)	85% (n=75)	66% (n=67)
	Remote	18% (n=11)	44% (n=16)	41% (n=22)	43% (n=14)	21% (n=14)
	Regional	87% (n=15)	93% (n=40)	94% (n=32)	97% (n=31)	95% (n=19)
	Urban	85% (n=13)	60% (n=25)	74% (n=31)	93% (n=30)	68% (n=34)
Are you aware of the IHPO based at the NACCHO State affiliate? CS, MS, PM ^a	Overall	46% (n=39)	35% (n=81)	37% (n=86)	41% (n=75)	49% (n=67)
	Remote	45% (n=11)	31% (n=16)	32% (n=22)	7% (n=14)	43% (n=14)
	Regional	27% (n=15)	35% (n=40)	39% (n=33)	35% (n=31)	26% (n=19)
	Urban	69% (n=13)	36% (n=25)	39% (n=31)	63% (n=30)	65% (n=34)
Are you aware of the IHPO based at the Division SBO? CS, MS, PM ^a	Overall	28% (n=39)	38% (n=81)	37% (n=86)	39% (n=75)	36% (n=67)
	Remote	18% (n=11)	31% (n=16)	36% (n=22)	14% (n=14)	21% (n=14)
	Regional	13% (n=15)	38% (n=40)	39% (n=33)	32% (n=31)	26% (n=19)
	Urban	54% (n=13)	44% (n=25)	35% (n=31)	57% (n=30)	47% (n=34)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n=number of people who responded to statement.

With the transition to Medicare Locals, IHPOs have responsibility to work with services from both the General Practice and AHS sector. Historically the DGPs worked primarily with General Practice and the inclusion of work with AHSs may take some time to be substantially progressed. At the time of the final evaluation cycle awareness of the IHPO position was higher in the General Practice sector than in the AHS sector, with no evidence of increased awareness in the AHS sector over time (Figure 14.1).

Awareness of these positions was lowest in the remote sites, and this is consistent with interview data that indicate challenges arising from vast geographic areas and few General Practices in remote sites.

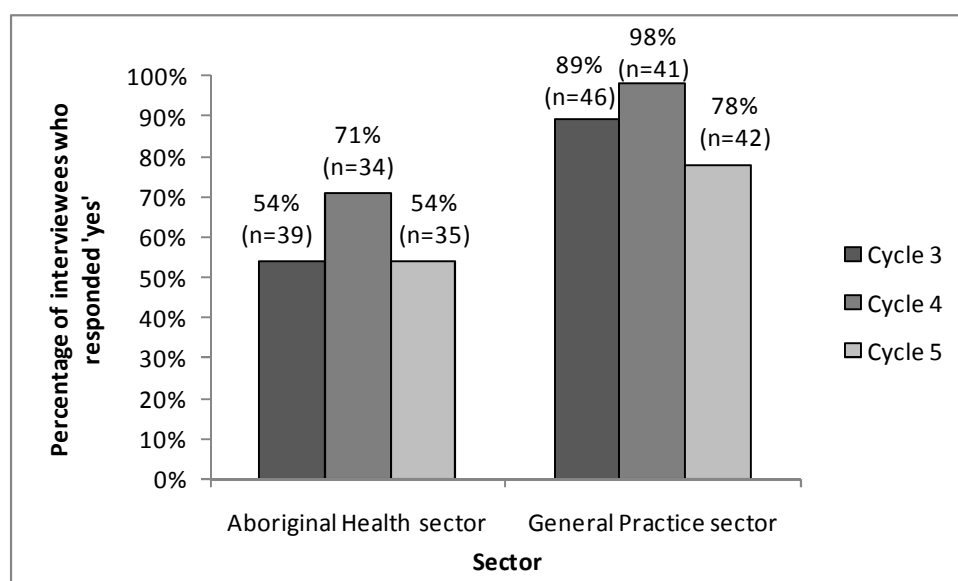


Figure 14.1: Awareness of Indigenous Health Project Officer based at the Division of General Practice (% who responded 'yes') by sector

Awareness of the IHPO based in the DGP differed by respondent type, with practice managers more likely than clinicians to be aware of the IHPO. This was supported by interview data indicating that the IHPO was more likely to communicate with practice managers, rather than with clinicians in the course of their work.

Awareness of the IHPO position based in the NACCHO affiliate increased amongst interviewees over the evaluation period.

When interviewees who indicated an awareness of an IHPO were asked which IHPO they had the most communication with, 67% (42/49) nominated the IHPO based at the DGP, 27% (13/49) nominated the IHPO based in the NACCHO affiliate and 6% (3/49) the IHPO at the Divisions SBO. The higher level of communication of stakeholders with the IHPOs based in DGPs was consistent with the larger number of IHPOs in such positions, the smaller areas for which they had responsibility, and their role in working more directly with stakeholders in front line service provider organisations. Communication with the IHPO based in the NACCHO affiliates increased over the period of the evaluation.

Awareness of Outreach Workers

Over the period of the evaluation awareness of the DGP-based OWs amongst the stakeholders interviewed in the Sentinel Sites increased to fairly high levels in regional sites, remained moderately high in urban sites, and remained at low levels in remote sites (Table 14.3).

Table 14.3: Awareness of Outreach Worker (% who responded 'yes') overall and by rurality

	Rurality	Evaluation cycle			
		Two	Three	Four	Five
Are you aware of an Outreach Worker based at the DGP in the Sentinel Site? MS, CS, PM ^a	Overall	57% (n=81)	70% (n=86)	74% (n=74)	66% (n=67)
	Remote	38% (n=16)	32% (n=22)	27% (n=15)	29% (n=14)
	Regional	60% (n=40)	94% (n=33)	93% (n=29)	90% (n=20)
	Urban	64% (n=25)	71% (n=31)	80% (n=30)	67% (n=33)

^a Type of interview respondents, see Appendix C for listing of interview and respondent types.

Note: n = number of people who responded to statement.

In the first three evaluation cycles community focus groups were generally unaware of the OW and IHPO positions based in the DGP. In the final two evaluation cycles, community focus group members were more frequently able to identify the OWs and their roles.

14.3.3. EFFECTIVENESS OF INDIGENOUS HEALTH PROJECT OFFICERS AND OUTREACH WORKERS BASED IN DGPS

KEY POINTS

- A range of activities was used to increase access to mainstream primary care services. OWs assisted patients with navigating the health system, facilitated transport to appointments, and acted as cultural brokers between community members and health professionals. In some sites, DGP-based OWs may have been less connected to communities than OWs based in AHSs, with less of a role in overcoming day-to-day obstacles to access, and more of a role in working with Health Services to create awareness of access barriers.
- Effectiveness of the workforce in improving capacity of General Practice to deliver culturally sensitive primary care services was particularly apparent in respect of 'soft capacities' – including awareness of the needs of Aboriginal and Torres Strait Islander people and understanding barriers to use of Health Services.
- Development of 'hard capacities' including systems, technical skills, and infrastructure, were less well addressed through the measure. Positive examples included skills and resources in relation to increasing technical knowledge of appropriate levels of care for Aboriginal and Torres Strait Islander patients, and provision of resources to assist practices to better use the Aboriginal and Torres Strait Islander -specific MBS item numbers.
- Promising approaches to increase capacity of General Practice to deliver culturally appropriate care included those that built on the work already done through practice support teams in DGPs, and working with these teams through their established relationships with General Practice.
- Owing to widely differing numbers of Aboriginal and Torres Strait Islander patients on practice lists and varying levels of interest in Aboriginal and Torres Strait Islander health, IHPOs and OWs in some sites developed workable models by 'segmenting' their audience according to how engaged they were in Aboriginal and Torres Strait Islander health issues, and tailoring messages and approaches to suit different segments. For some, this meant primarily working with General

Practices that had sufficient numbers of Aboriginal and Torres Strait Islander patients, and motivation to improve quality care for these patients.

- Some IHPOs were exploring how to increase use of care planning in General Practice and increase uptake of follow-up items, but there was no evidence from the Sentinel Sites of strategies having been implemented that resulted in increased use of these follow-up items, or triggering of Tier 1 payments for PIP Indigenous Health Incentive registered patients.
- Improving identification of Aboriginal and Torres Strait Islander patients included work with GPs to make their services more welcoming of Aboriginal and Torres Strait Islander people, reminding them of the importance of recording Aboriginal and Torres Strait Islander status and suggesting ways to improve this, and through encouraging community members to self-identify at Health Services.
- Over the period of the evaluation greater numbers of Health Services were able to retrieve information on Aboriginal and Torres Strait Islander status of their patients, and greater numbers of people were recorded on these systems as being identified as Aboriginal and Torres Strait Islander. This suggests that identification of Aboriginal and Torres Strait Islander identity may have increased over the period of evaluation. The ability to retrieve relevant data from clinical information systems may also have improved as a result of repeated requests for these data from the SSE team.
- Challenges in relation to the objective of fostering collaboration and support between General Practice and the Aboriginal and Torres Strait Islander health sectors related to short-term and siloed program funding, and to historically different approaches to work.
- Relevant stakeholders generally held positive perceptions about the contribution of DGP-based IHPOs and OWs to intended outcomes.

The effectiveness of the *Improving Indigenous Access to Mainstream Primary Care Program* Measure is discussed below in relation to the six objectives of the program (see section 14.1). Findings from the Sentinel Sites are presented for each of these program objectives, together with the roles of the workforce that were relevant to achieving each of the aims, indications of how well these worked at local level, factors influencing their success, and perceptions from interviewees in the sites about the extent to which the objectives were achieved.

Increasing access to mainstream primary care services by Aboriginal and Torres Strait Islander people

Across the Sentinel Sites, OWs and IHPOs based in DGPs/Medicare Locals were engaged in work that addressed a range of known barriers to access to mainstream primary care services.

OWs facilitated increased access to Health Services through assisting patients with making appointments and navigating the health system, including follow-up and specialist appointments. In some situations OWs reportedly took on other roles such as supporting patients with broader social concerns such as assistance with housing or social supports.

In some of the Sentinel Sites interviewees believed that the DGP-based OWs had less day to day contact with communities than the AHS-based OWs – and that some of the DGP-based OWs may not have had strong engagement with communities. This was identified as a potential barrier to the measure

enabling better access to services. However, this was not the case across all sites, and many instances were identified of DGP-based OWs providing direct support to patients to increase access to mainstream services, including provision of transport. Experience from the Sentinel Sites in relation to provision of transport is outlined below.

Addressing issues of cultural safety, and working to improve capacity of General Practice to provide culturally appropriate care, were also important aspects of improving access, and are discussed in the relevant sub-section below.

Transport as a barrier to care

Transport to attend health appointments was consistently identified in community focus groups as a key barrier to access to Health Services. Across the evaluation period, OWs played key roles in addressing transport needs. This included OWs making transport arrangements and acting as drivers transporting patients to health care appointments (including appointments to General Practice, specialists and allied health professionals).

Resources available to OWs to fulfil this role varied in different organisations. Since patient transport (and other requirements for communication, such as mobile phones) was not specifically funded through the measure, access to vehicles was an issue for some OWs, with some using their own vehicles and seeking reimbursement from the DGP. In other cases the employing organisation had vehicles that could be used by OWs, usually through a car pool arrangement. The measure guidelines indicated that funds were not be used to purchase assets or for finance leases, including for vehicles, unless agreed in writing by the DoHA. As indicated in Chapter 8, some OWs were able to assist patients to access Supplementary Services funding for transport needs, but this was only available to the subset of patients registered with the care coordination program.

Transport, along with coordination, was understood as playing a large role in achieving more regular attendance at the Health Service by chronically ill patients. Interviewees (including OWs and other stakeholders) generally perceived that people were attending more regularly as a result of the work of the OW (Table 14.4). This may have been due to assistance with transport arrangements, and to other factors.

Vignette – practical assistance for General Practice

In one urban Sentinel Site, staff at a General Practice recognise and value the productive working relationship they have with the OW employed at the DGP. *‘[We have] good close contact with the OW. I know if I have got a question I can ring anytime’.*

The OW sits in on medical consultations as a cultural broker when needed. *‘Patients really value the service’.*

The practice nurse, in particular, has good rapport with the staff at the DGP. *‘I have been going up to the Division for a long time and so I have gotten to know all the staff ... When the CTG program started I did extra training with them.’*

She explained how OW provides practical assistance with patient access and follow-up.

‘[The OW] will even bring the patients down for us. If there is a new person in the area that wants to see a doctor they will bring them down to the surgery. ... If I say I have got a patient

I have been trying to get a hold of and can't get them [the OW] will even try for me too and with their contacts they know a lot of the family groups and they [are able to] help out.'

'The OW also acknowledges that the patients are often 'hypersensitive' to side-way glances and attend thinking they are going to be discriminated against where in fact the staff may be just busy. The OW points out to the person, 'they are just busy and not ignoring you so you must wait'. (DGP, program manager)

'One Outreach Worker stated that she had been able to improve access for patients and that ... making a contact with a patient was important and making them feel comfortable enough to open up to me. In my first interview we would talk about everything else except why I was there, so I have found my approach has been spot on and gaining my patient's trust which I have, they have actually spoken about other members of the family that may be able to benefit from our services.' (DGP, OW)

Perceptions of increased access as a result of OW and IHPO work

Perceptions amongst interviewees that the OW and IHPO had improved access to services were generally positive. In the final evaluation cycle 52% (15/29) of interviewees from the General Practice sector agreed that *'Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker'* (Table 14.4) and 67% agreed that *'The IHPO has contributed to improved access to Health Services'* (Figure 14.2). The generally more positive assessment of the IHPO as having improved access to Health Services may have had to do with differences in the way the statements were phrased, with the first statement referring to the desired outcome of increased attendance, and the latter, referring to the earlier result of improved access (which may not have resulted in more regular attendance). It also may be related to the interviewees having better knowledge of the work of the IHPO than of the OW because of the types of tasks typically performed by IHPOs, which are more likely to bring them into direct contact with service providers and managers (who comprised two of the four interviewee types) (Table 14.4). The table shows responses to these statements from interviewees in the GP and AHS sectors. Different perceptions by interviewees in the different sectors are discussed in Chapter 13.

Table 14.4: Responses to the statement 'Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker' (% who responded 'strongly agree' or 'partly agree'), by sector

	Sector	Evaluation cycle		
		Three	Four	Five
Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker. MS, CS, PM, OW ^a	Overall	46% (n=78)	55% (n=79)	59% (n=61)
	Aboriginal Health Sector	40% (n=35)	49% (n=37)	66% (n=32)
	General Practice Sector	51% (n=43)	60% (n=42)	52% (n=29)

^a Type of interview respondent, see Appendix C for listing of interview and respondent types.

Note: n=number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.

Aboriginal Health Sector includes: AHSs, NACCHO State and Territory affiliates.

General Practice Sector includes: General Practice, DGPs and Division SBOs.

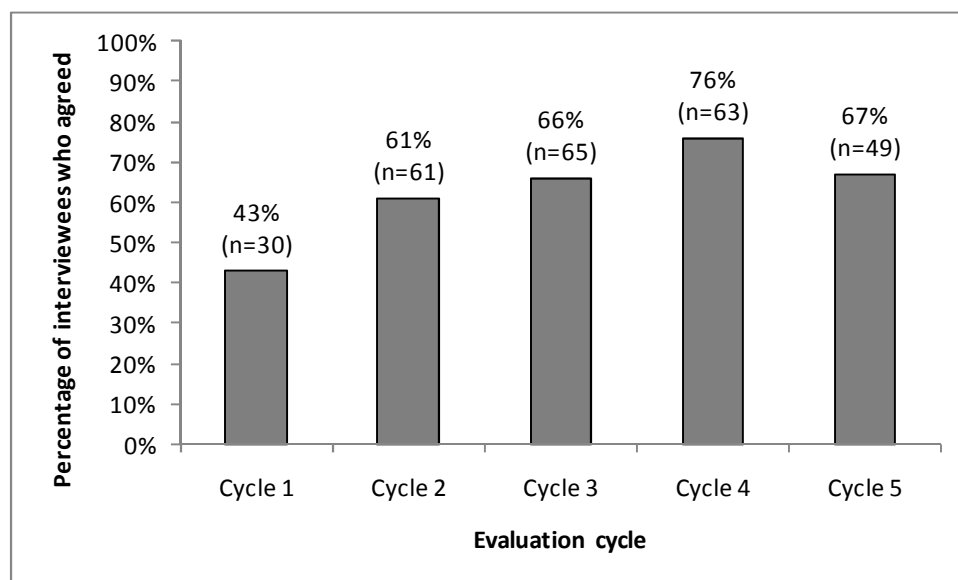


Figure 14.2: Interviewees' responses to the statement: 'The IHPO has contributed to improved access to Health Services' (% who responded 'strongly agree' or 'partly agree'), overall and by evaluation cycle

Improving the capacity of General Practice to deliver culturally sensitive primary care services

A balance between 'hard' and 'soft' capacity improvement

Literature suggests that improving capacity of organisations requires a balance of developing 'hard capacities' such as technical skills, functions, structures, systems, infrastructure, equipment and financial resources and 'soft capacities' including values, morale, engagement, confidence and motivation.¹⁷⁰

Interviewees in the Sentinel Sites described a range of activities undertaken by IHPOs and OWs that were relevant to improving both types of capacities in General Practice to deliver culturally sensitive primary care services. For the most part, roles in relation to improving 'hard capacities' related to the education, training and resources provided to General Practices by IHPOs on the use of the Aboriginal and Torres Strait Islander -specific MBS items, including adult health assessments and follow-up items. These were delivered through group sessions organised by the DGP/Medicare Local, and visits to General Practices. These aspects of capacity improvement were often integrated into the work of practice support teams (integration into the work of practice support teams is expanded on in the sub-section below). Some interviewees noted particular roles of IHPOs in working with overseas trained doctors, to increase cultural awareness amongst these GPs.

Also relevant to improving 'hard capacities' were the workshops and seminars organised by DGPs/Medicare Locals and SBOs that addressed technical aspects of good quality care for Aboriginal and Torres Strait Islander people – including information about the clinical conditions that many Aboriginal and Torres Strait Islander patients presented with, and best practice in management of these

¹⁷⁰ Tsey K, McCalman J, Bainbridge R & Brown C 2012. Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

conditions. In one DGP/Medicare Local that reported this clinical/technical training in Aboriginal and Torres Strait Islander health, it was noted that this aspect of capacity improvement had been organised by the Medicare Local on request from GPs from the General Practice sector. This request followed on from a large workshop attended by over 100 GPs, which addressed more generic 'soft' aspects of capacity, through the more general cultural awareness training. In this particular case, the clinical aspect of the training was conducted by a senior doctor in the large and well known AHS in the area, which may have contributed to the interest generated in the training and the relatively good attendance by GPs. Consistent with the literature, this example illustrates how both 'hard' and 'soft' elements of capacity improvement are important.

In the Sentinel Sites we found more evidence of activities relevant to improvement in 'soft' capacities than 'hard' capacities. This relative emphasis may have been appropriate for the GP sector at this time. With respect to 'soft' capacities cultural awareness training organised by IHPOs was often mentioned in the Sentinel Sites. In discussion of cultural awareness training that was accessed by GPs in General Practice as part of requirements for the PIP Indigenous Health Incentive registration, there were reports of substantial improvements in delivery of culturally sensitive care. This was usually in association with the cultural awareness training conducted by DGP-based IHPOs. Some OWs and IHPOs were also involved in providing advice on an individual basis to Health Services about improving cultural appropriateness of services.

There were few examples of IHPOs engaged in improving 'hard' capacities – for example, being engaged in developing systems and infrastructure for ensuring systematic recall and follow-up of Aboriginal and Torres Strait Islander patients with chronic illness across General Practice. Aside from appointment of AHWs in larger General Practices in one or two sites, it appears there has been a relative lack of initiatives in design of service delivery systems in order for General Practice to have improved capacity to delivery culturally appropriate care.

Perceptions amongst interviewees that the OW had improved cultural safety in the service increased over the evaluation period. In the final evaluation cycle 76% (13/17) of interviewees from the General Practice sector agreed that *'The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islander people'* (Chapter 13, Table 13.4).

Agreement with this statement was high amongst the practice managers and clinicians interviewed. Of the 12 practice managers and clinicians from General Practice who were interviewed in the final evaluation cycle, nine agreed with the statement.

Working through existing practice support teams

One approach used successfully in the Sentinel Sites was to start from an emphasis on what was already being done to improve capacity of General Practice more broadly (through the work of the practice support teams in DGPs) and to aim to add value to these existing efforts. In at least one example in the Sentinel Sites a Medicare Local contracted out the IHPO and OW workforce roles to another organisation. In one site, the initial model tried (and abandoned) was to contract the IHPO and OW workforce to an AHS, with the intention of the workforce supporting GPs in General Practice from the AHS. This model was not successful, and the new approach (that appeared to work more effectively) was to contract the role to a regional support organisation. Under this new arrangement, as indicated by the quotation below, it was still considered critical that the IHPO work closely with the practice support team, and the Medicare Local reported integrating the work of the IHPO into the existing practice support team.

'We have placed both of the workers (IHPO and OW) at (organisation name) now and integrated the role of the IHPO into every day work of the existing practice support team. Feel that they are better placed (the practice support team) as they are the ones that have contact with practices and know operating environment and how to integrate into structure. Will have monthly meetings and see it as a way to build links with IUIH.' (Medicare Local, program manager)

No 'one-size fits all' approach

It was also apparent that a 'one size fits all' approach to improving capacity of General Practice was not workable at the local level. One interviewee from an SBO described four categories of General Practice with whom the IHPOs needed to work – these were in a continuum – including those that were accredited and registered with the PIP Indigenous Health Incentive, those that were accredited only, those that were not accredited, but provided care to some Aboriginal and Torres Strait Islander patients, and those that were not interested in providing care or adapting their practice to be more cultural sensitive. In early evaluation cycles the IHPOs were trying to work across all categories of General Practice, and in later evaluation cycles, there was a general move to working only predominantly with those General Practices that had indicated an interest, and were already part of the way along the continuum described above. Whilst this is a logical and possibly more effective approach than attempting to work with all General Practices in a site, there were also concerns raised that this approach may lead to inequity in access to ICDP initiatives, particularly where there were no other local service providers who were engaged in the ICDP.

Increasing the uptake of Aboriginal and Torres Strait Islander specific Medical Benefits Schedule items including adult health assessments and follow-up items

IHPOs and OWs described activities consistent with facilitating uptake of Aboriginal and Torres Strait Islander specific MBS items. These included providing General Practice with information about the MBS item numbers, and creating awareness of the adult health assessments in communities.

Provision of information to General Practice about the Aboriginal and Torres Strait Islander specific MBS item numbers was logically done in association with the existing DGP/Medicare Local practice support teams that were already engaged with General Practice to improve practice systems and awareness and use of appropriate Medicare item numbers. In several DGPs/Medicare Locals in the Sentinel Sites it was apparent that the IHPOs and OWs worked together with the existing practice support teams and were able to introduce Aboriginal and Torres Strait Islander components into events, such as GP and practice staff education sessions hosted by the DGP/Medicare Local. Linking with practice support teams was viewed as valuable as it was the practice support teams that have had a longer prior history of engagement and relationships built with the General Practices. It also allowed for greater coverage and integration into core business. In response to funding uncertainty and concerns about sustainability of this aspect of the measure, some interviewees noted that careful attention had been paid in their site to making sure that the practice support teams were able to continue promoting use of Aboriginal and Torres Strait Islander specific MBS item numbers in the event that the IHPO and OW positions were no longer funded.

Also identified in the Sentinel Sites in relation to increasing uptake of the Aboriginal and Torres Strait Islander specific MBS items was the work done by Aboriginal and Torres Strait Islander health teams in DGPs/Medicare Locals. We noted in Chapter 6 that one of the common characteristics of those sites that achieved high population coverage of adult health assessments, particularly in urban areas, was that there was a high number of GPs engaged in doing adult health assessments in addition to high average numbers of adult health assessments being done by each GP. Many of the sites that achieved

good population coverage of health assessments had an Aboriginal and Torres Strait Islander health team support structure in place. This team structure was described as a support to IHPOs and OWs, and is likely to have contributed to their ability to expand the base of practices engaging in adult health assessments. Examples of how these teams were organised are described further below in section 14.3.4.

The program objectives for this measure include increasing both adult health assessments and follow-up items. Uptake of Aboriginal and Torres Strait Islander specific follow-up items was generally low, and there were ongoing challenges in increasing the use of follow-up items. In some cases it was felt that GPs were reluctant to use TCAs. For example, one IHPO interviewed felt that GPs in her site were not using TCAs, and she was unsure about how to change this situation. Whilst some GPs were reluctant to use these tools, others reported using them and making large numbers of referrals, but the patients were not attending. OWs and AHWs were used by some GPs to assist with getting patients to attend for allied health appointments, but that this was not always successful. Reasons for lack of success that were identified through the SSE are described in Chapter 6.

OWs in DGPs had roles in increasing community awareness of adult health assessments. Community members valued adult health assessments less than the PBS Co-payment for obvious monetary reasons. Strategies to increase uptake of adult health assessments were often linked to access to the PBS Co-payment measure in order to increase uptake of adult health assessments. DGP-based OWs and IHPOs may also have played a role in providing incentives for people to undergo adult health assessments, offering incentives such as t-shirts, water bottles or entry into competition for a bicycle – this may have been a motivating factor for some. Use of these incentives is described in Chapter 6.

Supporting General Practice services to encourage Aboriginal and Torres Strait Islander people to self-identify

Identification as a focus of work

Improvement in identification of Aboriginal and Torres Strait Islander patients at General Practices was consistently noted as being a major focus of the program of work of IHPOs and OWs. Appropriately identifying Aboriginal and Torres Strait Islander status was found to include the following aspects of work for OWs and IHPOs at local level:

- supporting General Practices to create 'Aboriginal and Torres Strait Islander -friendly environments'
- reminding practices that documentation of Aboriginal and Torres Strait Islander identity is important because of the differing best practice clinical guidelines recommended for Aboriginal and Torres Strait Islander people and others at high risk of certain conditions, for example highlighting that recommended screening intervals for certain conditions may differ because of varying risk profiles
- supporting practices to organise systems to embed routine identification by provision of examples and training of staff (particularly reception staff) on why and how to ask about Aboriginal or Torres Strait Islander status
- encouraging community members to self-identify
- raising awareness of the financial benefits to practices of identifying Aboriginal and Torres Strait Islander patients and service delivery to these patients.

Identification recorded in clinical information systems

Whilst the activities outlined above were likely to have led to better identification in some Health Services, in order for the identification to achieve its aim of enabling access to the enhanced care available through the ICDP, Aboriginal and Torres Strait Islander status needed to be recorded systematically in clinical information systems, and able to be retrieved at relevant points in the care process (for example, when generating prescriptions for patients registered for the PBS Co-payment measure, or when generating recall lists for recommended care at relevant intervals).

In each evaluation cycle the Sentinel Sites evaluation team requested clinical indicator data from General Practices, including requesting numbers of patients identified as Aboriginal and Torres Strait Islander on the clinical information system. Findings from the Sentinel Sites in relation to the state and functionality of clinical information systems in both General Practice and AHSs are presented in Appendix E. The numbers of people identified as Aboriginal or Torres Strait Islander on the clinical information system per practice, and trends in these numbers over time, are relevant to understanding the effectiveness of the IHPO and OW role in supporting General Practice to encouraging Aboriginal and Torres Strait Islander people to self-identify and are briefly summarised below.

In the final evaluation period, 22 of the 24 General Practices that provided clinical indicator data included numbers of patients identified as Aboriginal or Torres Strait Islander on the clinical information system. From these data, the number of regular patients identified in the clinical information system as Aboriginal or Torres Strait Islander ranged from 23 to 998 per practice. Seventeen of the 22 General Practices had more than 50 patients identified as Aboriginal or Torres Strait Islander, 16 had more than 100, nine had more than 200 and 4 had more than 500 (Appendix E). For most General Practices, the proportion of all regular patients who identified as Aboriginal and Torres Strait Islander was low, ranging from 0.4% (23/6348) to 2.3% (998/42 666). For four General Practices this percentage was equivalent to or higher than the percentage of Aboriginal and Torres Strait Islander people in the total population for the site. For the majority of practices (18/22) Aboriginal and Torres Strait Islander people made up a smaller proportion of regular patients than the proportion of the total site population who were identified as Aboriginal and Torres Strait Islander, suggesting that the profile of patients attending these practices is likely to be a selective group of the general Aboriginal and Torres Strait Islander populations in the sites.

There were 19 practices that provided clinical indicator data for both the fourth and fifth evaluation cycle (Figure 14.3). Numbers of patients identified as Aboriginal and Torres Strait Islander increased in almost all of these 19 practices between these two evaluation cycles, with an overall increase of about 14% (5051 to 5766). Eight practices showed increases of fifty or more identified as Aboriginal and Torres Strait Islander patients between the two cycles, and a further five General Practices showed increases of twenty or more patients. Three General Practices reported a decrease in the number of patients identified as Aboriginal and Torres Strait Islander. In one of these practices, interviewees reported that this was a consequence of a 'clean' of the clinical information system.

Trends over time in the numbers of people identified as Aboriginal and Torres Strait Islander suggest use of clinical information systems for retrieving information on Aboriginal and Torres Strait Islander identity over time was improving. This may have reflected improved identification processes, improved recording, improved retrieval, or better use of clinical information systems by staff. The repeated requests by the SSE team for these data over successive cycles of the evaluation, as well as other more general initiatives to improve reporting of key performance indicators for Aboriginal and Torres Strait Islander health, contributed to the ability of services to report such data. These initiatives probably had more influence on the capability to retrieve data than the work of the ICDP teams on the ground.

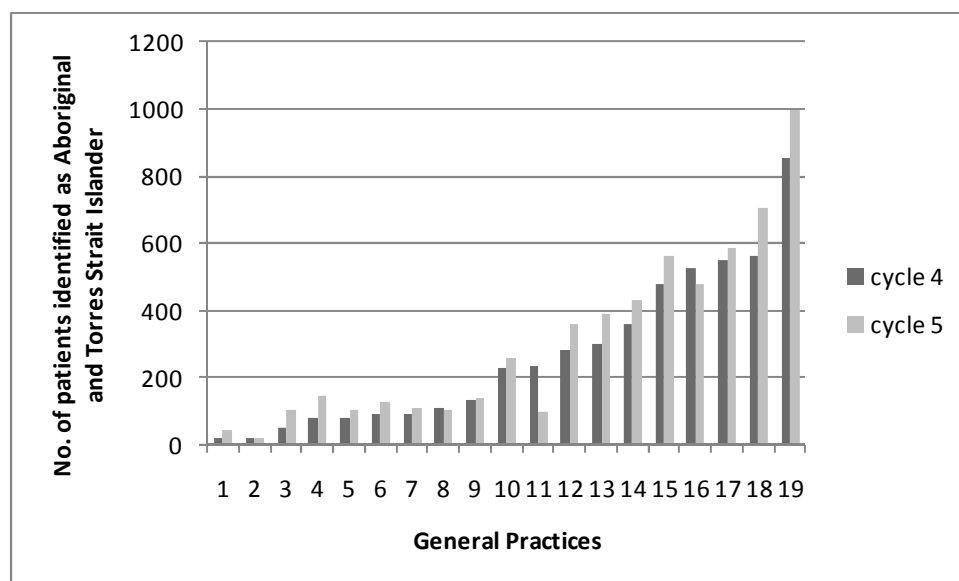


Figure 14.3: Number of patients on the clinical information system identified as Aboriginal and Torres Strait Islander by General Practice

Interviewees across both General Practices and AHSs indicated the need for further development of systems to support identification of Aboriginal and Torres Strait Islander patients. However, whilst IHPOs have a role in General Practices to facilitate identification, they do not have a similar role in AHSs. Interviewees from AHSs in Sentinel Sites did not indicate a need for this kind of support from IHPOs.

Perceptions of contribution

The role of IHPOs in contributing to improved identification of Aboriginal and Torres Strait Islander patients was recognised by interviewees. About half (26/49) of interviewees 'strongly or partly agreed' that the IHPO had contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practices (Figure 14.4). As indicated in the figure, the proportion of interviewees agreeing with this statement has generally steadily increased since the first evaluation period, with a decline in the final cycle. This decline may be a consequence of the process of transition from DGPs to Medical Locals detracting from the work of the IHPOs on the ground.

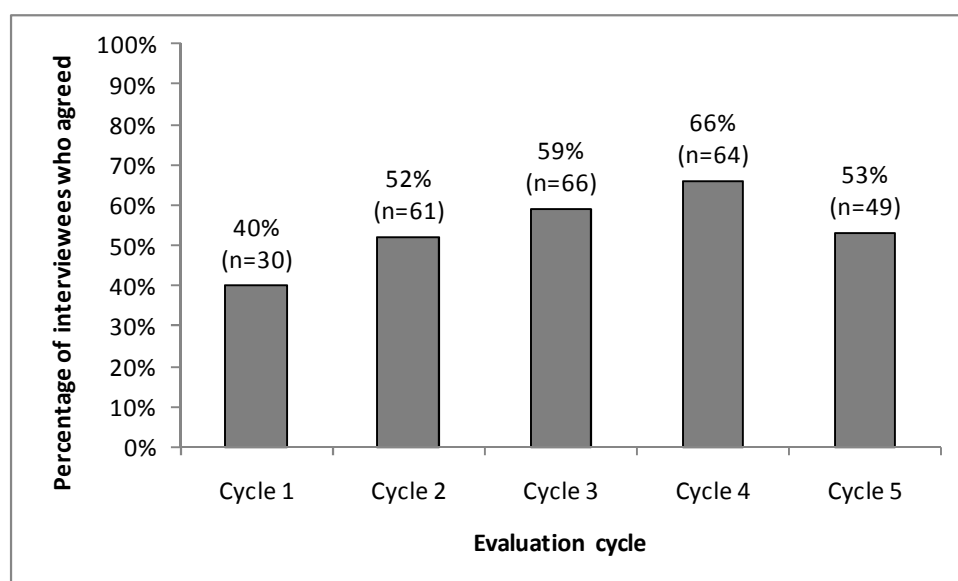


Figure 14.4: Interviewees' responses to the statement: 'The IHPO has contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practice' (% who responded 'strongly agree' or 'partly agree'), overall and by evaluation cycle

Increasing awareness and understanding of Closing the Gap measures relevant to mainstream primary care

One of the key roles envisaged for OWs and IHPOs at the local level was to assist in creating awareness and uptake of the various ICDP measures available. Interviewees across all sites (besides remote sites) spoke positively about the role of the IHPO in raising awareness of the ICDP measures. This included sharing of information internally within the DGP/Medicare Local, and sharing of information about the ICDP more broadly with General Practices in the site.

The role of IHPOs and OWs in sharing information within DGPs/Medicare Locals became more complex as the transition to Medicare Locals was complete, as the IHPO and OW needed to work more broadly, with a larger number of stakeholders.

Informal sharing of information

For some interviewees, the role of IHPOs and OWs in increasing awareness and understanding of CtG measures was more of an informal, rather than formal activity, as illustrated by the quotation below.

'The CtG team from the Medicare Local just pop in intermittently to check how the practice is going and drop off information and just to have a chat with us to see how we are going with everything. They seem to be doing a pretty good job. They have always got time to talk if I have any problem so I am happy with that.' (General Practice, practice manager)

Evolution of information requirements

The nature of work with General Practice changed during the evaluation period. Initially, IHPOs focused on awareness raising in relation to the ICDP measures, whilst in later evaluation cycles, some IHPOs were providing more detailed support and practical assistance in uptake of ICDP measures. In the final two evaluation cycles, some interviewees indicated that the workforce was providing more detailed information on measures such as requirements and systems development to trigger Tier 1 payments through the PIP Indigenous Health Incentive. It was only in later evaluation cycles that ICDP Care

Coordinators were employed. In the later evaluation cycles, IHPOs reported introducing Care Coordinators to General Practices, and that this was a means of offering some practical support.

Achieving balance in focus of work with communities and with General Practices

In early evaluation cycles there were some tensions related to the focus of the work of the IHPO. For example, concern was raised by an SBO about the limitations of an approach taken by one IHPO, based in a DGP, whose work seemed to be focused solely on community engagement rather than working with General Practices. In this site, stakeholder concerns about the effectiveness of this approach had apparently contributed to delays in roll out of the care coordination funding to the site. By contrast, in other sites, it was felt that OWs were overly focused on work with General Practice, and were losing the community connection. As indicated by the quotation below, this tension was not evident in all sites. Relevant activities undertaken by the OW (and to a lesser extent IHPOs) in working with communities included: consultations with individuals and families; organisation of presentations about the ICDP at community events and in public spaces, and organisation of specific community events to promote the ICDP measures.

'OW has assisted to raise that awareness by participating in information sessions at stall set up in local shopping centres.' (DGP, IHPO)

'Information days have been held which has established links between services and community. Also visited many organisations in [site name] to talk about the CtG program.' (DGP, OW)

'The CtG team goes out there and creates community awareness. The team has been networking with the Aboriginal staff and community to raise awareness on stuff.' (AHS, practice manager)

During participation in SBO workshops, IHPOs and OWs expressed uncertainty about where they should direct most of their efforts, whether to community or to General Practice. In some cases, as illustrated by the quotation below, community advocacy and working only with General Practices willing to engage, was felt to be more successful than trying to work with those General Practices that had no interest in participation.

Vignette – community action to engage General Practices

In an urban site in a capital city, some General Practices have been slow to take up the ICDP measures. ICDP staff at the DGP and the SBO are realistic about what their approaches can achieve.

'At times we feel as though we are struggling to engage some practices... We can't lose sight that [the General Practices] are private businesses so they can flatly refuse to participate in any of the measures.'

Instead of continuing to approach practice staff, the OW and IHPO at the site have facilitated community advocacy. They have encouraged individuals to attend practices, identify as Aboriginal and Torres Strait Islander and to request access to ICDP benefits.

'Where community are driving it [the practices] can't deny that they have an Aboriginal population. The Outreach Workers have been very strong in this approach in [site name]. Now [we don't] expend our energy there convincing them that they have an Aboriginal population - rather we are focusing on those who want to engage.' (SBO, IHPO)

Perceptions of increased awareness of ICDP measures as a result of IHPO work

Across the evaluation period, there was an increase in the proportion of interviewees strongly or partly agreeing that the IHPO had been helpful in raising awareness of the new measures available under the ICDP until the final evaluation cycle, when there was a decline (Figure 14.5). Similar to the statement on the contribution of the IHPO to improving identification of Aboriginal and Torres Strait Islander people (Table 14.4), this decline may be a consequence of the process of transition from DGPs to Medicare Locals detracting from the work of the IHPOs on the ground.

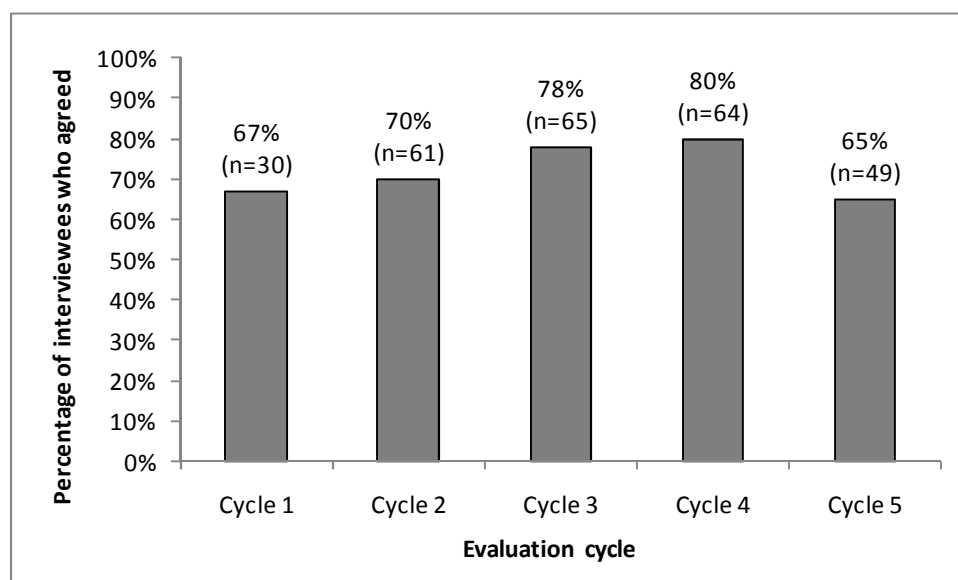


Figure 14.5: Interviewees' responses to the statement: 'The IHPO has been helpful in assisting to raise awareness of the new measures being implemented under the ICDP' (% who responded 'strongly agree' or 'partly agree'), overall and by evaluation cycle

There were a range of factors at site level that influenced uptake of the various ICDP measures. Despite the relevant activities undertaken by IHPOs and OWs in support of greater uptake of ICDP measures, we would not expect, and generally did not see, a direct one-to-one relationship between employment of the IHPOs and OWs, and uptake of the various ICDP measures at site-level. It was evident that for many sites, uptake of adult health assessments, and participation in the PIP Indigenous Health Incentive and the PBS Co-payment measure started increasing prior to the appointment of the IHPO and OW (Appendix B).

Appendix I presents an analysis of the relationship between different service use variables (for example PIP Indigenous Health Incentive, health assessments and follow-up items) and contextual variables (for example pre-existing uptake of related MBS items and the number of ICDP workers in the site).

Vignette – the evolving IHPO role

The work of an IHPO based in a DGP in a regional site has evolved as the ICDP program has become established. When she started in the role, the main focus of IHPO work was informing the community and General Practices about the new measures.

The IHPO worked in partnership with the DGP based OW to raise awareness and generate community interest in the program. They presented information about the Closing the Gap program at meetings of community groups, combining it with health education sessions whenever possible. For example, the IHPO arranged for the National Prescribing Service team member employed at the DGP to give a talk on safe medication use at an Elders meeting, where the IHPO also informed the group about assistance available through the new Care Coordination and Supplementary Services program. Community members increasingly asked about access to General Practices.

In this early phase, information was disseminated to General Practices through visits, memos and by incorporating information into education events organised by the DGP for GPs and General Practice staff. Links were made with the practice support team based in the DGP to ensure they were aware of the new measures and how they were administered.

Now that most General Practices and community are aware of the ICDP, the IHPO role is supporting General Practices to implement relevant measures, raise cultural awareness and improve cultural safety. Community awareness raising activities are ongoing, and work is being done to integrate the ICDP into other DGP programs.

Fostering collaboration and support between the mainstream primary care and the Aboriginal health sectors

IHPOs and OWs in a few of the sites were engaged in activities that were relevant to fostering collaboration between General Practice and the Aboriginal health sectors, but this generally did not appear to be a core part of their work in the Sentinel Sites.

In one DGP/Medicare Local, an experienced clinician from the AHS sector was invited by the DGP/Medicare Local to address GPs from General Practice and share experiences and best practice in Aboriginal and Torres Strait Islander health. It appeared the IHPO role had been important in arranging this. Other interviewees described both the OWs and the IHPOs as spending time establishing partnerships with primary health care services such as community Health Services and allied health professionals, but did not refer to working with AHSs to any great extent.

'The IHPO provides information about their role and Closing the Gap program to organisations and has established referral pathways between the hospital and IHPO for follow-up of patients after their discharge from hospital. Liaison Officer at hospital with the consent of the patient will refer patients to the IHPO. This also enables IHPO to gauge the types of support required by community.' (DGP, program manager)

Some examples of efforts to foster collaboration through the measure that were identified in the Sentinel Sites included:

- IHPOs based in the DGP sought to work with the AHS in the site in raising awareness about ICDP measures, but the AHS did not view this as a fruitful area of collaboration, and declined.
- A DGP offered support to the AHS in ICDP implementation, but the AHS declined, as they felt that the numerous General Practices in the area were in greater need of the support than they were.
- A DGP worked with the AHS to get MSOAP-ICD funding. This collaboration was underway at the time of the evaluation, but the AHS interviewee noted that they did not need the support of the DGP for any other aspect of the ICDP.
- In another site, the DGP allocated 0.5 FTE of an IHPO position to be based at the AHS in the site. The AHS used the IHPO to assist with submission and reporting processes, and the person was not involved in core IHPO roles, or working to any great extent with community organisations or General Practices.

Fostering collaboration between General Practice and the AHS sector was challenging. There were few precedents for this, and generally AHSs perceived that their source of support was the NACCHO affiliates, not the DGPs.

Throughout the evaluation there were many examples of the AHS and the General Practice sector not working together. The SSE team had difficulties getting the two sectors together for feedback sessions in a number of the Sentinel Sites owing to lack of interest in working together. In several other sites, the SSE feedback sessions were the first time the sectors had come together for some time. Some of the interviewees from AHSs reported that they had no contact with the IHPO from the DGP/Medicare Local.

'We haven't really had anything to do with the IHPO at the Division. We are pretty self contained here.' (AHS, practice manager)

In one site there was concern that a lack of collaboration may be leading to a duplication of services to one subset of the population. As indicated by the quotation below, generally outreach services were not planned collaboratively between the sectors.

'The OWs and the DGP and the AHS don't interact. The OWs in the DGP are focused on providing information to homeless people and people in crisis about where to access health services. There is the possibility this is occurring also with team at AHS.' (DGP, program manager)

Perceptions of contribution

In the final evaluation cycle, around one half of interviewees agreed with the statement that *'the employment of the IHPO had helped develop stronger links between primary health care services'*. This was a decline since the previous evaluation cycle, in which two-thirds of interviewees agreed with the statement (Figure 14.6).

Similar to data on other statements reported above, there was an increase in agreement with this statement over the first four evaluation cycles, with a decline in the final cycle. Reasons for this decline are likely to be the same as for the other statements.

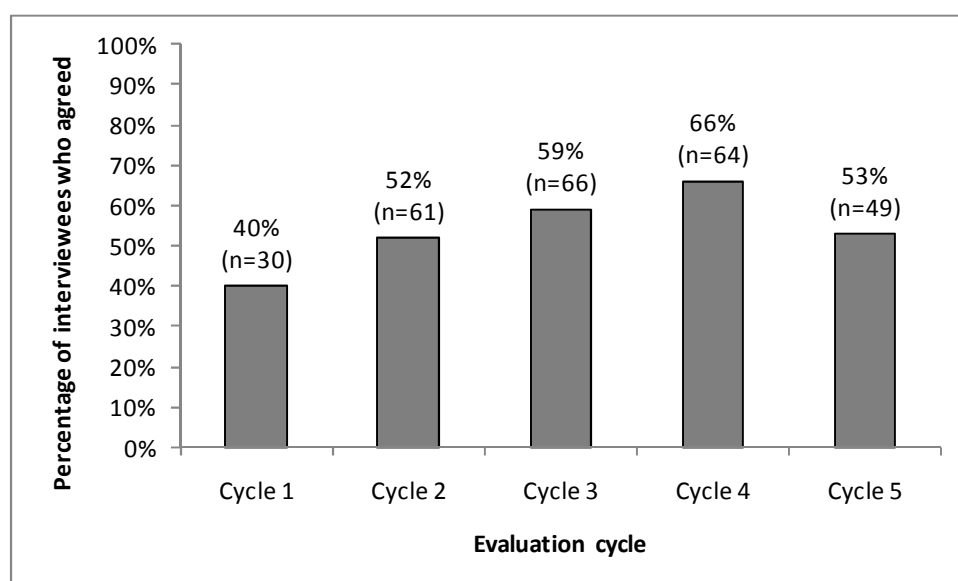


Figure 14.6: Interviewees' responses to the statement: 'The employment of IHPOs has helped to develop stronger links between primary health care services' (% who responded 'strongly agree' or 'partly agree'), overall and by report period

14.3.4. MANAGEMENT, SUPPORT AND SUPERVISION OF OUTREACH WORKERS AND INDIGENOUS HEALTH PROJECT OFFICERS

KEY POINTS

- Program reporting and associated monitoring appeared to contradict data obtained at local level in some cases, and generally seemed to lack emphasis on the learning function of program monitoring.
- In early evaluation cycles some DGPs grappled with challenges of integrating an Aboriginal and Torres Strait Islander workforce into a generally non-Aboriginal and Torres Strait Islander working environment. By the final evaluation cycle these issues had largely been resolved, often through strategic leadership and investment of time and resources to establish a shared understanding of roles.
- Development of culturally safe team-based approaches in some DGPs/Medicare Locals provided IHPOs and OWs with peer support, networking and collaboration opportunities that assisted them to be effective in their roles.
- Resources for middle management, particularly to support Aboriginal and Torres Strait Islander health teams in DGPs/Medicare Locals, appeared to be unevenly distributed across DGPs/Medicare Locals, and depended on the organisation recognising this need, and investing time and effort to address it.
- Organisational support provided by the SBOs was valued, including networking opportunities provided through shared workshops and orientation.

Management perceptions of success

Relevant to management and monitoring of the program overall, we noted in general, that managers, including CEOs and Program Managers in DGPs and SBOs tended to be more positive about the role and effectiveness of IHPOs and OWs than other interviewee types. This applied across the range of questions and perceptions that were covered in the SSE, and across evaluation cycles. Whilst there were some successes described in this chapter, the positive reports by managers were sometimes contradictory to reports by other interviewees, and similarly the DGP/Medicare Local reports that we had access to sometimes did not concur with what was observed at site level.

Since managers were generally responsible for the program reporting to DoHA, it will be important to continue to emphasise both the learning and accountability functions of program monitoring, and to avoid overly positive reporting since this is unlikely to contribute to learning and improvement.

Culturally safe team-based approaches

In the first three evaluation cycles, there were considerable concerns from interviewees regarding the difficulties of integrating an Aboriginal and Torres Strait Islander workforce into DGPs, but these concerns were less apparent in the final two evaluation cycles and it seemed that local solutions had begun to take effect. A number of sites had developed Aboriginal and Torres Strait Islander health teams and these were spoken of highly by interviewees who felt that they provided Aboriginal and Torres Strait Islander staff with peer support and the ability to assert their roles more effectively. Developing these teams was partly a 'trial and error' approach, as suggested by the quotation below.

'Talking about management support structure at the Divisions. Some Divisions do it well and others don't ... where you have an Aboriginal Health team, you've got Aboriginal people working in a team with non-Aboriginal people, it works well... if we look at our workforce recruitment and retention over time ... we haven't had the turnover that we thought we'd have ... we are looking ... to see what works and what doesn't.' (SBO, IHPO)

Building Aboriginal and Torres Strait Islander health teams was reported to have been successful in overcoming a sense of isolation among Aboriginal and Torres Strait Islander staff employed within DGPs and to 'share the load of Aboriginal and Torres Strait Islander health' within organisations.

The examples provided in the Vignette below illustrate the benefits of these teams being established, and also the importance of responsive and adaptable leadership in developing culturally safe team based approaches.

Vignette - Support structures and processes for Aboriginal and Torres Strait Islander staff in DGPs

One DGP that has a number of funded Aboriginal and Torres Strait Islander health programs has these programs managed by an overarching Aboriginal Health Manager. The teams work together and cross roles between programs to ensure they are not siloed. They recognise that there are numerous synergies across the programs and feel that the programs are better integrated as a result of this management structure. Benefits of working within the team, as noted by the IHPO, included:

- advocacy by the Aboriginal Health manager, who is able to advocate upwards to the DGP management and board in regard to program direction and implementation, rather than IHPO advocating as a 'lone voice in the team'

- support and networking between OWs and IHPOs
- pooled funding for items such as vehicle
- a sense of having greater influence and being more valued because of team membership.

Another DGP recognised the support needs of Aboriginal and Torres Strait Islander health team members and established a system of debriefing and counselling through the DGP-funded mental health team. The team manager indicated that, although time-consuming, additional debriefing opportunities were necessary for staff. She described taking the role of 'accidental counsellor' on many occasions. In recognition of the need for peer support and of the support role staff members have with patients, this DGP organised 'accidental counsellor' training for all members of their Aboriginal and Torres Strait Islander health team.

Not all organisations were able to create such teams. One interviewee indicated frustration that the funding for the IHPO, OW and Care Coordinator has come into the organisation with inadequate attention to supporting development of an appropriate management structure. This interviewee believed that the roll-out of the funding did not support the creation of teams, and perceived a lack of vision from DoHA in not funding middle managers, with DGPs being left to integrate management into existing structures.

'The fact they have rolled out separate packages that don't necessarily link together is an issue ... the team here at the Division have three programs [IHPO, Care Coordinator and OW] but they have no manager. I am a division manager; I have spent 15% of my time being a team leader to these people. For them to work as a team and work together is difficult without somebody helping.' (DGP, program manager)

Increasingly, interviewees indicated that middle managers in DGPs required training on how to support the Aboriginal and Torres Strait Islander workforce.

Networking and sharing of information

Over the evaluation period interviewees continued to highlight the importance of the networking and sharing of information that is facilitated by the SBOs and indicated that these roles have evolved and strengthened over time. The email communication and meetings facilitated by SBOs were seen to encourage sharing and collaboration between IHPOs based in the DGPs, avoid duplication of effort in developing resources and provide support to staff. One interviewee spoke about the support received from the SBO and networking opportunities offered through the state-wide networking events which occur twice a year, coordinated by the SBO. The interviewee perceived that the support and understanding of the program has matured, not only amongst IHPO and OWs, but also amongst the support organisations.

'The first twelve months of the program were shaky. The meetings at SBOs with IHPOs were challenging as there were tensions amongst IHPOs and OWs working in DGPs from different models. It was perceived that there was a cultural imbalance between non-Aboriginal and Torres Strait Islander and Indigenous IHPOs, differing views on the amount that should be invested in time and energy on developing cultural security within DGP and community approach for IHPOs rather than only focusing on GPs. There was a lot of animosity at meetings about the approaches being used and people felt culturally unsafe. [SBO name] developed a working group to bring together an agenda and to work towards making network meetings

constructive. The working group organised a healing session and as an outcome developed a mural. We have grown and strengthened and we are one mob now. Care Coordinators join the meeting too now.' (DGP, IHPO)

An additional aspect to information sharing was the presence of favourable pre-existing collaborative relationships. In particular, strong relationships between DGPs and General Practices were identified by informants as being particularly important for enabling roll-out of the ICDP measures, including Measure C3. This suggests that the ability of the developing Medicare Locals to retain and build on DGP-GP relationships is likely to continue to be important.

Organisational leadership

Interviewees highlighted that where there was strong organisational leadership for Aboriginal and Torres Strait Islander health and a clear strategic direction, IHPOs and OWs were able to work more effectively with staff at different levels.

'The DGP as an organisation has been very supportive in making Aboriginal Health a priority and this has filtered down to DGP staff.' (DGP, IHPO)

Without this 'mainstreaming' of Aboriginal and Torres Strait Islander health into management, the IHPO and/or OW were left trying to advocate for Aboriginal health matters to be given higher priority. The effectiveness of this advocacy role varied widely and as mentioned earlier, was largely dependent on the experience and confidence of the IHPO and their ability to exercise leadership.

'[Where there is] a more experienced IHPO that can act as a mentor within the organisation and is able to advocate for Aboriginal health was where there were gains. The younger Aboriginal staff struggle with this advocacy role which they adopt.' (SBO, interviewee)

14.3.5. ENABLERS AND CONSTRAINTS TO EFFECTIVE IMPLEMENTATION

KEY POINTS

- This measure appeared to have achieved its effects through the IHPO and OW roles becoming established within DGPs/Medicare Locals, the work of the IHPOs and OWs as change agents internally and externally, and development of complementary linkages with other aspects of the ICDP.
- The roles of the IHPO and OWs were more likely to become established in situations with good integration of the new positions into the work of practice support teams, with support of Aboriginal health teams, and where there was investment of time and resources into trouble-shooting and management. Constraining factors included limited adaptation of the funding to suit local context, which may have been related to short-term nature of the funding.
- Complex service environments, including urban environments with many potentially relevant service providers, remote environments, and environments where the DGP/Medicare Local was perceived to have a lesser role in supporting care for Aboriginal and Torres Strait Islander people were constraints to effective implementation.
- In some contexts, IHPOs and OWs were more able to act as change agents. Enabling contexts included: credibility of the IHPO/OW with the employing organisation, which was linked to recruitment criteria; IHPOs/OWs with capacity to bridge the cultural gap between health

organisations and between communities; and the support of Aboriginal and Torres Strait Islander health teams, who provided practical and social support to the IHPOs and OWs in their working environment. Ability to work across different parts of the organisation, and knowledge across the whole of the ICDP, were also important enablers.

- Effective implementation required linkages between local service providers and other aspects of the ICDP. These linkages were positively influenced by: embedding of the roles into the work of practice support teams; balancing improvement for ‘hard’ and ‘soft’ capacities; and networking and relationship-building opportunities between and amongst ICDP workers within the same sector and between sectors.
- Constraints to effective linkages included: lack of processes and capacity for adapting clinical information systems to work for Aboriginal and Torres Strait Islander patients of General Practice (who may make up a small proportion of the patient list); historical lack of effective working relationships between AHS and GP sectors; and lack of realistic and useful data for service planning.

Effective implementation of this measure as envisaged in the program logic would result in greater participation by the General Practice sector in provision of quality primary health care to Aboriginal and Torres Strait Islanders with or at risk of chronic disease, and that Aboriginal and Torres Strait Islander people using General Practice services would have access to the additional benefits available to them under the ICDP through their General Practice service providers.

The IHPO and OWs were new roles for many DGP/Medicare Locals. An overarching consideration for successful implementation of this measure was that the GPs in General Practice and the DGPs/Medicare Locals with whom the C3 workforce needed to work, did not necessarily already have a focus on Aboriginal and Torres Strait Islander health issues. This was unlike the situation for OWs in AHSs (Measure C2). For many GPs in General Practices, Aboriginal and Torres Strait Islander health was not an important focus or aspect of their work. This overarching consideration informed our analysis and the mechanisms of change that were identified.

Our analysis has identified three broad mechanisms for effective implementation of the measure (Figure 14.7). Constraints and enablers specific to each of the mechanisms are outlined below.

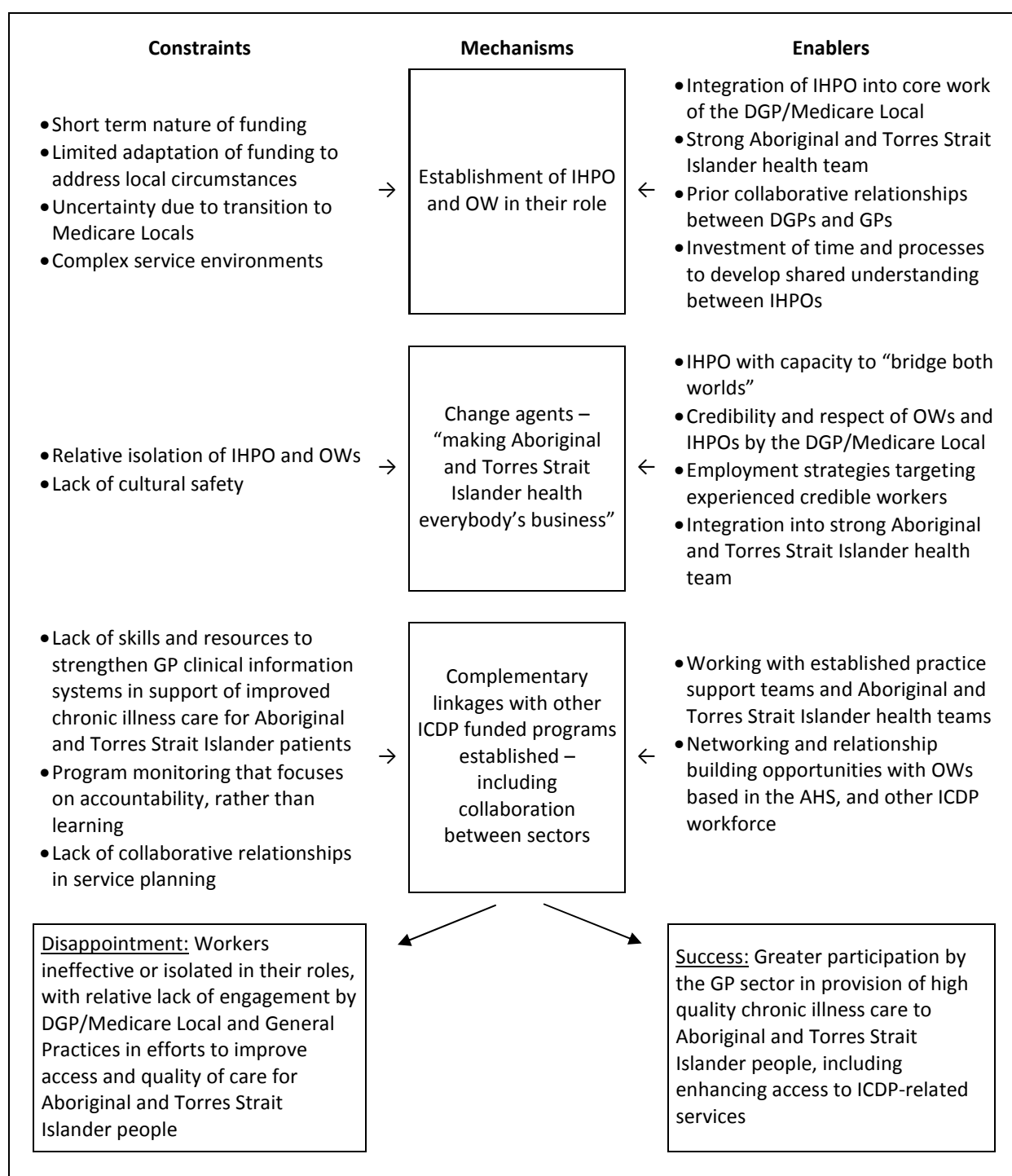


Figure 14.7: Enablers and constraints to effective implementation of Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care measure

Establishment of the IHPO and OW role

Effective implementation required that the IHPO and OW role became established successfully in the employing organisation. Where this happened, we would anticipate the role being valued and integrated into the work of the organisation, and the positions being allocated and used in a way that suited local context.

A key enabler for establishment of the IHPO and OW role within the employing organisation was that the role was set up for success and this generally meant having a strong team support structure in place. In those sites in which the IHPO in particular worked closely with the practice support team of the DGP/Medicare Local, the integration of the IHPO into a core part of the work of the organisation that went along with this and enabled establishment of the role.

There were several situations described in earlier parts of the chapter, where the funding for the IHPO was contracted out or disbursed to a different organisation, and the IHPO (and in one case also the OW) worked out of a different organisation to the DGP/Medicare Local. In several of these sites, the IHPO was closely linked in to the Medicare Local practice support team and this was considered successful, with the IHPO continuing to be engaged in activities relevant to the role. Conversely, in the two situations where the IHPO was based in an AHS, and was not included in the work of Medicare Local practice support teams, establishment of the role was constrained. In the sites in which this occurred, the roles described by interviewees as undertaken by the IHPO did not align well with the intention of the measure. For example in at least one of these situations, the IHPO who had been seconded to the AHSs to provide services under the measure appeared to have little contact with General Practice.

In contexts where IHPOs and OWs were employed in DGPs/Medicare Locals that had a strong Aboriginal and Torres Strait Islander health team, the establishment of the roles appeared to be enabled. In some, but not all cases, these teams pre-dated the ICDP. In one particular example, an Aboriginal and Torres Strait Islander health team was formed as a positive management strategy in response to difficulties that were being faced by the organisation in integrating an Aboriginal and Torres Strait Islander workforce into a largely non-Aboriginal and Torres Strait Islander working environment. The formation of this team and its functioning was identified by interviewees at the site as having been successful in resolving the issues that had been faced. There was also some evidence that sites with strong Aboriginal and Torres Strait Islander health teams were more able to effectively fulfil a number of objectives of the C3 program, including greater uptake of Aboriginal and Torres Strait Islander-specific MBS item numbers.

The short-term nature of the funding for positions was a constraint on establishment of the IHPO and OW roles. In discussing the program implementation, interviewees referred to the expectation in both the DGP and AHS sectors that the funding was coming to an end. The perceived short-term nature of the funding appeared to have contributed to the general limited use of the potential flexibility of the funding to suit local context, with some interviewees noting that they were adopting a 'wait and see' attitude to what was essentially a new type of program for many DGPs. This appeared to be less of a concern in later evaluation cycles, but it does appear to have influenced implementation during the evaluation period.

Although there were some local differences, the general way in which the measure was rolled out was broadly similar in the different Sentinel Sites, with the general absence of innovative implementation models. This may have related to the perceived short-term nature of the funding as outlined above. It may also have related to the fairly early stage of implementation of the measure, and that it was implemented during the period of transition to Medicare Locals, where there were many other changes to manage.

The nature of the service environment of General Practice was a general influence on the establishment of the IHPO and OW roles, and on the extent to which DGPs/Medicare Locals were able to offer good support to GPs. It was evident in the Sentinel Sites that complex urban environments with many GPs involved in care, and more dispersed Aboriginal and Torres Strait Islander communities, and remote environments with relatively fewer GPs involved in care of Aboriginal and Torres Strait Islander patients, were constraints on establishment of the roles. Some of the urban-based DGP/Medicare

Locals took strategic decisions to focus their efforts on supporting GPs who had expressed an interest in engagement, rather than trying to involve all GPs. Other DGP/Medicare Locals responded by focusing the area of work of IHPOs and OWs to specific geographic areas. In some cases, this meant that members of the ICDP workforce were further geographically dispersed from one another.

Where there was investment in time and processes to achieve a shared understanding between IHPOs from different DGPs about what they were aiming to do and how to achieve it (for example, through networking workshops facilitated by SBOs), this appeared to be an enabler to the IHPO role becoming established. In one site there had initially been animosity between IHPOs from different DGPs at these SBO workshops. When this was resolved, through an extended process of facilitation and in-depth discussion addressing some of the underlying issues and expectations, the outcome in this site appeared to be greater clarity of roles and ways of working.

Change agents - 'making Aboriginal and Torres Strait Islander health everybody's business'

In some, but not all sites, the IHPOs and OWs appeared to act as 'change agents'. This included working widely across the DGP/Medicare Local organisation to bring about positive change in attitudes and approaches to Aboriginal and Torres Strait Islander health, and working externally, acting as change agents for General Practices with whom they worked, including work with reception staff, GPs and other providers. There were several interconnected factors that were relevant to these internal and external change agent roles.

For IHPOs and OWs to act effectively as change agents they needed to be respected by the DGPs/Medicare Local staff. Where IHPOs and OWs were skilled and experienced workers, and were respected as such, they were more likely to be asked to work across the organisation, and with a range of stakeholders to ensure that Aboriginal and Torres Strait Islander health issues and ways of working were understood and embedded across the organisation. In the one site where this was described in some detail, the IHPO felt concerned that she may be being 'stretched too thin', but in general, realised that this broader role across the organisation was likely to have positive outcomes in terms of increased sustainability, or getting 'change to stick', in the longer term. In this site, this broader role across the organisation had in part been prompted by the DGP transitioning to a Medicare Local, and the broader range of stakeholders who became involved with the transition.

Credibility of IHPOs and OWs was also related to the process of recruitment that was used – with some DGPs stating that they had deliberately gone against the policy guidance of recruiting entry level people to the OW role, as they recognised the complexity of the role. Skilled and experienced workers were more likely to be able to be influential, or at least the organisation may have been more predisposed to accept their roles in relation to change.

It was also important that the IHPO and OWs were able to 'bridge both worlds' – in other words, to connect with community and with the organisations with which they worked (both DGP/Medicare Local, and General Practice). These IHPOs and OWs were able to 'bridge' the divide between community and DGP/GPs, and develop shared understanding about what was required to improve Aboriginal and Torres Strait Islander health, and what it might take for service providers to be motivated to change. This capacity for connection with both community and service provider organisations was evident in the context described previously in relation to embedding change across the organisation. It was also evident to some extent at the micro level. For example, some OWs reported that they helped develop greater cultural sensitivity amongst the specialists and GPs with whom they worked, and also explained to Aboriginal and Torres Strait Islander patients the way things

worked in different services, so they would not feel offended by standard processes in the waiting room, and not 'take it personally'. In contexts in which this occurred, change was seen as applicable to 'all', including the reception staff and the patient, and their interaction, not just the health professional delivering care, or just the patient, who 'did not turn up' for appointments.

A key aspect of the IHPO role in relation to being a 'change agent', as identified in some of the Sentinel Sites, was the ability of the IHPO to provide information to General Practice about the whole of the ICDP. This type of change agent role (described in the change agent literature as 'academic type detailing') was also played to some extent by the SSE team – indicating the gap in many sites for this type of role in relation to effective implementation of the ICDP.

In some contexts, IHPOs and OWs felt culturally unsafe and disempowered in their role. This appeared to constrain their ability to act as change agents in the organisation and was particularly evident in early evaluation cycles, with some workers feeling isolated as Aboriginal and Torres Strait Islander workers in a non-Aboriginal and Torres Strait Islander organisation. This relative disempowerment was countered in several DGPs/Medicare Locals by the development of Aboriginal and Torres Strait Islander health teams. The development of these teams was identified as an enabler for establishment of the IHPO and OW role, and was also an enabler for ability of these workers to act as change agents. These Aboriginal and Torres Strait Islander health teams were made up of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander staff. These teams functioned to improve morale and confidence, and empower IHPOs and OWs in their role. Empowered and effective IHPOs and OWs were able to adapt to different changes in various stages of implementation – for example, adjusting the focus of work from awareness raising to provision of greater support with the detail of ICDP implementation, trialling different approaches to engagement of practices, and abandoning strategies that did not work.

Complementary linkages with other ICDP funded activities, including collaborative relationships between sectors

Linkages with other ICDP funded activities were a core part of the role of the IHPOs and OWs in DGPs, and was one of the ways in which effective implementation was achieved at site level.

Complementary linkages with other ICDP funded activities are implicit in two of the main objectives of the program: '*Increasing the uptake of Indigenous specific Medical Benefits Schedule (MBS) items including Indigenous health checks and follow-up items*', and '*Increasing awareness and understanding of Closing the Gap measures relevant to mainstream primary care*'. Complementary linkages are also implicit in the objective '*Supporting mainstream primary care services to encourage Indigenous Australians to self-identify*', since implementation of a number of ICDP measures are dependent on Aboriginal and Torres Strait Islander identity being known by the service provider. The effectiveness of the IHPO and OW positions in meeting these objectives has been outlined in section 14.3.3 above. The main enabling and constraining factors emerging from the analyses presented in these sub-sections are synthesised below.

A key enabling factor for developing complementary linkages with other ICDP funded activities was that IHPO and OW roles were embedded in the work of local practice support teams and strong Aboriginal and Torres Strait Islander health teams. Relevant to the mechanism of complementary linkages between other ICDP funded activities, these teams were able to assist IHPOs and OWs in developing capacity in General Practice to use correct MBS items numbers for adult health assessments, and promote greater delivery of the relevant services. Aboriginal and Torres Strait Islander health teams were able to promote awareness in communities about the PBS Co-payment measure, and availability of adult health assessments.

A further enabler identified for developing complementary linkages between ICDP activities was a balance between work to improve ‘hard’ and ‘soft’ capacities – for example, holding a workshop to discuss specific clinical aspects of care for conditions that Aboriginal and Torres Strait Islander patients commonly present with, and best practice in management of these conditions. This followed ‘soft’ capacity development, which addressed more general awareness and knowledge of Aboriginal and Torres Strait Islander people. In this example, learnings were transferred from the AHS to General Practice sectors. However, a general lack of development of ‘hard’ capacities constrained implementation across the sites, as outlined below.

Constraining factors included a general lack of clear processes and capacity for adapting the clinical information systems used by General Practice to work optimally for Aboriginal and Torres Strait Islander patients. There was no clear evidence that IHPOs or OWs had the skills or influence to intervene in strengthening clinical information systems for this purpose. Although it appeared that IHPOs and OWs were able to positively influence Aboriginal and Torres Strait Islander identity being known by the practice, this is only an early step in the process for improving clinical care for Aboriginal and Torres Strait Islander people. The ability of these workers to influence processes relevant to subsequent steps in the process of improving care, such as the recording of Aboriginal and Torres Strait Islander status on clinical information systems and being able to retrieve the information at relevant points in the care process to positively influence care and aid in clinical decision making, was generally less apparent.

In some of the sites, there was clear evidence of a lack of collaborative working relationships between the AHS and DGP sectors, and this constrained the development of complementary linkages between the various ICDP measures. For example, where this constraint was predominant, there was a lack of service planning between the work of the OW in the AHS and the OW in the DGP, with concerns over some duplication of effort, and some suggestion of ‘turf’ infringements.

Related to this was the further constraint identified generally across the program, that program monitoring did not appear to be well oriented to learning, and this constrained complementarity through a lack of realistic and accurate data that were useful for service planning.

Enablers to complementarity between the measures included the networking opportunities provided by joint OW orientation, which were generally conducted for OWs from both sectors together, and a national OW workshop hosted by NACCHO, which was also for OWs from both sectors. Networks and linkages are likely to be important to development of stronger collaboration in day-to-day work, with potential benefits to quality of care provided by both sectors. There was some evidence from the sites of the operation of this enabler. For example, in one site an OW training to be an AHW was co-located at the AHS for a clinical placement. The opportunities for networking and relationship building that this co-location provided were appreciated and resulted in peer support for these workers.

14.4. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 14.5). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

14.4.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

Table 14.5: Summary of key findings in relation to the program logic - Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care measure

	Summary of key findings from SSE
Outputs for year 1 and beyond	
The measure is implemented according to work plan (eighty OWs and eighty IHPOs positions are recruited and retained).	Recruitment and retention of IHPOs and OWs was generally high in the Sentinel Sites. OWs recruited tended to be more experienced workers, than had been envisaged in the program design. Some of these were experienced Registered Nurses or AHWs, and their experience and knowledge of the service environment, together with credibility in the community, was considered a key success factor in several sites.
Expected early results for years 2 – 4	
Stronger links are forged between primary health care services to assist Aboriginal and Torres Strait Islander people.	There was some evidence of linkage between primary health care services, in respect of transfer of information and skills about Aboriginal and Torres Strait Islander health from AHS to DGP sector and information about the roles and interests of different PHC organisations. There was little evidence of strengthening of local level linkages, for example in joint planning and coordination of the work of OWs based in DGPs and AHSs, or of positive influence on other work between PHC service organisations.
General Practices have a greater understanding of the health needs of Aboriginal and Torres Strait Islander people and improved capacity to provide quality care.	Some of the activities reported by IHPOs were consistent with General Practice developing greater understanding of the health needs of Aboriginal and Torres Strait Islander people. General Practices differed in their level of interest in improving systems of care, in part dependent on the proportion of their patient list who were Aboriginal and Torres Strait Islander people. Work through the practice teams in promoting greater uptake of the Aboriginal and Torres Strait Islander specific MBS item numbers may have contributed to increased understanding of available resources. There was evidence of some improvement in identification of Aboriginal and Torres Strait Islander status in clinical information systems, but little evidence of improvements in design of service delivery systems to provide higher quality chronic illness care for Aboriginal and Torres Strait Islander people.

	Summary of key findings from SSE
Collaboration is improved between participating General Practice networks and Aboriginal Health Services to identify and address barriers to the provision of primary health care to Aboriginal and Torres Strait Islander people.	Collaboration between the DGP and AHS sector was variable, and generally reported to be not well developed, with few systematic and demonstrably effective efforts to increase collaboration.
Specific initiatives addressing the needs of local Aboriginal and Torres Strait Islander people are developed and implemented.	There were many examples of initiatives to address needs of Aboriginal and Torres Strait Islander people developed and implemented directly by the IHPO and OWs in the DGPs/Medicare Locals. Examples included provision of transport, and accompanying patients to specialists, and increasing understanding of ICDP measures. There was some evidence to suggest that some staff from General Practice who participated in cultural awareness training that had been conducted or arranged by IHPOs in the DGPs/Medicare Locals had changed practice substantially as a result of the training.
Aboriginal and Torres Strait Islander people in contact with participating primary health care providers value the enhanced services.	Community focus group members valued the role of OWs, particularly in relation to transport to services. It was difficult to attribute any other reports of enhanced services from community focus group participants directly to the work of the IHPO or the OW. This is likely to be to some extent due to the broad scope of work of the IHPOs, and the work being primarily with DGPs/Medicare Locals and General Practices. IHPOs have had limited direct engagement with community members, and there has been relatively limited impact at the community level of many aspects of the ICDP at this early stage of implementation.
Expected medium term results for years 4+	
Access to mainstream primary health care for Aboriginal and Torres Strait Islander people with or at risk of chronic disease is increased.	Provision or arrangement of transport, and cultural brokerage, were likely to have contributed to improving access to General Practice, and to care recommended by General Practice, such as specialist visits and following prescribed medications.
General practices deliver better quality primary health care to Aboriginal and Torres Strait Islander people.	There is some evidence to suggest that General Practices delivered greater numbers of adult health assessments owing to contact with the measure, particularly where the OW and IHPO worked in the context of a strong Aboriginal and Torres Strait Islander health team in the DGP and where roles were embedded into the work of DGP practice teams. There was little evidence of systems established through the measure's resources for systematic follow-up and recall. However, there was some evidence of increasing Tier 1 payments to General Practices over the evaluation period in some sites. This may be at least partly due to the work of the IHPO and the OW, and may reflect an increasing orientation in General Practices to multidisciplinary team-based approaches to care for Aboriginal and Torres Strait Islander people.

	Summary of key findings from SSE
OWs have established effective community links to increase access to mainstream primary health care by Aboriginal and Torres Strait Islander people.	There is good evidence to suggest that in most sites OWs were establishing effective links and working practices that would be likely to improve access to mainstream primary health care by Aboriginal and Torres Strait Islander people.

14.4.2. KEY FINDINGS

This section provides a summary of the key findings in relation to the Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care measure.

Recruitment, adaptations and impact of recruitment on other Aboriginal and Torres Strait Islander Health Workforce

DGPs were successful in recruiting and, to a large extent, retaining IPHO and OW workforce across urban, regional and remote sites. Recruitment differed from the program design, in that for the most part OWs, as well as IHPOs, were qualified and experienced professionals.

Funding was intended to be flexible, but in general the potential of this flexibility to suit local context was limited. With a few exceptions, implementation models were in similar across the sites. This may be related to the early phase of implementation, with limited time for adaptation, or to lack of service capability to conceptualise or undertake appropriate adaptation.

The work of some IHPOs and OWs in DGPs changed after transition to Medicare Locals. Changes included being expected to work across larger organisations, with concerns about being spread too thin, and re-deployment to different geographic areas on the basis of perceived need. The opportunity to increase focus on Aboriginal and Torres Strait Islander health, because of the role of Medicare Locals in population health, and the possibility of forming larger Aboriginal and Torres Strait Islander health teams, were welcomed.

Awareness of the workforce

High levels of awareness of the DGP-based IHPOs and OWs were evident amongst interviewees in the General Practice sector. There were lower levels of awareness, and less communication with, the IHPOs based in SBOs and NACCHO affiliates.

The urban sites are generally more complex service environments than regional sites due to the number of Health Services and stakeholders, and this may have been a factor in the relatively later increase in awareness in urban compared to regional sites. Lower awareness in remote sites appeared to be explained by different types of roles fulfilled by the workforce and limited deployment in these areas, and the vast geographical areas covered by the DGPs and Medicare Locals in remote areas.

Effectiveness of the IHPOs and OWs based in DGPs/Medicare Locals

Increased access to mainstream primary care services was addressed through OW roles in assisting patients to navigate the health system, arranging transport to attend health care appointments, and a

cultural brokerage role between community members and health professionals. In some sites, there were concerns that DGP-based OWs may have been less connected to communities, constraining the effectiveness of their roles in increasing access to services.

Effectiveness of the workforce in improving capacity of General Practice to deliver culturally sensitive primary care services was particularly apparent in respect of ‘soft capacities’ – including awareness of the needs of Aboriginal and Torres Strait Islander people and understanding barriers to greater use of Health Services. It was less apparent in respect of development of ‘hard capacities’, including systems, technical skills, and infrastructure. Working through existing practice support teams in DGPs/Medicare Locals appeared to be a promising approach to improving capacity of General Practice.

IHPOs and OWs developed workable models in some sites by ‘segmenting’ their audience according to how engaged they were in Aboriginal and Torres Strait Islander health issues, and tailoring messages and approaches to suit different segments. For example, working intensively only with those who were already engaged in providing care to substantial numbers of Aboriginal and Torres Strait Islander patients.

There was no direct evidence from the Sentinel Sites of effective strategies having been implemented that resulted in increased use of relevant MBS follow-up items. There was evidence of increasing Tier 1 payments to General Practices in some sites, but it is not clear to what extent this could be attributed to the work of the IHPO or the OWs.

Improving identification of Aboriginal and Torres Strait Islander patients included work with General Practices to make their services more welcoming of Aboriginal and Torres Strait Islander people, reminding them of importance of Aboriginal and Torres Strait Islander status and suggesting ways to achieve this, and through encouraging community members to self-identify at Health Services. Over the period of the evaluation, greater numbers of Health Services were able to retrieve information on Aboriginal and Torres Strait Islander status of their patients, and greater numbers of people were recorded on these systems as being identified as Aboriginal or Torres Strait Islander. While IHPOs and OWs may have contributed in some way to these developments, it is probable that the repeated requests by the SSE team for these data over successive cycles of the evaluation as well as other more general initiatives to improve reporting of key performance indicators for Aboriginal and Torres Strait Islander health also contributed to the ability of services to report such data.

Short-term and siloed program funding, and different approaches to primary health care work, presented challenges to fostering collaboration and support between the General Practice and the Aboriginal and Torres Strait Islander health sectors.

Management, support and supervision

Data obtained by the SSE through DoHA program reporting and associated monitoring appeared to be inconsistent with data obtained at local level in some cases, and generally seemed to lack emphasis on the learning function of program monitoring.

Strategic leadership to address issues of integration of the new workforce, and investment of time and resources to establish a shared understanding of roles was identified as a success factor in several sites. Development of culturally safe team-based approaches in some DGPs/Medicare Locals provided IHPOs and OWs with peer support, networking and collaboration opportunities that assisted them in being effective in their roles.

Resources for middle management, particularly to support Aboriginal and Torres Strait Islander health teams in DGPs/Medicare Locals, appeared to be unevenly distributed across DGPs/Medicare Locals, and depended on the organisation recognising this need, and investing time and effort to address it.

14.4.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings:

- a) Consider how OW and IHPO roles can be further clarified in a way that allows for flexibility/adaptability to meet priority needs at the local level and complements existing service delivery arrangements.
- b) Consider how policy can more effectively enhance development of Aboriginal and Torres Strait Islander health teams that are embedded in the work of Medicare Locals and General Practices across the range of settings in which these teams need to work if they are to have an impact on improving Aboriginal and Torres Strait Islander health at a population level. Consider how policy in this area can directly address known barriers to development and effective operation of such teams across a variety of settings, specifically including support for effective operation of teams in remote settings.
- c) Consider focusing efforts and resources on General Practices that can demonstrate that they are providing care to significant numbers of Aboriginal and Torres Strait Islander people and that they have a commitment to developing systems to provide high quality chronic illness care for Aboriginal and Torres Strait Islander people, including through enhanced delivery system design and clinical information systems. Then ensure that resources are adequate to provide effective support to these General Practices, and that they are adequately rewarded for their efforts.
- d) Strengthen the quality improvement and health promotion aspects of the work of IHPOs and OWs. These are areas of work that are included in the description of the roles of these positions, but for which there is little evidence of activity on the ground.
- e) Consider how policy can enable development of collaboration between the General Practice and Aboriginal and Torres Strait Islander health sectors through the operation of these teams and with the range of other ICDP funded positions as well as existing and other new workers in complementary roles.
- f) Consider how structures and processes within DoHA might be used to facilitate greater complementarity between this measure and other related measures.
- g) Consider how supervisory and management positions, as well as IHPO and OW positions can be specified in a way that strengthens core workforce competencies for chronic illness care^{171,172} and strengthens models and systems to support high quality chronic illness care, while enabling flexibility/adaptability in system development in a way that addresses local needs and adds value to local service delivery arrangements.

¹⁷¹ WHO, 2005 'Preparing a health care workforce for the 21st century: the challenge of chronic conditions.'

¹⁷² Pruitt, S, Epping-Jordan JE. Preparing the 21st century global healthcare workforce. BMJ (2005); 330:63.

- h) Consider how evidence-informed and internationally accepted models of chronic illness care (such as the Chronic Care Model^{173,174} and the Innovative Care for Chronic Conditions framework¹⁷⁵) might be used to guide development of high quality systems at the local level, designed to fit with local needs and circumstances.

¹⁷³ Katie Coleman, Brian T. Austin, Cindy Brach and Edward H. 'Wagner Evidence On The Chronic Care Model In The New Millennium' *Health Affairs*, 28, no.1 (2009): 75-85.

¹⁷⁴ E.H. Wagner, B.T. Austin, and M. Von Korff, 'Organising Care for Patients with Chronic Illness,' *Milbank Quarterly* 74, no. 4 (1996): 511–544.

¹⁷⁵ World Health Organisation, *Innovative Care for Chronic Conditions: Building Blocks* [website] <<http://www.who.int/chp/knowledge/publications/iccreport/en/>> (accessed 13 January 2013).

15. ATTRACTING MORE PEOPLE TO WORK IN INDIGENOUS HEALTH (MEASURE C4)

This measure has not been included in the scope of the SSE. The information is included below to describe the role of this measure within the broader ICDP and the reported state of implementation at a national level.

15.1. Description of measure

The primary focus of the **Attracting More People to Work in Indigenous Health** campaign is to encourage Aboriginal and Torres Strait Islander secondary students to consider careers in health. This approach is based on evidence that Aboriginal and Torres Strait Islander people are more likely to seek out primary health care when their health care is provided by a person of Aboriginal and/or Torres Strait Islander descent. Currently, the Aboriginal and Torres Strait Islander population is significantly under-represented in the health sector.

This long-term approach has a complementary strategy to encourage existing health professionals, and final year students training to be health professionals (primarily non-Indigenous people), to take-up roles in Aboriginal and Torres Strait Islander health. The strategy aims to bolster Health Services in the more immediate term. Market research will form the basis of a national marketing and communication program.¹⁷⁶

15.2. State of Implementation – national context

At the time of the final evaluation cycle, information provided by DoHA indicated that the formative research to inform the communication campaign to encourage Aboriginal and Torres Strait Islander secondary school students to take up careers in health was completed by November 2010. The development of advertising materials, resources and website were delayed until 2011 due to the need for additional work and to develop the marketing strategy¹⁷⁷

- In March 2011 Boxing Clever Pty Ltd was appointed and developed two strategies; a public relations strategy to support the advertising campaign targeting secondary school students; a strategy to encourage existing health professionals and students to consider working in Aboriginal and Torres Strait Islander health. Both of these were planned to be implemented in 2011-2012.
- The 'Health Heroes' advertising campaign, which prompts Aboriginal and Torres Strait Islander secondary students to visit the 'Health Heroes' campaign website¹⁷⁸, was launched on 24 July

¹⁷⁶ DoHA, Attracting more people to work in Indigenous Health – Factsheet
<[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/attracting-indigenous-health/\\$file/Copy%20of%20DHA6136%20C4%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/attracting-indigenous-health/$file/Copy%20of%20DHA6136%20C4%20Factsheet.pdf)> (accessed 4 December 2012).

¹⁷⁷ Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report on the Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes - November 2010 <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-gp-kit-annual-progress-report-toc~ctg-gp-kit-annual-progress-report-Implementation-Progress>> (accessed 4 December 2012).

¹⁷⁸ Health Heroes [website] <<http://healthheroes.health.gov.au/campaign-material>> (accessed 4 December 2012).

2011. The campaign focused on real people in a diverse range of careers in the health sector. It was intended to be broadcast via a mix of Aboriginal and Torres Strait Islander media channels (television, radio and print) in conjunction with mainstream channels (online and regional radio), online (Facebook and YouTube) and print (targeting parents/guardians).

- A resource kit for school career advisors was being development (poster, brochures and DVD) and scheduled for delivery to approximately 1300 schools in August 2011.
- A national program of community engagement sessions and school workshops, which were to be attended by health professionals and with the aim of encouraging students to take up careers in health commenced in late 2011. In August - November 2011 there were 20 sessions planned in NSW, Qld, Vic and SA, with further sessions planned for 2012 and 2013.
- Funding was increased to allow for a second phase of community engagement sessions to be held in secondary schools with a high proportion of Aboriginal and Torres Strait Islander students in 2011-2012. Sessions were expected to continue in the 2012-2012 year.
- The 'Do Something Real' website¹⁷⁹, which targeted existing health professionals and health students, was launched by Minister Snowdon on 9 August 2011.

¹⁷⁹ Do Something Real [website] < <http://dosomethingreal.govspace.gov.au/> > (accessed 4 December 2012).

16. CLINICAL PRACTICE AND DECISION SUPPORT GUIDELINES (MEASURE C5)

This measure has not been included in the scope of the SSE. The information is included below to describe the role of this measure within the broader ICDP.

16.1. Description of measure

This measure was to support the development of a web based primary health care resource for use by health care professionals in the prevention and primary care management of chronic diseases for Aboriginal and Torres Strait Islander people. The resource is intended to bring together, in a single resource, existing tools, guides and other information that promoted best practice in the prevention, identification and primary care management of chronic disease for Aboriginal and Torres Strait Islander people. In addition, mainstream chronic disease guidelines are expected to be amended to include information specific to Aboriginal and Torres Strait Islander people.¹⁸⁰

16.2. State of Implementation – national context

At the time of the final evaluation cycle, information provided by DoHA indicated that at a national level:

The Primary Health Care Resource Technical Reference Group was established by November 2010 and commenced advising the DoHA on the development of the primary health care resource. Work had already commenced on the development of the primary health care resource.¹⁸¹

DoHA reported that the development of the resource involved two rounds of pilot testing. Twenty-eight users across six AHSs and General Practices had the opportunity to participate in the second pilot, held in late 2011.

The production phase was due to start in late 2011 with the final resource planned to be available in 2011-2012.¹⁸²

By September 2012 the DoHA report that a web based primary health care resource had been developed. The resource was developed by Hewlett-Packard at a cost of \$1.9m. Once fully operational, the resource aims to provide quality online information to support chronic disease management of Indigenous Australians.

¹⁸⁰ DoHA, Clinical Practice and Decision Support Guidelines – Fact Sheet

<[http://www.health.gov.au/internet/ctg/publishing.nsf/Content/clinical-practice/\\$file/DHA6136%20C5%20Factsheet.pdf](http://www.health.gov.au/internet/ctg/publishing.nsf/Content/clinical-practice/$file/DHA6136%20C5%20Factsheet.pdf)> (accessed 4 December 2012).

¹⁸¹ Closing the Gap - The Indigenous Chronic Disease Package in 2009-10 - Annual Progress Report on the Australian Government's contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes - November 2010 <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-gp-kit-annual-progress-report-toc~ctg-gp-kit-annual-progress-report-implementation-progress>> (accessed 4 December 2012).

¹⁸² Indigenous Chronic Disease Package in 2010-11 - Annual Progress Report <<http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ctg-2010-11-annual-progress-report~implementation-progress~progress-against-benchmarks-and-deliverables>> (accessed 4 December 2012).

A competitive tender process for the public version of the web based resource closed on 16 December 2011 and was finalised in June 2012. Edith Cowan University had been contracted to provide the Indigenous Web based Primary Health Care Resource to the public and health professionals. The site was expected to go live in November 2012.

In addition, the “National Guide To A Preventive Health Assessment for Aboriginal and Torres Strait Islander People” Second Edition was completed as planned and promoted by press release and a national ministerial launch in May 2010 and was mailed to all General Practices and AHSs in June 2012.

17. OVERALL ICDP

17.1. Introduction

17.1.1. THE ICDP AS A SYSTEM-LEVEL INTERVENTION

The overall aim of the ICDP is to contribute to closing the gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people within a generation.¹⁸³ The design of the ICDP specifies three priority areas - 1) reducing the risk of chronic disease; 2) improving chronic disease management and follow-up; and 3) workforce expansion and support – each of which includes multiple activities and funding streams. The priority areas, and the measures within these priority areas, mean the ICDP acts across multiple parts of the health system. The ICDP as a whole is clearly a system-level intervention.

The 2009 WHO report on ‘Systems Thinking for Health Systems Strengthening’¹⁸⁴ describes the health system as comprising six main building blocks - service delivery, health workforce, health information, medical technologies, health financing, and leadership and governance. The report defines ‘system-level interventions’ as targeting one or multiple system building blocks (as opposed to more narrow interventions that target a specific health problem). However, the WHO report makes it clear that ‘the building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that convert these blocks into a system. As such, a health system may be understood through the arrangement and interaction of its parts, and how they enable the system to achieve the purpose for which it was designed.’¹⁸⁵

The WHO conceptualisation of health systems, specifically the importance of interactions between components of the health system, can be usefully applied to the analysis of the ICDP as a whole.

17.1.2. APPLICATION OF SYSTEMS THINKING AND REALIST EVALUATION TO THE WHOLE OF THE ICDP

‘Systems thinking’ is defined as ‘an approach to problem solving that views ‘problems’ as part of a wider dynamic system ... involves much more than a reaction to present outcomes or events ... demands a deeper understanding of the linkages, relationships, interactions and behaviours among the elements that characterise the entire system.’

¹⁸³ Urbis, ICDP Monitoring and Evaluation Framework, September 2010, op cit.

¹⁸⁴ De Savigny and Adam 2009, Systems thinking for Health Systems strengthening. Alliance for Health Policy and Systems Research, WHO.

¹⁸⁵ Ibid.

‘Application of systems thinking to the health sector ‘shifts the focus to:

- the nature of the relationships among the building blocks
- the spaces between the blocks (and understanding what happens there)
- the synergies emerging from interactions among the blocks.’

Application of systems thinking in the health sector is seen to be ‘accelerating a more realistic understanding of what works, for whom, and under what circumstances.’¹⁸⁶

The emphasis of systems thinking on understanding linkages, relationships, interactions and behaviours, and on context means systems thinking is consistent with, and complementary to, the realist evaluation¹⁸⁷ approach we have applied in the above chapters on specific ICDP measures. Systems thinking is particularly relevant to the SSE in the potential for early identification of unintended consequences of activities or programs, both positive and negative, and for encouraging adaptation of activities or programs to maximise emerging benefits and minimise emerging harms. From an evaluation perspective, attributing any observed change to specific interventions or influences within a complex intervention and in the context of a complex system is difficult, with inherent and unavoidable uncertainties. In this chapter we have applied realist evaluation methods to gain insight into how the different ICDP measures can influence, and be influenced by, various aspects of the complex health system, the interactions between the measures within the system, the contexts in which these measures are being implemented (including other health programs operating in the local area), and how these factors and interactions were contributing to the intended outcomes of the ICDP.

This chapter has two main sections:

Realist analysis of mechanisms, enablers and constraints for implementation of the overall ICDP at a site level. The realist evaluation¹⁸⁸ approach used in the SSE aims to provide more in-depth understanding of the interaction between contextual influences and mechanisms by which the ICDP measures were generating various outcomes across the diverse range of locations in which the ICDP was being implemented. The realist evaluation has built on the program logics that were presented in the ICDP evaluation framework to develop a refined program theory of ‘what works for whom under what conditions’ for the whole of the ICDP overall. In this chapter we describe the higher-level context-mechanism-outcome configurations that appear to be most relevant to achievement of the general aims of the ICDP.

Summary and conclusions. Consistent with the above chapters on specific ICDP measures, we present an analysis of progress with implementation of the overall ICDP against the outputs and results specified in the National Framework as relevant to the SSE. Also consistent with the above chapters on specific ICDP measures, we present a synthesis of the key findings of the SSE in relation to the whole of the ICDP, and set out our main recommendations in relation to these findings, in the form of policy considerations.

As is to be expected for a complex intervention such as the ICDP, implemented in a complex service environment, the ICDP activities, method of implementation, and areas of focus, were not static or wholly predetermined, but evolved over the course of the evaluation.

¹⁸⁶ De Savigny and Adam 2009, op cit.

¹⁸⁷ Pawson, R and Tilley, N 1997, Realistic evaluation. SAGE publishing.

¹⁸⁸ Ibid.

17.2. Enablers and constraints to effective implementation of the overall Indigenous Chronic Disease Package

This section reports on findings from the application of realist evaluation methods (as described in the Introduction and methods section, in Appendix C - Evaluation process and methods, and in the introduction to this chapter) to describe the high-level context-mechanism-outcome configurations that appear to be most relevant to achieving the general aims of the ICDP in the Sentinel Sites.

A range of factors influenced the mechanisms, and how they operated as enablers and constraints, reflecting ‘what works for whom under what conditions’. These enablers and constraints (or ‘contexts’) describe features such as organisational or broader system context, program stakeholders and their actions, staffing, geographical and historical context and so on (as shown in the context-mechanism-outcome diagram, Figure 17.1). Higher-level analysis and discussion is provided for the purpose of informing the overall evaluation and identifying potential areas or options for program strengthening to enhance effectiveness at local level.

Consistent with previous chapters, we have focused the discussion below on those enablers and constraints that: (1) are amenable to change – for example, where action is needed to make contexts more favourable and supportive of implementation of the ICDP, or (2) suggest areas where elements of the program design may need to be refined to make it more effective in different contexts.

The SSE identified seven main ‘mechanisms’ which appear to drive change in sites and support the ICDP to achieve intended outcomes including a health workforce with skills and capacity, and Health Services with capacity to improve access to, and deliver, culturally appropriate, affordable high quality services and programs for prevention and management of chronic disease in Aboriginal and Torres Strait Islander populations. The seven mechanisms operated in an interdependent and interacting manner, and are not presented as a continuum or hierarchy:

- a systems approach to developing and engaging the workforce
- a systems approach to developing and optimising chronic disease service delivery systems
- primary health care organisations oriented to Aboriginal and Torres Strait Islander community needs and values, open to re-orienting service delivery approaches, creating increased demand for services
- primary health care organisations engage with ICDP measures and utilise them within existing systems
- partnering and mobilisation within and across organisations to achieve common ICDP goals
- core values align with best practice in Aboriginal and Torres Strait Islander primary health care
- complementary linkages between programs, activities, services.

Our discussion of the enablers and constraints to activating the mechanisms reflects several general findings:

- Local context greatly affected implementation of the ICDP as a whole.
- Contexts were extremely varied across sites and services.
- Specific local contexts were more significant influences on ICDP implementation than geographic location (urban, regional or remote), although geographic location was associated with some

particular contexts (for example poor infrastructure, vast distances, relatively few service providers and populations made up predominantly of Aboriginal people were common features of remote sites; and multiple service providers, relatively complex service environments, and Aboriginal and Torres Strait Islander people making up a relatively small proportion of the population and being relatively dispersed among the general population were common features of urban sites).

- The nature of the constraints and enablers to the effective operation of the mechanisms was diverse, and included structural/systemic, administrative, relational, physical, individual/behavioural, socio-cultural and economic, with particular dimensions present in individual sites and circumstances.

The main mechanisms through which the ICDP appeared to achieve change identified through our analysis are outlined below, and shown in the central boxes in Figure 17.1. Enablers and constraints related to each of the main mechanisms are also shown in the figure.

Constraints		Mechanisms		Enablers
• Limited available pool of skilled workers in sites • Diversity of workforce capacity and context, plus administrative burden detracts from focus on ICDP goals • Operational systems not well integrated • Limited service capacity for mentoring, supervising, on-the-job training and development • High need for acute care and skills • Lack of alignment of orientation and training with core competencies for chronic illness care	→	Systems approach to developing and engaging the workforce	←	• Clear articulation and communication of ICDP vision and workforce requirements for achieving the vision • Leadership commitment to appropriate workforce development • Management structured and informed to support achievement of ICDP vision • Tiered approach to dissemination of program information and practical support • Clear guidelines to managers and staff in all sectors with resources, structures, plans and processes in place, balanced with flexibility for local adaptation
• Lack of workforce recognition of, and commitment to, the use of data for systems improvement and population health coverage • Limited capacity or utilisation of information systems to coordinate patient s services and share information across sectors • Diversity of systems capability • Diversity and complexity of delivery context • Limited capacity for systems approaches due to administrative burden	→	Systems approach to developing and optimising chronic disease service delivery systems.	←	• Leadership commitment to promoting a systems perspective to delivery system design for high quality chronic illness care • Clinical information systems function to support quality chronic illness care, staff skilled to use them effectively • Information systems support population health monitoring and evaluation • Services and sectors have a systematic approach to service delivery, referrals, information sharing and system coordination • Management educated and organisations structured to support achievement of ICDP vision
• Key workers without necessary competency to fulfil ICDP role and program aims • Limited reach into target populations due to complex environments • Providers don't understand or accept clinical relevance of Aboriginal and Torres Strait Islander history and identity • Lack of robust links with community	→	PHC organisations oriented to Aboriginal and Torres Strait Islander community needs and values, open to re-orienting service delivery approaches to chronic disease prevention and care, creating increased demand for services	←	• Good knowledge of services and local operating environment • Pre-existing partnerships, programs • History of constructive engagement in Aboriginal and Torres Strait Islander health • Effective structures for community participation • Interactive cultural awareness training, linked to clinical relevance • Integrated and culturally safe work environment for Aboriginal and Torres Strait islander workers (General Practice sector)



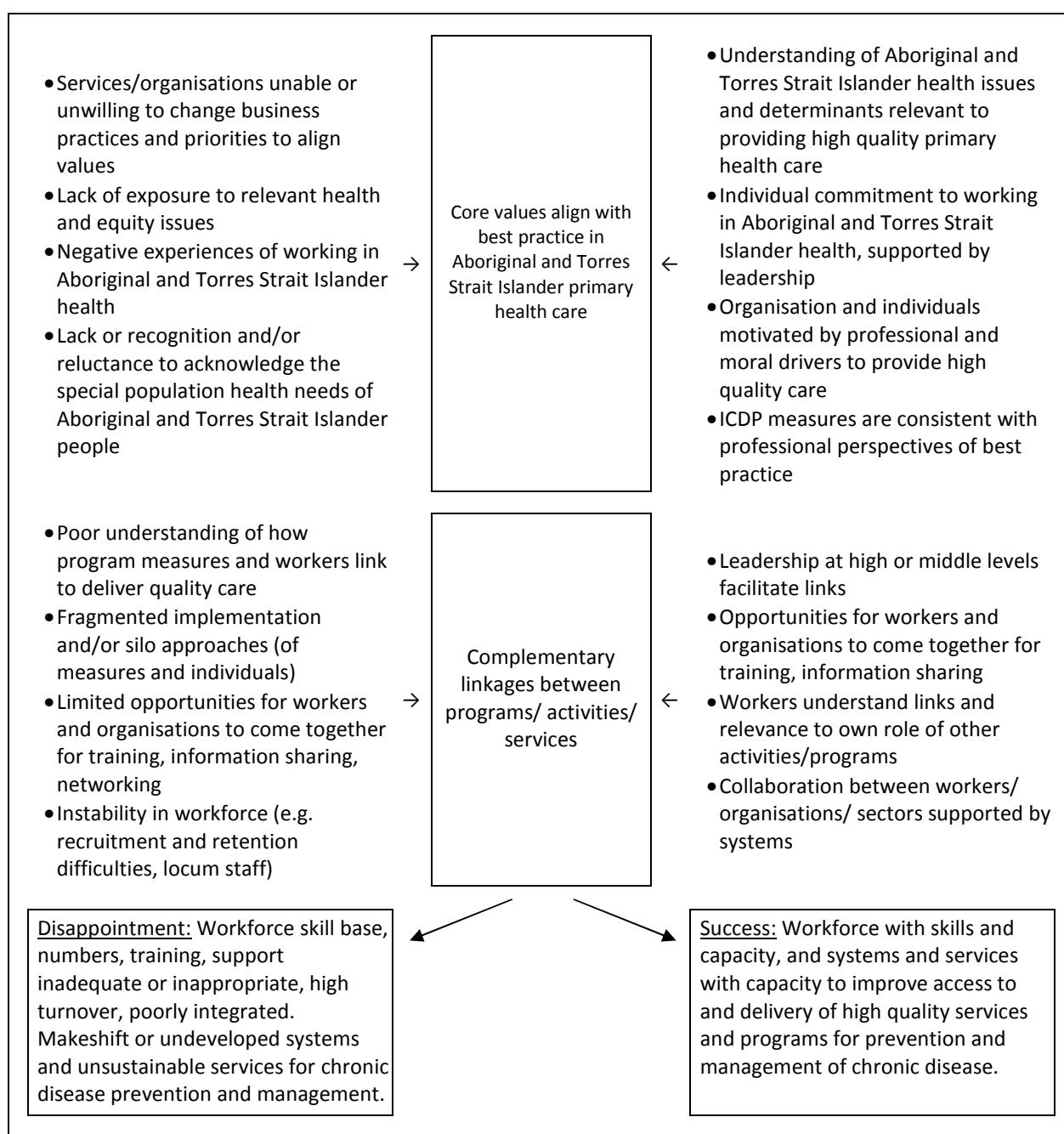


Figure 17.1: Enablers and constraints to achieving effective implementation of the Indigenous Chronic Disease Package

17.2.1. A SYSTEMS APPROACH TO DEVELOPING AND ENGAGING THE WORKFORCE

The mechanism

The SSE found that a systems approach to developing and engaging the health workforce needed to be operating for the ICDP to work effectively in sites. A systems approach considered workforce development and engagement to be part of a whole-of-service system response to providing improved chronic disease services to Aboriginal and Torres Strait Islander people. At the site level, use of a systems approach involved: planning and integrating the varied roles and role functions; ICDP guidelines and resources; ICDP orientation and training of new workers and training and professional development of existing workers with other relevant chronic disease and training and professional development activities, and within broader primary health care systems. A systems approach took into account and planned responses to the interactions and synergies between systems components, as reflected by the WHO 'Framework for Action' on health systems strengthening, while being responsive to site population and organisation characteristics, approaches, responses and intended directions. The WHO 'Framework for Action' on health systems strengthening components are health workforce, service delivery, health information and health financing, medical technologies, leadership and governance.

Systems thinking was particularly important for integrating new workers, especially in the context of the ICDP where host organisations had the added dimension of integrating non-clinical Regional Tackling Smoking and Healthy Lifestyle workers into predominantly clinical environments. It was important for developing professional development opportunities for new and existing workers, and for recognising the benefits of, and supporting, linkages between workers as program implementation progressed. It was also relevant to mapping how ICDP funded measures related to and augmented existing chronic disease services, or fixed gaps in service delivery at site level, in order to engage the wider workforce in the ICDP.

In general, a systems approach to developing and engaging the workforce operated well in contexts where host services were stable and functioning well. Important contextual factors were pre-existing capability and leadership for systems thinking, and resources to support new and existing staff to develop new knowledge and competencies to engage with ICDP measures. These factors were more likely to be present in urban sites. Across sites overall, we found that a systems approach was not being optimised across a majority of Sentinel Sites to develop the primary health care workforce to deliver improved chronic disease prevention, management and care services- constraints appeared to predominate over enabling contexts.

Enablers and constraints to activating the mechanism

Clear articulation and communication of ICDP vision and workforce requirements for achieving the vision

Clear articulation and communication of the ICDP vision and workforce requirements for achieving the vision was a powerful enabler at site level. Interviewees were often able to identify with 'closing the gap', but the articulation of how this was to be achieved was generally not well developed. It was challenging to achieve within Health Services and organisations for a variety of reasons (staff and management turnover, access to information, level of understanding required by leaders in order to explain the ICDP vision and package to workers, understanding of chronic illness care). However, where it occurred, a systems approach was more likely to be activated. For example, in a regional organisation in which the ICDP vision was embraced by leadership and was articulated and communicated clearly,

Regional Tackling Smoking and Healthy Lifestyle workers were appointed early in program implementation, had appropriate mentoring and professional development plans in place, appeared confident to plan and perform their work and were able to explain plans for team development and program expansion to the SSE team.

Leadership commitment to appropriate workforce development

Organisations with strong leadership commitment to workforce development were more likely to engage systems thinking approaches to develop and engage the workforce in ICDP measures. Leadership commitment often meant there was a pre-established culture of support for learning and existing systems to facilitate staff access to training and development. These organisations appeared to have greater capacity to structure practical support for new staff through planned supervision and whole of organisation learning. In mainstream organisations, commitment at management levels to Aboriginal and Torres Strait Islander health, as well as to workforce development, appeared to enable a systematic investment in team-building and learning that supported and integrated new roles. This was highlighted in a number of DGPs that were integrating an Aboriginal and Torres Strait Islander workforce into a generally non-Aboriginal and Torres Strait Islander working environment. Leadership in workforce learning at middle levels within organisations was able to activate systems approaches to professional development, as observed in those sites where IHPOs took leadership in developing and delivering cultural awareness training for groups comprising staff from various services and Health Services, and established systems for DGP-based Aboriginal and Torres Strait Islander workers to provide follow on cultural brokering and advice. IHPOs who were able to advocate 'up' and 'down' to influence senior management (and in some cases boards of directors) in relation to prioritising Aboriginal and Torres Strait Islander health and also motivating teams within the organisation had positive influence on integrating ICDP related workforce development.

Pre-existing staff competency was a significant factor that enabled the mechanism - this was most evident when professionally experienced workers came into ICDP funded positions. A number of those workers were able to take leadership and initiative to develop systems for community and health service provider engagement, highlighting the value of appointing experienced and well-connected workers into these roles.

Responsive program leadership at high level was also an enabler to the activation of systems approaches to developing and engaging the local workforce, as was evident in relation to the A measures workforce – a policy change at national level enabled workers in related health promotion roles to form teams, which strengthened systems for local workforce engagement and mobilisation.

Data showed that leadership vision and commitment to the professional and career development of Aboriginal and Torres Strait Islander staff underpinned the integration of mentoring and individualised training of ICDP funded staff into team structures and program planning, as part of a wider, systematic approach in well functioning services.

Dissemination of program information and practical support across multiple levels of the system and organisations - Management support for achievement of ICDP vision

A great deal of information about the ICDP was widely available to services. Systems thinking was more likely to be activated when a tiered approach to information dissemination was put into place, so that individual workers/providers had information adequate and appropriate to performing their ICDP related work and to understanding how the work and activities fitted into the wider program of measures. In sites, this involved managers and practice support organisations tailoring information and support for professional groups so that it had direct relevance and was timely. The ability to reinforce to staff (and at a higher level, to services and practices) the potential benefits of the program to

populations and patients, to make it relatively easy to engage with ICDP measures and to integrate them within operational systems required a reasonably level of understanding and skill on the part of managers and leaders. Where it occurred, it seemed to reflect their considerable time in management roles and within organisations, in addition to more general service engagement in the ICDP.

Dissemination of accurate, relevant information and development of staff competencies in accessing ICDP benefits for patients and providers needed to be systematic. This was especially important where there was reliance on locum staff, and for visiting clinicians and specialist service providers.

Information dissemination and practical support was often challenging to achieve across levels of the health systems and across multiple levels of organisations. There were multiple influences on dissemination of program information and workforce support in sites – including timing of the release of program resources by DoHA, information structures and administrative processes within services (information systems, training policies, organisational commitment to the ICDP, governance stability) and individual knowledge/skills, understanding of the ICDP and motivation. Activating systems thinking seemed to require these influences to come together and work in a positive way.

Contexts that constrained a systems approach were often, (but not always), the converse of enabling factors. For example, where operational systems and new staff were not well integrated and there was limited capacity for supervision, mentoring and team-building of Aboriginal and Torres Strait Islander staff, it was challenging for Aboriginal and Torres Strait Islander workers to establish roles effectively within broader service delivery systems. In many sites, there were inadequate or inappropriate structures and processes for supporting ICDP staff, particularly Aboriginal and Torres Strait Islander staff in positions defined as entry level (such as OWs). In the final evaluation cycle, ICDP funded staff in a small number of DGPs were concerned that no plans or provisions had been made for their supervision and support following the transition to Medicare Locals – they noted potential for breakdown in team integration and the operational systems that had been established.

Limited available pool of skilled workers and high need for acute care

Across ICDP measures, organisations with a limited available pool of workers skilled in chronic disease care were constrained in engaging with a systems approach to workforce development, regardless of organisation and leadership commitment. Recruitment and retention challenges related to various factors, especially the physical environment (isolation and lack of infrastructure including accommodation in remote sites) but also the nature of the work. High local population need for acute care services and related clinical skills limited the capacity of services to develop systems to build staff competencies in chronic disease service delivery.

Lack of alignment with core competencies for chronic illness care, coupled with limited capacity for mentoring, supervision, on-the-job training and development

Over the duration of the SSE there was little or no evidence to indicate that organisations within and across sites were being guided by overarching training program guidelines that might help services align ICDP workforce development with internationally endorsed healthcare workforce core competencies for chronic disease management (patient centred care, partnering, quality improvement, information and communication technology, public health perspective.)¹⁸⁹ Host organisations did not appear to be guided by specified units of competency relevant to skill/knowledge levels required to fulfil job functions when facilitating individualised training plans for Aboriginal and Torres Strait Islander workers; there was some evidence from interviewees that reliance on workplace performance appraisal processes focused on employment and career opportunities within the host service following

¹⁸⁹ WHO 2005, Preparing a health care workforce for the 21st century: the challenge of chronic conditions.

completion of the ICDP contract (possibly contributing to the uptake across sites of AHW training courses by entry level Aboriginal and Torres Strait Islander staff).

Limited or no access to relevant training in some locations and/or organisations constrained a systematic approach to training and role development. In a number of sites, host organisations had limited capacity for mentoring, arranging training access and delivering on-the-job training for entry-level staff. Factors influencing this capacity included the size of the organisation and number of staff, the core business of the organisation (e.g. clinical service delivery or practice/service support), prior involvement in on-the-job training programs, the physical location and skill-sets of supervisors, workloads, staff shortages and use of locum staff. These varied contexts created disparities between sites and organisations in relation to training and professional development opportunities for ICDP workers - a systems approach to workforce development was less evident in those organisations with less capacity to fulfil these activities.

Diversity of workforce capacity and context, plus administrative burden, detracts from focus on ICDP goals

Successful role performance in new positions often reflected individual incumbents' professional and Aboriginal and Torres Strait Islander community experience prior to taking up an ICDP role rather than more systematic development and support processes to achieve ICDP goals.

Dependence on primary health care services' internal capacities to mentor, negotiate and provide training appeared to result in inequitable access to development opportunities for staff (e.g. comparing the capacity of a regional urban support organisation strategically positioned to develop ICDP funded teams with that of smaller AHSs, especially those in regional and remote sites). We observed similar issues in regard to organisations' relative capacity to prepare submissions and apply for ICDP grant funding while meeting day-to-day administration and service delivery demands. A systems approach, when applied at a higher level, has potential to anticipate and resolve these types of issues as part of a 'big picture' because it assesses relative capacity and need across sectors and locations, and looks at ways to provide those with less capacity with additional support and resources to achieve some equity in workforce development.

SSE data demonstrated that information management and technology system constraints have impacted on workforce engagement in ICDP and other chronic disease service activities in a number of sites, particularly those in which operationally, these systems are not well integrated. However, our analysis also indicated that providing scope for evolution of ICDP funded roles in ways not anticipated in the program design assisted staff to address such constraints and establish local systems (e.g. working partnerships) to enhance engagement with the initiative, including coordination and continuity of care for patients with complex chronic conditions. This was evident in working partnerships established between, for example, Care Coordinators and OWs in some sites, and between clinical and Regional Tackling Smoking and Healthy Lifestyle teams supporting patient self-management.

In summary, our analysis indicated that constraints to a systems approach to developing and engaging the workforce in the ICDP were largely influenced by structural and/or systemic factors in sites, which included limitations in policies and procedures, limited capacity for systems thinking, and prioritisation of acute care services over chronic illness care. Limited available staff, and limited orientation and training resources in some sites were also constraints, especially in remote and regional sites.

Contexts that activated a systems approach in relation to ICDP workforce development and engagement combined supportive policies and clear procedures, systems thinking and effective, tiered information dissemination and organisational orientation to PHC with socio-cultural and behavioural

influences. Positive professional values and attitudes towards chronic illness care, cultural competency and cultural values, motivation, education and training underpinned the enablers, in which leadership and management were important aspects. Flexibility in the program and measure guidelines for local adaptation was a crucial enabler to activating systems approaches within services and practices and across site types; it was necessary to activate systems thinking to meet workforce development needs and to integrate ICDP funded positions into existing staff /organisational structures and work planning (in some cases through modification of position descriptions and configurations to optimise service delivery).

17.2.2. A SYSTEMS APPROACH TO DEVELOPING AND OPTIMISING CHRONIC DISEASE SERVICE DELIVERY SYSTEMS

The mechanism

A systems approach to developing and optimising chronic disease service delivery systems was necessary for the ICDP to operate effectively, achieve coordination and create synergies between measures at the site level. While a systems approach was implicit in the design of this complex program, it relied on this being activated at organisation and site levels to support services/staff to make the system improvements necessary to integrate services and improve community and patient access and experiences in order to improve clinical care and, consequently, health outcomes.

Systems thinking in the implementation of the ICDP within broader chronic disease service delivery systems revealed the underlying characteristics of and relationships between the various ICDP measures, pre-existing chronic disease-related services, service delivery patterns and target populations, policy guidelines and protocols for coordinating interventions, referrals, follow-up, and ongoing management. It could help anticipate how measures might flow through, connect, react with, impinge upon and change 'business as usual' within a site, in and between Health Services. A systems approach provided opportunities to adapt or redesign some activities to work effectively in local contexts.

In general, a systems approach to developing and optimising chronic disease service delivery systems operated in contexts where services were functioning well, particularly where operational systems were well developed and programs and/or organisations had pre-existing partnerships with other providers and established referral pathways. Systems thinking for ICDP implementation was more likely to be evident, for example, in well established stable Health Services that specifically targeted Aboriginal and Torres Strait Islander patients and had pre-existing resources and arrangements for integrated chronic disease care.

Systems approaches were less likely to be activated in sites where Health Services were challenged to deliver primary health care services due to contextual factors such as management instability, staff shortages, and underdeveloped information and administration systems. Systems for chronic disease care and service planning were generally not well developed. Constraining contexts appeared to predominate over enabling contexts.

Enablers and constraints to activating the mechanism

Our analysis found that a number of contexts needed to be present to activate a systems approach to developing and optimising chronic disease service delivery systems.

Leadership commitment to promoting a systems perspective, management educated and organisations structured to support achievement of ICDP vision

Two of the most powerful enablers appeared to be managers informed and organisations structured to support achievement of the ICDP vision. Through informed managers with sound knowledge and understanding of the ICDP, administrative and service delivery teams were more likely to be well informed and supported to use chronic disease service delivery systems effectively (as highlighted for the previous mechanism). This enabler was apparent in Health Services in which management/governance arrangements were stable and there was leadership experience and commitment to systems development for service improvement. In these contexts, strategic approaches to resourcing, planning and delivering services were more likely. For example, a regional support organisation responsible for implementing the A measures across a large densely populated urban region did not have staff resources to work with individual services at a grass-roots level, investing instead in a schools based health promotion program targeting Aboriginal and Torres Strait Islander youth. Once the program was successfully established, further ICDP resources were acquired and were harnessed to develop smoking cessation intervention training for AHS staff across the region.

In the General Practice sector, DGP managers and management structures that accorded priority to Aboriginal and Torres Strait Islander health issues and actively supported the work of ICDP funded positions supported establishment of effective systems to communicate information about ICDP measures and support development of cultural safety competencies in General Practice.

These enablers were observed in a limited number of sites, evidently due to the multiple influences on leadership and management responses to the ICDP at the site level. Contextual influences included individual capacity for systems thinking; individual knowledge, skills, education and motivation; cultural competency and values; and professional values. Management responses were also influenced by policies and established procedures; organisational orientation to chronic disease care; state of development of systems for coordination, integration and decision support; precedents for team approaches and external linkages.

Services and sectors have a systematic approach to referrals, information sharing and system coordination

A systematic approach to referrals, information sharing and coordination both supported and were enabled by systems thinking. In the limited contexts where this occurred, it was positively influenced by team approaches, established linkages, collaborations and professional networks rather than formalised systems. For example, interview data indicated that workshops convened by SBOs to orient new Care Coordinators to the CCSS program were highly valued as opportunities to network and share implementation experiences with other ICDP funded workers based within DGPs, such as OWs and IHPOs, as well as state-funded program workers (where relevant). We also noted that training in use of clinical information systems was an expressed priority of attendees. These findings suggest that (1) systematic efforts to connect people would support systems approaches and (2) electronic clinical information systems are under-developed to support referrals and system coordination.

Clinical information systems function to support quality chronic illness care, population health monitoring and evaluation - Staff skilled to use systems effectively

In services and practices in which clinical information systems functioned to support quality chronic illness care, and where staff had the skills to use them effectively, similar influences were apparent. We found that leadership commitment to systems development and data management resulted in better integrated care and greater financial benefits to Health Service (in terms of incentives and Medicare payments), especially when coupled with a commitment to developing staff skills in system use. This

was evident in an AHS in a regional site, which had an efficient system for checking patient details and following up on care needs when patients presented at the AHS, complemented by a clinical information system that enabled immediate patient referrals between clinical and Regional Tackling Smoking and Healthy Lifestyle teams. We observed a similar process for checking patient records and coordinating follow-up in another regional site AHS, resulting in relatively high Tier 1 payments. Similarly, some DGPs (working at least partly through IHPOs) assisted General Practices to develop systems by providing paper based and electronic templates that were ready to load onto information systems (e.g. for adult health assessments).

Information systems with capacity to support population health monitoring and evaluation supported systems thinking. Some services were using continuous quality improvement (CQI) processes to monitor population health in relation to chronic disease care.

Constraints to a systems approach to developing and optimising chronic disease service delivery systems were generally the converse of those factors that activated the mechanism.

The very low levels of Tier 1 payments made to organisations across all Sentinel Sites reflects the generally undeveloped state of clinical information systems and billing systems in relation to the requirements for Tier 1 payments. Currently available clinical information system software generally appears to have the functionality to generate the required disease registers and recalls and reminders to support clinicians to identify and manage patients who may be eligible for GPMPs, TCAs and relevant reviews, however, the software systems tend not to be sufficiently well set up or used effectively by practice staff. Furthermore, the current approach or level of incentive payments (through the PIP Indigenous Health Incentive) appears to be generally inadequate to stimulate the service level investment in staff and system development that is required to increase use of GPMPs, TCAs and associated reviews, in order to trigger Tier 1 payments. The clinical indicator data from the SSE data (Appendix E) also highlight the low level of recording of Aboriginal and Torres Strait Islander status in clinical information systems in many Health Services. There are also limitations on access to clinical information systems in General Practices by ICDP funded staff with specific responsibility for enhancing coordination of chronic illness care, such as Care Coordinators. This limited capacity and/or use of information systems to share information and coordinate patient services across services and sectors was a significant constraint to a systems approach. It also limited ability of Health Service staff to identify or follow-up patients who might benefit from the service (supporting the finding that these systems are generally not being used as tools for planning).

Underdeveloped systems for sharing information across sectors constrained the capacity of specialist outreach services to function as envisaged in the National Framework program logic. Firstly, system constraints within host organisations - including lack of staff in relevant roles and staff lacking relevant skills - limited capacity to set up specialist visits and assist with billing for specialist services. Second, referrals and feedback between GPs and specialists were inhibited in a number of sites because visiting specialists did not (or could not) access local systems to record patient information, or they were unfamiliar with the clinical information system used by the Health Service. High use of locum and temporary staff in some host organisations also made it difficult to systematise referrals, especially as the program signified a major shift in conventional referral pathways (for example, under the specialist outreach program General Practice needed to refer patients to AHS hosted specialists).

Overall, good clinical information systems were observed to be of limited benefit unless used competently by staff. There was limited evidence of appropriate development and oversight of clinical information systems for the purpose of service level monitoring and planning, and limited evidence of efforts to develop staff capability in this area or to enhance the functionality or user friendliness of clinical information systems for this purpose. Effective use of systems appeared most constrained

where dependence on locum nursing and GP staff was high (due to lack of training or orientation to use of internal information systems).

High staff turnover, staffing constraints and poor administrative capacity in remote sites particularly hindered system use by staff. For example, in one site the clinical information system could not be utilised effectively because the AHS lacked the administrative resources and communication infrastructure to update information about its widely dispersed and transient patients.

Lack of workforce recognition of, and commitment to, the use of data for systems improvement and population health coverage

It was apparent that the workforce often lacked awareness or understanding of the potential for clinical information systems to be used for population and service level systems planning, monitoring and evaluation.

Staff in some Health Services referred to continuous quality improvement processes that provide opportunities to drive improvements in patient care systems. There appeared to be limited understanding of, or interest in, how to use clinical information systems to identify and respond systematically to health inequities or service access issues experienced by Aboriginal and Torres Strait Islander people, or specific population subgroups.

Diversity of systems capability; diversity and complexity of delivery context - Limited capacity for systems thinking and approaches, partly due to the administrative burden

The diversity between services and Health Services in systems capability, diversity in delivery contexts and the ever-dynamic nature of these elements made it difficult in many instances to predict ongoing service capabilities and linkages. Factors such as management instability, governance upheavals, staff turnover and delays in recruitment constrained systems thinking in several AHSs, where efforts were directed towards day-to-day functions rather than longer term planning. In General Practice environments, diversity in practice sizes and resources, orientation to using MBS items such as GPMPs and TCAs for their general patient population, and variation in capacity to adapt information and administration systems to identify Aboriginal and Torres Strait Islander patients and incorporate ICDP-related activities resulted in varied capacity for systems thinking. This often related to whether the number of Aboriginal and Torres Strait Islander patients in the practice was adequate to justify system changes (and associated time/cost). At the meso-system level, transition to Medicare Local arrangements was in some sites a distraction from ICDP related activities for DGP-based staff. In relation to specialist services, there was uncertainty in some sites about how to arrange for visiting specialists to bulk-bill and some services lacked administrative capacity to manage the billing. Across urban, regional and remote sites there was a perceived lack of overarching procedural guidance for USOAP and MSOAP-ICD. Contextual diversity and perceived administrative barriers were felt by stakeholders to contribute to specialist recruitment and retention issues.

In summary, we found that constraints to a systems approach to developing and optimising chronic disease service delivery systems were largely influenced by structural and/or systemic factors in sites. These factors included limitations in information systems, system access and staff skills, limited capability in systems thinking, and lack of workforce recognition of the usefulness of data for systems improvement. Together they helped to explain why a systems approach to optimising chronic disease service delivery systems was not activated in a number of Sentinel Sites. It was more difficult to systematise measures when service providers were struggling with a shortage of staff, particularly in the face of socio-cultural and physical challenges, such as transient target populations dispersed over a wide geographic area in remote sites. Our analysis suggests that structural/system and policy reforms

need to be coupled with behavioural changes – investment in training and knowledge/skill development – in order to implement systems approaches.

Contexts that activated a systems approach to developing and optimising chronic disease service delivery systems combined supportive policies and clear procedures, systems thinking and strong leadership. Key enablers were organisational orientation and management commitment to use of data for service planning and population health purposes and systems improvement. These enablers were underpinned by understanding that elements within systems are inter-dependent and multi-level and result in linkages, collaborative work and improved staff competency in use of information systems. Where managers and leaders were knowledgeable and skilled and organisations were structured to support achievement of the ICDP vision, recognising that *‘every intervention, from the simplest to the most complex, has an effect on the overall system, and the overall system has an effect on every intervention,’*¹⁹⁰ a systems approach was more likely to be activated.

17.2.3. PRIMARY HEALTH CARE ORGANISATIONS ORIENTED TO ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITY NEEDS AND VALUES, OPEN TO RE-ORIENTING SERVICE DELIVERY APPROACHES TO CHRONIC DISEASE PREVENTION AND CARE, CREATING INCREASED DEMAND FOR SERVICES

The mechanism

Primary health care organisations oriented to Aboriginal and Torres Strait Islander community needs and open to re-orienting service delivery approaches were able to implement the ICDP effectively. This orientation and receptivity to change helped to create increased demand for chronic disease services among local Aboriginal and Torres Strait Islander communities.

Orientation to cultural values and community needs was indicated by the design or adaptation of activities and approaches to accommodate cultural values and service trends. Simple examples are the planning and delivery of gender specific health roles - for example, employing women to work with female patients; setting up a dedicated men’s health clinic with male staff where men are under-represented as a patient group. Recognition of the factors that contribute to the respect and participation of the community, as demonstrated by the employment of older people of influence and high community regard in key ICDP positions, was an indicator of orientation to Aboriginal and Torres Strait Islander community needs. Re-orientation of general and specialist practices’ business models in order to increase access for Aboriginal and Torres Strait Islander patients were other examples, as demonstrated through strategies such as bulk-billing for consultations, and use of OWs to enhance cultural safety. However, the mechanism is more than the ‘mechanics’ of change: for a number of Health Services it involved a change in thinking to acknowledge the validity of Aboriginal and Torres Strait Islander-specific programs and approaches, to prioritise reform and to set up the links necessary to integrate and improve services for Aboriginal and Torres Strait Islander patients/communities. Success in relation to this mechanism created increased demand for chronic disease services among Aboriginal and Torres Strait Islander communities, because it resulted in increased recognition of chronic disease risk, and increased confidence and ease in accessing Health Services.

In general, orientation to Aboriginal and Torres Strait Islander community needs and openness to re-orienting service delivery approaches were more evident in contexts where services were set up to

¹⁹⁰ De Savigny and Adam 2009, op cit.

specifically meet community needs (including representative governance arrangements) and/or where health professionals and managers had experience working in the Aboriginal and Torres Strait Islander services sector. Orientation to Aboriginal and Torres Strait Islander community needs and related changes were less likely to be activated in sites and organisations where there was limited actual or perceived demand for services to Aboriginal and Torres Strait Islander people and, related to this factor, limited motivation to change service approaches for a particular population group.

Enablers and constraints to activating the mechanism

Our analysis found a number of contexts activated orientation to Aboriginal and Torres Strait Islander community needs and changes to service delivery approaches.

Good knowledge of services and local operating environment

Good knowledge of the local operating environment and available services supported orientation to Aboriginal and Torres Strait Islander community values and needs, evident in contexts where AHSs and General Practices had established linkages with providers and community leaders considered appropriate by Aboriginal and Torres Strait Islander patients (as indicated by patient feedback), and where they had sufficient history in the local community to determine the providers most open to changing their approaches and/or providing culturally appropriate services.

It was apparent that individual staff members with a combination of local knowledge, community influence and standing and professional networks were important enablers in referring Aboriginal and Torres Strait Islander patients to culturally appropriate providers and activities.

General Practices and pharmacies that were adopting ICDP measures in culturally appropriate ways and meeting the needs of Aboriginal and Torres Strait Islander patients became known through local 'community grapevines' early in ICDP implementation. There were numerous instances of community focus group participants discussing the creation of increased demand at these services, with particular references to appropriate communication styles, understanding of people's financial and transport issues, and absence of racist attitudes.

Pre-existing partnerships, programs - History of constructive engagement in Aboriginal and Torres Strait Islander health

Closely related to the enablers identified above, the SSE found a history of constructive engagement in Aboriginal and Torres Strait Islander health to be a significant enabler in adopting changes to service approaches, and promoting changes with colleagues. For example, a private pharmacy operator drew on experience of working in the community and the local AHS to voluntarily train staff in other pharmacies to dispense PBS Co-payment measure annotated prescriptions. Pre-existing partnerships between providers and pre-existing programs that brought providers together (such as care coordination programs) made organisations more receptive to the linkages needed to implement the ICDP. More specifically, however, a history of constructive engagement in the sector meant that individuals were more likely to be culturally competent and uphold appropriate cultural values, and organisations were more likely to have systems oriented to Aboriginal and Torres Strait Islander primary health care.

Effective structures for community participation

Effective structures for community participation were powerful enablers of orientation to community needs. They usually indicated effective procedures for community decision making, commitment to providing culturally and clinically responsive services and community/staff collaboration and links.

Community controlled AHSs are expected to have formal governance structures that are representative of communities they serve. The SSE found diverse DGP histories in terms of mechanisms for Aboriginal and Torres Strait Islander community input, however the ICDP funded positions have been important in mobilising Aboriginal and Torres Strait Islander community input to DGPs, especially when held by professionally experienced people known and respected in the community. In a number of sites, the IHPO and OWs were able to motivate community activism to increase the number of PIP Indigenous Health Incentive registered General Practices. There has been a steady increase in PIP Indigenous Health Incentive registrations through General Practices, and there was relatively greater increase in Tier 1 payments made to General Practices compared to AHSs, indicating increasingly positive engagement with the ICDP by some General Practices.

At least some AHSs appeared to have effective structures for community participation in decision-making, including decisions about ICDP implementation. In one remote site, the all-Aboriginal and Torres Strait Islander governing Board was directly involved in the selection of ICDP funded staff. It also determined the targeting and nature of ICDP funded health promotion activities in accordance with regional priorities. In another, the regional council determined how position descriptions would be modified and located to optimise reach and community benefit. The challenges associated with delivering 'business as usual' in remote areas appeared to be well understood by community representatives - decisions reflected these realities.

Conversely, lack of robust links between providers and Aboriginal and Torres Strait Islander communities inhibited orientation to community needs. Development of robust links may have been inhibited for a range of reasons (e.g., structural, relational, socio-cultural, physical environment).

Interactive cultural awareness training, linked to clinical relevance

Cultural awareness training helped practitioners and other staff in General Practice settings to re-orient service delivery. Cultural awareness training was perceived by participants to have most positive benefit when it was conducted through group training sessions and focused on locally relevant matters and practical communication advice (including how to encourage self-identification). In terms of content, participants reported most benefit when Aboriginal and Torres Strait Islander culture and history were made explicitly relevant to clinical practice, and when self-reflection regarding prejudicial attitudes and behaviours at a personal and organisational level was encouraged. In some sites cultural awareness sessions were delivered in pharmacies by the DGP (they included role play to highlight culturally appropriate/inappropriate interactions).

Face-to-face cultural awareness training was not part of the program design and was therefore not guided by centrally provided resources - these might have reduced the preparation time required. However, it was regarded by the IHPOs and OWs who designed and delivered the training in some urban and regional sites as good investment in relationships with service providers, because it opened doors to ongoing provision of cultural advice to interested providers and laid foundations for culturally respectful care. Informal one-on-one discussions between, for example, OWs or IHPOs and General Practice reception staff were also reported to be very helpful. While in Australia there is limited evidence for the effectiveness of Aboriginal and Torres Strait Islander cultural awareness training, positive changes have been suggested, assessed in relation to satisfaction with training and general behavioural intentions.¹⁹¹ This is consistent with our evaluation findings that training helped to break

¹⁹¹ Downing, R., Kowal, E. & Paradies, Y. 2011, Indigenous cultural training for health workers in Australia. *International Journal for Quality in Health Care* 2011; 23 (3): 247–257.

down stereotyping and changed behaviour toward Aboriginal and Torres Strait Islander patients, as reported by community focus group participants and service providers.

Integrated and culturally safe work environment for Aboriginal and Torres Strait Islander workers (General Practice sector)

The SSE found that culturally safe work environments, in which Aboriginal and Torres Strait Islander workers were integrated within the broader workplace, were more likely to activate positive orientation to Aboriginal and Torres Strait Islander cultural values and community needs. This was evident in those DGPs where Aboriginal and Torres Strait Islander workers were structured as teams, where the pressures associated with being an Aboriginal and Torres Strait Islander person working in Health Services were acknowledged and support provided, and where Aboriginal and Torres Strait Islander programs were accorded high organisational priority. In General Practices we found that Aboriginal and Torres Strait Islander workers who felt they were listened to and accorded authority and respect were able to influence change.

The SSE identified a number of factors that constrained openness to change service approaches to meet Aboriginal and Torres Strait Islander community needs. They included:

Key workforce without necessary competency to fulfil ICDP roles and program aims

Related to the staff shortages and recruitment challenges raised elsewhere, our evaluation found that the mechanism was constrained where key members of the workforce did not have the competencies needed to fulfil ICDP roles and work effectively towards program aims. For example, an ICDP funded worker in a remote site lacked English literacy and cross cultural competence to undertake orientation and other recommended training, negotiate travel requirements or connect with ICDP workers across other sites. Entry level workers appointed as OWs to transport ill patients lacked competency to make assessments of patient needs, apply first aid and provide social/emotional support. Some workers lacked necessary connections with community despite good skills sets. Conversely, some ICDP funded workers were 'over-qualified' for their roles, for example, several workers in 'entry level' Regional Tackling Smoking and Healthy Lifestyle positions had specialist allied health professional and/or post graduate qualifications.

People in leadership roles within Health Services were not necessarily knowledgeable about the ICDP, or able to engage in ICDP implementation and guide others in the complex interactions required. For example, practice managers and AHWs in AHSs were expected to support, mentor and supervise OWs. This could not always be achieved due to lack of information about expected roles and interactions, and contextual factors such as the lack of an AHW workforce in one remote site, inexperience of recently appointed colleagues, high workloads, lack of specific skills to fulfil 'teaching' roles and the diversity of skills and learning/supervision needs of newly recruited staff. There were suggestions from informants that training needs of managers in DGPs included training on how to manage and support Aboriginal and Torres Strait Islander staff most effectively.

Limited reach into target populations due to complex environments

A constraint to reorientation in General Practice was the small number of Aboriginal and Torres Strait Islander patients in practice populations. Most General Practices in Australia do not have patients identified as Aboriginal and Torres Strait Islander people, and for the majority of others, proportions of patients identified as Aboriginal or Torres Strait Islander are well under 10%¹⁹². For many, the limited reach into target populations did not warrant the work and financial investment involved in re-orienting practice systems and approaches.

Aboriginal and Torres Strait Islander service delivery environments are in themselves complex in regard to community reach, stakeholder networks and linkages: Aboriginal and Torres Strait Islander representative groups and individuals who are in a position to advise on matters such as achieving community reach often need to deal with multiple approaches and demands by a variety of service providers (relevant in all sites types). The difficulty that some sites experienced in convening community focus groups provided evidence of how complex environments could constrain reach, often due to cultural and physical factors (funerals, cultural business, road closures due to seasonal flooding).

Providers don't understand or accept the clinical relevance of Aboriginal and Torres Strait Islander history and identity

Orientation to Aboriginal and Torres Strait Islander community needs was constrained when providers did not understand, or did not accept, the relevance of Aboriginal and Torres Strait Islander history and identity to health outcomes. Cultural competence and attitudes, cognition and motivation, education, training and experience appeared to influence understanding of the relevance of Aboriginal and Torres Strait Islander history and identity to health outcomes.

17.2.4. PRIMARY HEALTH CARE ORGANISATIONS ENGAGE WITH ICDP MEASURES AND UTILISE THEM WITHIN EXISTING SYSTEMS

The mechanism

Effective operation of the ICDP in sites required primary health care organisations to engage with ICDP measures and utilise them within existing operational systems, so they became part of a holistic approach to chronic disease prevention and care, rather than 'add-on'. 'Engagement' implies pro-active involvement and taking initiative to support the utilisation of measures. In the context of the SSE, engaging with ICDP measures involved making the necessary adjustment to procedures, staff orientation and training to utilise ICDP measures within, and to augment, existing programs and operational systems. This mechanism is linked to the mechanisms that focus on systems approaches.

In general, engagement with ICDP measures and utilisation of the measures within existing systems was evident in contexts in which primary health care organisations knew the operating environment well, and had well functioning information and organisational systems that supported experienced managers and leaders to adapt the ICDP measures and available resources to local contexts. Positive staff attitude and skills were important contextual factors that were more apparent in sites where the workforce were not working under the constraints of staff recruitment and retention, infrastructure or management stability issues.

¹⁹² M. Kelaher, A. Parry, S. Day, Y. Paradies, J. Lawlor & L. Solomon 2010, Improving the Identification of Aboriginal and Torres Strait Islander People in Mainstream General Practice. The Lowitja institute, Melbourne.

Enablers and constraints to activating the mechanism

Services/organisations receptive to re-orientation and change - Staff with positive attitude and necessary skills

A factor that supported activation of this measure was receptivity to service re-orientation to chronic disease management within primary health care delivery. As previously identified, influences on this enabler were systemic and historical, and were related to staff skills and motivation as well as policy and service models. A high level of engagement occurred in contexts where staff understood and embraced use of MBS items designed to support chronic disease management as 'core business'. Good practice examples occurred in some urban and regional AHSs (as indicated by Tier 1 payments). Positive attitudes of managers and staff within organisations supported re-orientation to embrace program measures – this related to having the necessary understanding, skills and motivation, as well as cultural competency to work appropriately with community and patients.

Knowledge, experience of systems and sectors

Knowledge and experience in using the systems to efficiently manage and integrate chronic disease management and care enabled engagement with ICDP measures, as did sound knowledge of services beyond the organisation. Successful engagement of some measures depended on engagement across sectors, or at the least, understanding the values and priorities of another sector. We found that where staff had experience working in another relevant organisation - for example, where IHPOs and OWs employed in DGPs had worked in the AHS sector (and visa versa) – they were able to bring perspectives that added value to their roles and to the employing organisation. Another important aspect in relation to these workers was the professional networks IHPOs and OWs brought to the positions and the capacity of Aboriginal and Torres Strait Islander workers to facilitate connections into the local Aboriginal and Torres Strait Islander community. Engagement was enhanced where clinicians working in General Practice had prior experience in the AHS sector. In general, cross-sector experience brought valuable cultural values and competency to activate engagement with ICDP measures.

Well functioning information systems that are used to support identification of relevant patients for chronic disease management

The SSE provided evidence that Health Services with systems capable of identifying patients who would benefit from chronic disease management had greater capacity to engage with the ICDP measures. At a basic level, clinical information systems needed to include record of identification of patients as Aboriginal or Torres Strait Islander people [which was not the case in many services in both sectors throughout the period of the SSE, although there was evidence of some improvement in identification in the clinical indicator data (Appendix E)]. While systems to identify and prioritise patients for chronic disease management were not widely evident across organisations, those with well functioning systems were better able to identify and prioritise patients for chronic disease services - for example, to complete and update GPMPs and TCAs in a timely manner. Underpinning this enabler is motivation and understanding at management level, and procedures to support coordination and continuity.

Organisational management, structures and processes to manage the workforce and engage new resources to meet local needs

It was evident throughout the evaluation that engaging the workforce and available ICDP resources required more than information about the measures – it required practical information, tools and support to understand how to really utilise and link the measures to enhance the quality of care for Aboriginal and Torres Strait Islander patients. Staff in Health Services could identify the broad intent of measures ('closing the gap'), but needed assistance in developing a clear vision of what engagement in the measures could mean to patients, and how to improve structures and processes in ways that would

optimise the resources available and improve patient experiences. Pockets of good practice were identified. They included AHSs that were using ICDP income to employ staff to systematically identify targeted chronic disease patients for follow-up services and coordinate consultations, or to purchase relevant medical equipment to expand available 'in-service' treatment. Some General Practices with a high proportion of Aboriginal and Torres Strait Islander patients took a similar approach.

Patient knowledge and understanding about chronic diseases, available services and how they work

SSE data indicated a high level of community and patient awareness of chronic disease risk factors. Patient knowledge in terms of their chronic disease, available services and how they work (or should work) was an enabler to Health Service engagement. For example, community advocacy, facilitated by an IHPO, resulted in early and broad registration of General Practices in the PIP Indigenous Health Incentive program in one urban site.

The SSE team found that participation in community focus groups assisted in informing people about the ICDP benefits and raised expectations about the scope of chronic disease related services delivered by General Practices, AHSs and specialist providers. It was noted that in the final evaluation cycle some community focus group participants remained unaware of the PBS Co-payment measure, raising the question of how much additional patient benefit and Health Service engagement could be achieved if information about chronic disease services, including benefits available through the ICDP, reached more Aboriginal and Torres Strait Islander community members.

Adequate funding provided through ICDP

An important enabler for engagement with the ICDP was adequate funding. Throughout the period of the SSE, there were few instances where service providers indicated that aspects of the ICDP were under-funded. Issues on which there were comments on inadequate funding included inadequate budgets to attract sufficiently experienced and qualified staff and cover costs of travel for staff working in remote sites to reach all services and service populations in the areas for which they were responsible. In urban, regional and remote sites, the number of funded positions were not adequate to achieve population coverage, and funding for certain programs, such as USOAP, was limited to selected locations which did not necessarily include all locations in which there was limited access to specialist care. Where implementation was delayed, it tended to be attributed by informants to local contextual factors (such as lack of suitable staff) or to restrictive guidelines, but not to lack of monetary resources. This was a significant observation in a service sector accustomed to advocating for increased resources for Aboriginal and Torres Strait Islander Health Services. Also relevant to engagement in the measures was the finding that some AHSs welcomed the opportunity to strengthen services through funding tied to additional Medicare items (as opposed to program grants). However, it was clear that many services, specifically including AHSs, did not have the staff or system capability to access the funding that was available through Medicare.

Underdeveloped systems and processes to support multi-provider service delivery, including administration and clinical information systems

Many primary health care services lacked systems to identify and follow-up patients with complex care needs, and were not well oriented to using GMPs/TCAs or other team care planning to support multi-provider service delivery. Consequently, coordinating client management between service providers often relied, where it occurred, on informal links, and information sharing between primary health care clinicians and specialists was inefficient. Poor identification of Aboriginal and Torres Strait Islander patients impaired the functionality of clinical information systems for electronic annotation of PBS Co-payment measure prescriptions in a number of Health Services, which was found to cause inefficiencies

or difficulties for pharmacists and patients. Overall, services were more likely to be fragmented and inconsistent when administration and information systems were underdeveloped.

Systems and services struggling to meet 'business as usual' demands; inability to make necessary changes

The needs of patients with chronic illness are long term and fluctuating, while many primary care services are built on providing acute, episodic models of care. Some services were reluctant or struggled to make the changes necessary to implement ICDP measures, particularly those struggling to meet 'business as usual' demands due to management instability, high staff turnover or service populations who relied upon the Health Service to provide accident and emergency care (e.g. in small towns in remote sites). Such pressures could defer basic changes to systems, such as provision to record Aboriginal and Torres Strait islander identity, patient registration for ICDP benefits and setting up of systems to claim additional MBS items. Some AHSs continued to pay for pharmaceuticals on behalf of patients, unable to resolve confusion about access to the PBS Co-payment measure when patients from remote locations visited services in regional centres, or to harness sufficient administrative resources to register patients visiting from remote locations for the PBS Co-payment measure. These decisions were influenced by resistance to changing established practices, program design and administrative requirements not being suited to the variety of patterns of service utilisation, and administrative burden – collectively forming significant constraints.

Overly prescriptive guidelines and lack of flexibility

A constraint that emerged in relation to a number of measures was the perception that some program guidelines were overly prescriptive and lacked flexibility for Health Services to respond appropriately to local population needs and contexts. Access to some services, for example specialist outreach services, could be inhibited by inflexible interpretation of guidelines by fundholders program managers or administrators, or lack of a problem solving approach to implementation of guidelines to ensure that programs meet patient and community needs. Some AHSs believed ICDP guidelines restricted their scope to modify job specifications and allocate resources to meet the priorities set by governance bodies and service populations needs (e.g. in relation to cultural safety, service reach, local capacity development).

Some clinicians believed measure guidelines did not provide scope for professional discretion in interpreting eligibility of patients for particular benefits and determining patient care requirements.

These and similar issues restricted or delayed efforts to fully embrace some measures.

17.2.5. PARTNERING AND MOBILISATION WITHIN AND ACROSS ORGANISATIONS AND SECTORS TO ACHIEVE ICDP GOALS

The mechanism

Organisations needed to partner and to mobilise with the express purpose of achieving intended ICDP outcomes. This mobilisation needed to occur within organisations, across programs and teams (including the partnering of the Aboriginal and Torres Strait Islander workforce with other teams). We also found that organisations needed to partner with each other and mobilise across services and sectors to provide the range of services and support that comprise best practice chronic disease prevention and management services.

In general, partnering and mobilisation within and across organisations were evident in contexts where organisations and sectors understood the nature of each others' work and workforce, and staff communicated well across sectors. This tended to occur in locations where staff had high level skills, cross sector work experience and were well established within sites. This mechanism was also evident where community/patients were accustomed to consistent good quality care. Partnering and mobilisation were less likely to be activated in sites in which community reach by providers was difficult to achieve.

Enablers and constraints to activating the mechanism

Individual skills/adaptability to work within differing organisational cultures - Experience, knowledge and networks to support working in different sectors

As explained in relation to a previous described mechanism, individual staff adaptability and competency in respect to working across sectors and in different organisational cultures was an enabler to partnering between primary health care and support organisations. Cross sector and cross-cultural work experience were enabling for general members of the health workforce involved in ICDP implementation. In particular, we found that IHPOs, OWs and Care Coordinators who were experienced and knowledgeable in AHS approaches and values were highly influential in facilitating partnerships between Health Service providers to improve patient access to chronic disease services, particularly when they had well developed professional networks and the ability to advocate for the necessary changes. Similarly, partnerships were facilitated where staff from DGPs with good knowledge of clinical information and other organisational systems worked to support AHSs. While these capabilities were implicit in job descriptions, our evaluation found them to be explicitly important to partnering and mobilisation.

Also implicit in ICDP implementation was the aim to increase Aboriginal and Torres Strait Islander representation in the GP sector. We found the engagement of Aboriginal and Torres Strait Islander workers to be an important factor in activating the mechanism.

Organisations and sectors recognise and understand differences and synergies between each others' role - Workers have professional credibility with peers and are valued and viewed as part of the wider health system

Understanding the roles of other organisations and workers was critical to partnering and mobilisation. Prior relationships between workers involved in service delivery were powerful activators, as were staff members who perceived their roles as part of a wider health system and understood and valued the roles of others. Underpinning these enablers were training, knowledge and competencies of individual staff and managers; the procedures that support service coordination, continuity and decision-making; team approaches and linkages; and cultural competency and values.

Where organisations and sectors came together to implement ICDP measures, such as in the provision of orientation to new ICDP funded workers, greater understanding of each others' core business and ICDP roles enhanced mobilisation. Workers were more likely to develop networks and form working relationships.

Conventional peer relationships between service providers supported the mechanism, such as referral links between GPs and specialists, and appreciation of each others' service models, with examples in urban and regional sites where AHSs and specialists adapted the outreach service model to optimise efficiency while meeting patient needs (e.g. by transporting patients to nearby specialist rooms).

Individuals with cross cultural competence working within and across organisations

Our evaluation found that cultural competence of workers was required for partnering between organisations to operate effectively. This competence incorporated understanding and skills to work with those from a different organisational culture (Aboriginal and Torres Strait Islander community controlled health sector, private Health Services sector), as well as competence to work with people from another cultural background. We observed that people's understanding of different ways of seeing, doing and being was often the result of workers' experience in cross-cultural service delivery contexts. For many non-Aboriginal and Torres Strait Islander workers engaged in the ICDP, cross-cultural competence was more specifically a result of working in Aboriginal and Torres Strait Islander health. For others, the ability to interact effectively with Aboriginal and Torres Strait Islander communities and patients depended on factors such as background and motivation of individual staff and their development of professional relationships with highly effective Aboriginal and Torres Strait Islander people in critical positions (e.g. where GPs had positive engagement with IHPOs and OWs).

Newly appointed workers, and service providers with limited or no experience working with Aboriginal and Torres Strait Islander people, often found cross-cultural awareness training to be an important foundation for developing cultural knowledge, understanding and skills. In one site where a non-Aboriginal and Torres Strait Islander RTC with limited cross-cultural experience was appointed, successful outcomes were achieved through the host organisation's implementation of a program of cultural mentoring and supervision for some months prior to the RTC's independent decision making and field work. These findings are supported by other evidence from Aboriginal and Torres Strait Islander health care delivery settings, which indicates that programs in culturally respectful health care delivery can lead to short-term improvements to practice.¹⁹³ Implications identified by Durey are that strategies need to include education to prepare undergraduates and health professionals in culturally respectful practice in order to deliver appropriate health services - strategies consistent with the design of ICDP workforce expansion and support measures (cultural awareness training, clinical placements and scholarships).

Individuals active in roles to make Aboriginal and Torres Strait Islander health everybody's business

Our evaluation found that where individuals were active in roles to make Aboriginal and Torres Strait Islander health 'everybody's business', partnering and mobilisation to achieve ICDP goals were more likely to be activated. Relevant examples at site level included high profile Indigenous leaders of AHSs who worked directly with Health Service providers to expand service provision to communities, and IHPOs who actively advocated for improved access to chronic disease services at the local level. DGPs were critical in activating this mechanism in the General Practice sector. Across sites, IHPOs and DGP based OWs informed General Practices about the program through various modes (newsletters, bulletins, presentations, resources). In some regional and urban sites they took up opportunities to enhance the cultural awareness training offered through the ICDP with face-to-face sessions (as previously explained). Some OWs supported patients during specialist and GP consultations, leading to ongoing partnering arrangements for improved cultural safety. Some IHPOs responded to consumer complaints about non-participating pharmacies, reinforcing to pharmacists that acceptance of CtG scripts was mandatory Australia wide. Some IHPOs and Care Coordinators successfully advocated for policy guidelines to change in order to improve access to services (e.g. through changes in Supplementary Services funding guidelines). As previously explained, we found that IHPO positions were particularly vital to this enabler, and were effectively performed when held by experienced

¹⁹³ Durey, A. 2010, Reducing racism in Aboriginal health care in Australia: where does cultural education fit? Australian and New Zealand Journal of Public Health, 2010. 34 (1): 87-92.

Aboriginal and Torres Strait Islander workers with high level communication skills and cross cultural competency.

Raised community expectations of chronic disease services and high level of community understanding of ICDP and relevant entitlements

Over the period of the SSE, improved community understanding of ICDP entitlements and raised community expectations of chronic disease services assisted in mobilising services. In addition to examples from urban sites, in which consumer knowledge of PBS Co-payment measure entitlements led to consumer advocacy for registration, it appeared that increased community knowledge about availability of transport to appointments, and about not needing to pay specialist and allied health professionals ‘up-front’, increased service utilisation. Community focus group participants spoke about their efforts to acquire specific medications under the ICDP (to reduce the number of medications taken) and of their advocacy to obtain Webster Packs through the ICDP. Some reported that prior attendance in a focus group had prompted them to request PIP Indigenous Health Incentive registration. We also noted, however, that long-standing relationships with GPs were more important to some patients than the financial benefits of attending a PIP Indigenous Health Incentive registered General Practice – consumers continued to exercise choice in relation to preferred providers. In addition, it appeared that wide community knowledge about specific ICDP funded entitlements such as Nicotine Replacement Therapy did not necessarily increase mobilisation, suggesting that community knowledge needed to be coupled with motivation/ demand to activate service mobilisation.

Our evaluation found that community members tended to associate improvements in services with individuals rather than with ICDP roles – this influenced data about community knowledge of the ICDP and is consistent with the priority accorded to relationships and community/family connections within Aboriginal and Torres Strait Islander communities.

Organisational stability

Organisational stability helped to activate this mechanism. Partnering between organisations was more likely as a result of continuity of leadership and service delivery, and the resulting professional relationships. Conversely, we observed that organisations distracted from ICDP implementation due to financial constraints, transitional governance arrangements, ineffective leadership or staff shortages were less able to form partnerships with other organisations to achieve program goals, apparently due to low staff morale and lack of mobilisation of procedures and resources to support engagement.

History of poor inter-organisational cooperation and mistrust

The SSE found that where inter-organisational cooperation and trust were poor, partnering to achieve ICDP goals was constrained by lack of motivation to work together, disparate values and lack of pre-existing linkages. This constraint could be exacerbated by community attitudes – in one site, for example, an Aboriginal and Torres Strait Islander worker was discouraged from undertaking an ICDP role because of the community perception that little could be achieved under the existing DGP/Medicare local arrangements, and a history of lack of engagement and attention to meeting the needs of the local Aboriginal and Torres Strait Islander community.

Lack of understanding of intentions of the ICDP, including distribution of resources

It did not appear to be widely understood, at site level and particularly in the AHS sector, that the ICDP aims to increase engagement of the General Practice sector in Aboriginal and Torres Strait Islander health. A history of competition for resources for Aboriginal and Torres Strait Islander health appeared to support ongoing competition in some sites to register patients and qualify for PIP Indigenous Health Incentive funding (further motivated by the ICDP requirement that patients be registered with only one

provider). In addition, there was a perception among key stakeholders in some sites that Aboriginal and Torres Strait Islander health is primarily the domain of AHSs, with an apparent lack of appreciation of the potential complementary roles of the AHS and GP sectors in providing care for Aboriginal and Torres Strait Islander people. These factors have constrained understanding among service providers that an intention of the ICDP is to increase the capacity of the General Practice sector to provide appropriate high quality care for Aboriginal and Torres Strait Islander people, and have to some extent inhibited mobilisation around the ICDP. Attitudinal change, and appropriate system change, will require carefully targeted initiatives and considerable time to achieve.

Lack of experience of organisation in, and/or inflexibility towards, working with different organisations and cultures

The lack of appreciation of the potential complementary roles of the AHS and GP sectors, and tensions between the sectors in some sites, appeared to have restricted cross-sector and cross-cultural experience. In addition, some service providers were reluctant to change their way of working to accommodate ICDP measures and the partnering required for effective implementation of the measures. For example, it was generally challenging (at this stage of measure implementation) for Care Coordinators to gain the level of recognition and integration of their roles within General Practices, in order to perform their roles effectively.

Person in job or in influential position without suitable skills or support

Where an individual did not have the skills or support to perform their ICDP related work effectively, or where a person in an influential position did not have the understanding or motivation to engage with the relevant ICDP measures and support the ICDP workforce, partnering and mobilisation to achieve ICDP goals was constrained. Entry level workers in ICDP funded positions did not necessarily have adequate authority, adequate knowledge of other service providers' work, or adequate workplace support to provide advice, negotiate partnering arrangements or speak on behalf of the community. Not all health professionals were suitably skilled to provide coordinated services in partnership with other providers.

17.2.6. CORE VALUES ALIGN WITH BEST PRACTICE IN ABORIGINAL AND TORRES STRAIT ISLANDER PRIMARY HEALTH CARE

The mechanism

Best practice primary health care is care that adheres to the principles of 'socially appropriate, universally accessible, scientifically sound first level care provided by Health Services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. [It] includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation' (APHCRI, 2009)¹⁹⁴. NACCHO describes Aboriginal and Torres Strait Islander primary health care as a 'comprehensive approach in accordance with the Aboriginal holistic definition of health and arises out

¹⁹⁴ Commonwealth of Australia 2009, Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy. Australian Government Department of Health and Ageing, <[http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc/\\$FILE/NPHC-suppl.pdf](http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc/$FILE/NPHC-suppl.pdf)> (accessed 3 March 2013).

of the practical experience [and knowledge] within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities' (NACCHO 2006)¹⁹⁵.

The ICDP aims concerning accessibility of services, equity of access, cultural respect and safety are therefore consistent with best practice in primary health care, including specifically in the context of Aboriginal and Torres Strait Islander health. The SSE found that the ICDP was more likely to work effectively in sites and organisations where the core values of organisations and individuals were aligned with best practice in Aboriginal and Torres Strait Islander primary health care.

In general, alignment of values with best practice in Aboriginal and Torres Strait Islander primary health care occurred in contexts where organisations and individuals had relevant understanding, knowledge, skills, motivation and support. This alignment was most evident among organisations and the workforce in the AHS sector. In sites with comparatively higher populations of Aboriginal and Torres Strait Islander patients this alignment was also evident in some General Practices, particularly where supported by DGPs with a strategic focus on integrating Aboriginal and Torres Strait Islander health within the wider system of primary health care. There was less evidence of values alignment where service providers had little background or experience in Aboriginal and Torres Strait Islander health, and were not motivated (for a variety of reasons) to change their way of working.

Enablers and constraints to activating the mechanism

Understanding of Aboriginal and Torres Strait Islander health issues and determinants relevant to providing high quality primary health care

Understanding of Aboriginal and Torres Strait Islander health issues relevant to providing high quality primary health care was helpful in activating the core values described. Health professionals with understanding of the social, economic, cultural and political determinants of health for Aboriginal and Torres Strait Islander people, who acknowledged the service access and health inequities between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander people, held values that accorded with best practice. These values were influenced in practice settings by education and workplace orientation, cognition and motivation, cultural competency/values and particularly by workforce background – workplace teams that included Aboriginal and Torres Strait Islander workers and non-Aboriginal and Torres Strait Islander workers appeared to have increased awareness of health determinants and relevant issues. Whole of organisation orientation to primary health care also supported appropriate values.

Individual commitment to working in Aboriginal and Torres Strait Islander health, supported by leadership - Organisations and individuals motivated by professional and moral drivers to provide high quality care

Similar influences underpinned individual commitment to working in Aboriginal and Torres Strait Islander health, and recognition of the resulting benefits (to self and to patients/community members). A desire to make a difference – to help address disadvantage and improve social equity – was an important motivator. SSE data revealed that leadership commitment to improving Aboriginal and Torres Strait Islander health outcomes supported the commitment of individuals. There were examples reported from both sectors where managers and leaders positively influenced the commitment of others, including GP registrars, AHS and General Practice staff and newly engaged ICDP funded workers. Commitment of individuals who provided community representation on Health Service governance and

¹⁹⁵ NACCHO 2006, NACCHO Constitution <<http://www.naccho.org.au/download/naccho-governance/NACCHO%20CONSTITUTION%20Ratified%20Ver%20151111%20for%20ASIC%20.pdf>> (accessed 3 March 2013).

advisory groups appeared important for aligning organisational values with best practice in Aboriginal and Torres Strait Islander primary health care – through community participation and control, services were made more socially acceptable and accessible.

A number of GPs emphasised that they were committed to providing quality care to all patients, regardless of cultural background. Stakeholders from both sectors argued that completion of adult health assessments, GPMPs or TCAs were not necessarily an indication of high quality care, that use of these Medicare items did not fit well with many service contexts, and that some services were providing high quality care without completion of these Medicare items. Quality care was supported by professional and organisational cultures that valued continuous quality improvement in service delivery, and this context enhanced activation of the mechanism of alignment of core values with best practice in Aboriginal and Torres Strait Islander primary health care.

ICDP measures are consistent with professional perspectives of best practice

Data relevant to the alignment of core values highlighted the consistency of the ICDP measures with professional perspectives of best practice in primary health care. For example, ICDP expectations in relation to GPMPs and TCAs accord with practice guidelines for integrated chronic disease management; identification of patients with complex conditions who would benefit from care coordination through ICDP is consistent with best practice in chronic disease care; ICDP targeting of health issues/ groups/ settings and the community campaign grant funding requirement for partnerships between local providers are consistent with best practice in health promotion.

Professional values, resources and health infrastructure, and decision support through ICDP and practice guidelines influenced this enabler in positive ways.

Services/organisations unable or unwilling to change business practices and priorities to align values - Lack of recognition and/or reluctance to acknowledge the special population health needs of Aboriginal and Torres Strait Islander people

It was evident that where services were less willing, or not in a position, to change practices and priorities, there was frequently a lack of alignment of core values with best practice primary health care, and this context of unwillingness or inability to change practices and priorities was therefore a constraint on activation of this mechanism.

Despite the commitment and efforts of individuals to deliver best practice primary health care, many Health Services seemed unclear how to develop responsive and equity-oriented systems for delivering high quality care to Aboriginal and Torres Strait Islander people. This was particularly the case in General Practice where many providers lacked exposure to Aboriginal and Torres Strait Islander health and equity issues (and many practices had few identified Aboriginal and Torres Strait Islander patients). For some providers, lack of recognition and/or reluctance to acknowledge the special population health needs of Aboriginal and Torres Strait Islander people created dissonance between professional values and best practice in Aboriginal and Torres Strait Islander primary health care. As explained above, a few clinicians in General Practice argued that they provided equitable care to patients of all cultural backgrounds. Some highlighted that their practices did not have the time to create systems for one particular group amongst the numerous cultures represented by their patients (for example, to set up systems to identify Aboriginal and Torres Strait Islander patients, or to register Aboriginal and Torres Strait Islander patients for the PIP Indigenous Health Incentive). Data also demonstrated that General Practice involvement in the ICDP needed to be motivated by professional/personal values rather than simply desire for business growth, if Aboriginal and Torres Strait Islander people were to feel culturally safe and to register with the practice (community networks appeared to work in this respect).

Prior negative experiences working in Aboriginal and Torres Strait Islander health discouraged a few individual providers from embracing Aboriginal and Torres Strait Islander health values. For example, staff in a few specialist practices and some GPs were reticent to engage with the ICDP measures due to their experiences of Aboriginal and Torres Strait Islander patients not attending appointments.

17.2.7. COMPLEMENTARY LINKAGES BETWEEN PROGRAMS, ACTIVITIES, SERVICES

The mechanism

Complementary linkages between programs, activities and services were important to effective implementation of the overall ICDP. These linkages are implicit in best practice chronic disease management and care, which requires complex models of care and collaboration between individual workers and between organisations.

The SSE found that effective operation of the whole of the ICDP in sites required primary health care organisations to identify and facilitate complementary linkages, not only between ICDP measures, but also between programs and services more broadly.

International literature supports this finding: a system-level intervention to strengthen health service delivery, such as the ICDP, *‘involves much more than a reaction to present outcomes or events. It demands a deeper understanding of the linkages, relationships, interactions and behaviours among the elements that characterise the entire system’* (WHO 2009).

In general, complementary linkages were present in contexts where organisations had the vision, leadership and practical resources to foster connections. They did not appear to be explicit in the program design and there was considerable variation between sites in the extent to which efforts were being made to establish such connections.

Enablers and constraints to activating the mechanism

Leadership at high or middle levels facilitate links - Workers understand links and the relevance of other activities/programs to own role

Complementary linkages were activated when leaders at middle and higher levels understood the inter-dependent nature of ICDP measures, and worked to facilitate the links within and beyond their organisations. Understanding of how the measures worked to strengthen pre-existing services to reduce chronic disease risk factors and provide integrated care to their service populations was an important element. The workforce needed to understand the links and the relevance of their own work to the program (and broader chronic disease relevant services) as a whole in order to establish linkages between activities. Some organisations implemented the ICDP as a ‘package’ with eligible patients, assisted by DGP based ICDP workers who promoted awareness in communities and in General Practices.

A number of ICDP funded roles were directly engaged in developing service provider linkages – it was implicit in the job descriptions of IHPOs, OWs, Care Coordinators and, to some extent, practice managers. It was fundamental to the roles of RTCs, TAWs and HLWs, since good health promotion practice involves working in partnership with others within and beyond Health Services, and in target communities, to support healthy lifestyle choices and behaviours. We found that Regional Tackling Smoking and Healthy Lifestyle teams with the capacity and skills to foster these connections were important to activating linkages between workers and activities, especially when A measure activities

were building on pre-existing health promotion programs in sites. While there was frequently need to clarify health promotion roles and responsibilities among other members of the ICDP workforce, we found that where AHSs worked to establish referral pathways between clinical and health promotion teams, and worked on joint health promotion projects within services, complementary linkages were activated. Healthy Community Days promoted complementary linkages between roles and services.

In one urban site the complementary linkages were highlighted by a clinician, who was able to describe the ICDP as an effective model that flowed from clinical care to prevention and healthy lifestyle. However, we found such understanding of complementary linkages among the health Services workforce to be limited.

Opportunities for workers and organisations to come together for training, information sharing - Collaboration between workers/ organisations/ sectors supported by systems

Opportunities for workers and organisations to work collaboratively were important for establishing linkages between ICDP and other Health Service activities. Training events which brought ICDP workers together fostered linkages and information sharing, especially when they included the non-ICDP workforce – they served as orientation to the ICDP and reinforced its complementary nature in relation to other programs.

Healthy Community Days linked measures, programs and teams; Regional Tackling Smoking and Healthy Lifestyle teams worked with clinical workers from local AHSs to make adult health assessments part of these health promotion events. Criteria to secure grants for local campaigns to promote better health required the formation of partnerships between local providers. Some grants funded the continuation of pre-existing programs to raise awareness of chronic disease risk factors, thereby promoting complementarity/synergy with the ICDP and other programs.

Some role connections emerged as the ICDP was implemented. As indicated above, Healthy Community Days emerged as adult health assessment drives within sites and, at the system level within services, linked A measure initiatives and claims for adult health assessment MBS items. In some sites, orientating and supporting pharmacists to implement the PBS Co-payment measure became part of the IHPO role.

SSE data indicated that constraints to the establishment of complementary linkages were mostly the converse of enablers. For example, where there was poor understanding of how program measures and workers link to deliver quality care it inhibited the establishment and continuation of linkages. Collaboration was inhibited by limited opportunities for workers and organisations to come together for training and information sharing. This was usually due to factors such as recruitment delays and the physical environment (e.g., difficulty with travel to and from remote sites) rather than planning, however, it highlighted the importance of relational influences on how people work. These relational influences include the value of informal networks, relationship development and community connections to effective role function, particularly in the Aboriginal and Torres Strait Islander services sector. It also highlighted the importance of providing carefully structured orientation programs that focus beyond individual role functions and sectors to develop understanding of the bigger picture, and the skills needed for team approaches and service integration/coordination for good practice in chronic disease service delivery.

Fragmented implementation and/or silo approaches (of measures and individuals)

The business or service models, and information systems, of many Health Services support fragmented and silo approaches. (A role of DGPs, for example, has been to encourage integrated clinical care in General Practice). For some providers, changing ways of working to foster and expand complementary

linkages between ICDP measures and other programs has been challenging or not feasible. A few workers have been restricted in their capacity to form complementary linkages by resource constraints, or by physical location when isolated from other providers.

The SSE did not identify evidence of systemic organisation level interventions to promote linkages at a local level between local service providers (for example, in relation to OW roles, in which service links are implicit). Services did not appear to be directed by guidelines with a focus on linkages between ICDP measures.

Instability in workforce (e.g. recruitment and retention difficulties, locum staff)

A significant inhibitor to understanding and establishing complementary linkages was workforce instability. As previously emphasised, ICDP implementation relies on the primary health care workforce in sites having local knowledge, well developed systems and resources to make appropriate and timely referrals and provide coordinated support and care. Sites that experienced challenges recruiting and retaining a suitably qualified health workforce, including the ICDP workforce, experienced difficulty establishing and maintaining complementary linkages. Local solutions, such as the employment of locum clinicians (nursing staff and GPs), generally did not support these linkages due to poor local knowledge of many locum staff and under-developed or under-utilised systems.

This issue was particularly constraining in some regional and most remote sites – although detailed knowledge of the local community and available services and resources also operated well where members of the workforce were long term local residents.

In summary, the SSE found that constraints to complementary linkages were due to systemic/structural, administrative and relational influences, as well as the education/orientation and physical environment of the workforce. Contexts that activated complementary linkages were similar to those that supported systems thinking – organisational orientation to primary health care, leaders and managers who facilitated the linkages and collaboration, procedures and systems that supported coordination and understanding among the workforce of individual and team roles within the ‘bigger picture’ of best practice in prevention and management of chronic disease.

17.3. Summary and conclusions

This section consists of three parts. The first part describes the key findings of the Sentinel Sites Evaluation in relation to the outputs and results specified in the National Framework program logic (Table 17.1). This section is fundamental to understanding progress with implementation in relation to the original planning and design of the ICDP, and therefore to meeting the objectives of the SSE. The second part provides a more general concise summary of key findings of the SSE, and the third part identifies key policy considerations emerging from the SSE findings.

17.3.1. KEY FINDINGS IN RELATION TO THE PROGRAM LOGIC

The table below describes the key findings of the SSE in relation to the outputs and results specified in the National Framework program logic.

Note that the following summary of key findings does not present findings for the medium term (for years 4+). There was very limited evidence from the SSE to make any meaningful assessment of the indicators for the whole of the ICDP for this timeframe, due to the stage of implementation of most measures. A number of these measures require systemic and socio-cultural, individual/behavioural changes over several years (e.g. changing conventional relationships between patients and health professionals to increase patient self-management, developing systems to deliver more comprehensive and coordinated approaches, increasing the skilled workforce providing health services to Aboriginal and Torres Strait Islander people).

Table 17.1: Summary of key findings in relation to the program logic – Indigenous Chronic Disease Program

	Summary of key findings from SSE
Outputs for year 1 and beyond	
The workforce required to implement the ICDP is recruited, oriented and trained.	Recruitment generally took longer than expected, primarily due to time taken to establish guidelines and funding contracts with host organisations for the new positions, to (justifiable) plans in some sites to recruit to higher level positions (e.g. RTCs, IHPOs) before recruiting to other positions, and to time taken to find suitable candidates for some positions in some sites. Recruitment has subsequently generally progressed well. The timing and staggered recruitment, the diverse range of skill levels amongst people recruited to ICDP positions, and the different needs of workers in various sites and in different host organisations, presented significant challenges for orientation and training. There appeared to be a lack of emphasis in the orientation and training on recognised competencies for chronic illness care, and lack of capacity in many host organisations to design and source training that would build the specific competencies relevant to these new positions. The general design and guidelines for orientation and training were not well suited to the needs of some types of workers in some sites, particularly those in remote locations.
Package measures are implemented in accordance with agreed guidelines and timelines.	Implementation of many measures was slower than expected, for similar reasons to those outlined above, in addition to time taken to establish working relationships between the various organisations with key roles in implementation of the ICDP. With progress in recruitment to new positions, with establishment and refinement of guidelines, development of structures and processes suited to local conditions, and establishment of working relationships between various organisations, there has been recent progress with implementation of all of the ICDP measures, albeit with some variation in progress between different measures and between different locations.

	Summary of key findings from SSE
Monitoring and reporting requirements are met.	Experience in obtaining program data from DoHA for the purposes of the SSE shows variability in the nature, extent and timeframes for reporting for different measures. Collecting data, monitoring and reporting progress on the national implementation of a complex package of varied measures is challenging at all levels, particularly in relation to assessing the quality of progress and services, and the emphasis in this establishment phase has been on reporting service data. To date there has been limited attention to monitoring and reporting on quality of services. As a result, for all measures there is limited or no evidence of effective support or use of systems that enhance both quality of services and quality of reporting, with the focus being almost exclusively on meeting contractual reporting requirements. There is evidence that the focus on meeting contractual reporting requirements results in managers providing reports that demonstrate compliance with contractual requirements that do not necessarily provide a meaningful reflection of progress with implementation or quality of services. There is also evidence of limited focus and capability at various levels of the system to design, manage, interpret and use data for the purpose of improving system performance. There are significant limitations in the extent to which administrative data can be used to assess changes in access or quality of care, and potential to improve the quality of reporting in the next stage of program implementation.
Internal and external stakeholders, Sentinel Sites and service-providers consider the implementation of the Package to be addressing identified needs and enhancing the existing service system.	There were generally increasingly positive perceptions from key stakeholders in the Sentinel Sites regarding the progress with implementation of all measures and the extent to which measures were addressing identified needs, albeit with some variability in perceptions regarding different measures and in different locations. The general perception was that elements of the package were addressing identified needs and enhancing the service delivery system, but it was clear that services with the greatest capacity, which were generally those that were already performing at relatively high levels, were gaining greatest benefit, and those services with relatively limited capacity (which constituted a large proportion of services) and the populations that were served by these services, were gaining relatively limited benefit from many of the ICDP measures. To this extent, the ICDP in general does not appear to be delivering an appropriate level of benefit to services and populations that are most in need of support.

	Summary of key findings from SSE
Expected early results for years 2 – 4	
Chronic disease risk factors	
Resources for designing and delivering health promotion campaigns for Aboriginal and Torres Strait Islander with or at risk of chronic disease are accessible, effective and evidence-based.	Generally, there were positive responses to the range of new national resources have been developed and distributed. However there was variable awareness and utilisation across Sentinel Sites, partly due to delay in distribution, and little evidence of use and uptake of the CHAP or Live Longer! website, including in those sites with targeted grant funding for local community campaigns. Data highlights that more practical hands-on training on how to use the resources is required. The extent to which the range of resources was meeting local needs was unclear, largely due to continuing lack of information and systems for monitoring use and evaluating effectiveness of health promotion resources in enhancing the quality of local and regional program delivery. There was high demand across sites for operational funds for local community health promotion campaigns. Many local teams placed more priority on using existing resources effectively than developing new resources. Supporting grassroots community development and enhancing synergies with other complementary programs is likely to encourage community participation and development of local resources.
Aboriginal and Torres Strait Islander people who have had contact with the ICDP have a better knowledge and understanding of the impact of preventable chronic disease risk factors on their wellbeing.	There were pre-existing high levels of awareness of the key messages of chronic disease risk factors and the importance of healthy lifestyles, but little evidence of increasing awareness of the importance of accessing primary health care in the prevention and management of chronic disease. In the final evaluation cycle clinicians indicated increased interest from people seeking support to quit smoking. Data highlights that efforts to quit were constrained by individual motivation and broader structural barriers, indicating need for a broad social determinants approach that reduces structural barriers and enhances self-efficacy.
Aboriginal and Torres Strait Islander people who have had contact with the ICDP are more aware of and utilise (according to their need) the expanded range of health services and supports available to them to adopt healthy lifestyle choices and reduce smoking.	Community awareness of the Regional Tackling Smoking and Healthy Lifestyle teams has increased over the evaluation, in some sites more than others. GP awareness of the Regional Tackling Smoking and Health Lifestyle workers was generally low. However, there was a high level of awareness of availability of NRT amongst community members and clinicians, and PBS Co-payment data shows an overall general upward trend in NRT prescriptions. A range of local level activities has been supported and delivered including brief interventions, support for access to Quitline, provision of information on NRT, social marketing and health education and skill development. A general perception was that locally relevant counselling services need to be enhanced, particularly where phone support has not been meeting needs.

	Summary of key findings from SSE
Aboriginal and Torres Strait Islander people who have had contact with the ICDP make positive decisions about their health and lifestyle.	Decisions about health and lifestyle cannot be assessed at this stage of implementation and there is a lack of established systems to monitor decision making. SSE evidence indicates a continuing lack of clear evidence based strategic planning, monitoring and evaluation of health promotion strategies at the local Health Service or regional level. The potential of health service clinical information systems to provide meaningful data on smoking status and trends is constrained by the patchy state of development of clinical information systems, lack of staff capability to use data for population health purposes, and lack of systems to provide data at a regional level.
Chronic disease management and follow-up care	
ICDP funded health system supports, incentives and subsidies are operating to facilitate the provision of quality primary health care for Aboriginal and Torres Strait Islander people with chronic disease.	There is evidence from the SSE that ICDP funded positions and other aspects of the ICDP are improving access to primary health care, specifically including facilitating access to medications and to more culturally appropriate care in General Practice and specialist and allied health services. There is some evidence that efforts to increase uptake of adult health assessment may be encouraging access to primary health care. The evidence on improvements in other aspects of quality of care is more limited. While health assessments may in some instances be contributing to improved quality of care through a structured and comprehensive assessment that results in earlier diagnosis of chronic conditions or identification and raising awareness of risk factors, it is not clear that increased uptake of health assessments is necessarily or generally associated with improved quality of care. This is partly because the way that health assessments are being conducted in some locations appears more oriented to income generation for Health Services through Medicare than to provision of high quality care, and partly because the design and implementation of the health assessments may not be consistent with established models of comprehensive primary health care and existing practice approaches. There is limited or no evidence that the PIP Indigenous Health Incentive registration process, or the PIP Indigenous Health Incentive related payments, is resulting in improved quality of care. To the extent that there have been improvements in recording of Aboriginal or Torres Strait Islander identity, this appears to have been driven largely by the perceived benefits of the PBS Co-payment, with little evidence of impact of the PIP Indigenous Health Incentive registration process. While there is some evidence of new income through PIP Indigenous Health Incentive related payments contributing to improved infrastructure, staffing and systems, the evidence is opaque and is limited to a relatively small number of services with relatively high capacity and that were already performing at relatively high levels. There is little or no evidence that PIP Indigenous Health Incentive related payments are providing any significant benefit to services that are providing care to large numbers of Aboriginal and Torres Strait Islander people, but that have inadequate capacity, and inadequately developed systems to enable them to access the funding that is channelled through the PIP Indigenous Health Incentive.

	Summary of key findings from SSE
Financial and other barriers to accessing health care and medicines are reduced.	The PBS Co-payment measure has clearly been very significant in reducing financial barriers to medicines, and this has had more general flow on effects to encouraging patients to attend for care. There continue to be financial barriers to access to care through limited availability and ability for patients to identify services that will bulk-bill. This is the case for General Practice in many locations, but also specifically and importantly for allied health services and specialist care. There is evidence in some locations of reduced financial barriers to some specialist services, but this is variable and appears to be dependent on attitudes and practices of individual specialists and their willingness and adaptability in providing care in a way that meets the needs of local Aboriginal and Torres Strait Islander people. This variability and its associated opacity has been a deterrent to patients accessing specialist and allied health professional services.
Health services funded under the ICDP demonstrate cultural awareness and commitment	There is evidence that the ICDP has contributed significantly to increasing cultural awareness amongst staff of General Practices and DGPs/Medicare Locals that have an interest and commitment to providing good quality care for Aboriginal and Torres Strait Islander people. However, it is clear that not all services that are benefiting from ICDP related funding are demonstrating cultural awareness and commitment, and this is particularly the case where engagement with the ICDP is driven primarily by financial or business interests ahead of professional motivation consistent with the general CtG agenda.
Care coordination within ICDP funded services is improved for Aboriginal and Torres Strait Islander people with or at risk of chronic disease.	There is limited evidence of improvement in care coordination, with relatively few care coordination positions being funded in relation to population need, and challenges with establishment of models that consistently reach patients who are most likely to benefit from assistance with care coordination and which achieve effective integration into the General Practice sector.

	Summary of key findings from SSE
Aboriginal and Torres Strait Islander people with chronic disease or associated risk factors have more services and supports available to help them manage their condition.	There is emerging evidence that Aboriginal and Torres Strait Islander people with chronic disease or associated risk factors are benefiting through increased availability of services to help them manage their conditions as a result of the ICDP. Specific examples include: more available community based health promotion activities and support; increased availability of NRT therapy to support smoking cessation; removal of cost barriers to medicines; more access to General Practice and to specialist and allied health professional services, less transport barriers to access services; increased resources to support General Practice to provide culturally appropriate care; more access to direct support provided by ICDP workforce. Issues for attention/challenges include: ways to meet high demand for community based health promotion strategies that tackle broad social determinants including structural barriers to reducing chronic disease risk factors, and ways to monitor quality of strategy delivery and resources; continuing fragmentation of services – further attention could be paid to integration of patient services, particularly across sectors; strengthening of clinical information and service systems to support this integration; local/service systems for identification of individual patients who have most potential to benefit from chronic disease services and support; system responses to facilitate increased allocation of resources to those communities and patients with relatively higher service delivery needs and to services with limited current capacity to meet demands – this highlights the need for greater attention to developing information and service systems to accurately monitor needs and quality of services.
The number of Aboriginal and Torres Strait Islander people with or at risk of chronic disease who access primary health care services is increased.	The data available through the SSE does not provide clear evidence on this indicator. While there was quantitative evidence of increasing numbers of people registering for the PIP Indigenous Health Incentive, having health assessments that are billed through Medicare, and who are having PBS Co-payment prescriptions filled, the extent to which these data reflect any increase in access to primary health care is uncertain. Data indicates increasing involvement by General Practices in registration for the PIP Indigenous Health Incentive, and triggering of Tier 1 payments by General Practices. There was qualitative evidence from a variety of sources that indicates an increase in access related to a range of ICDP-related activities, including removal of cost barriers to medicines, removal of transport barriers to attend services, improved cultural safety in General Practices, support and assistance provided by OWs, IHPOs, and Regional Tobacco Action and Healthy Lifestyle teams, encouragement and incentives for Aboriginal and Torres Strait Islander people to have health assessments, arrangements for improved access to specialist and allied health services, more community programs/ resources to support healthy lifestyle choices and health seeking behaviours.
Aboriginal and Torres Strait Islander people in contact with ICDP measures value the enhanced services.	There is emerging evidence that Aboriginal and Torres Strait Islander people who have contact with ICDP related services appreciate the enhanced level of care associated with the ICDP measures. Specific examples include positive feedback from community focus groups regarding improved access to medicines through PBS Co-payment measure, improved access to Health Services through OW support (including transport), more specialist services available through AHSs (e.g. podiatrists), reduced wait times and cost of specialist and allied health professional services through the USOAP, MSOAP-ICD and CCSS measures, access to health promotion activities (e.g., exercise classes, fresh food hampers, diabetes education).

	Summary of key findings from SSE
The number of Aboriginal and Torres Strait Islander people with or at risk of chronic disease who access specialist and multi-disciplinary follow-up care is increased.	There are significant limitations in the extent to which available administrative or program data can be used to assess changes in access to specialist or multi-disciplinary follow-up care. Specifically, the administrative data on follow-up by nurses or Aboriginal Health Workers, or by allied health professionals, shows limited or no evidence of increased access to follow-up care in Sentinel Sites, but it is clear that the lack of evidence on this question from these data does not necessarily mean there has been no improvement in follow-up care. There was qualitative evidence from different sources in a number of sites that indicates an increase in access to specialist and allied health services as a result of ICDP related activity, but the evidence on the extent of improvement varies substantially between sites and types of services. There is substantial work to be done in both enhancing systems to provide access to appropriate care in a way that fits with local needs and service delivery systems, and in development of systems to effectively monitor access and quality of such care.
Workforce Expansion and Support	
Health care providers demonstrate increased knowledge and improved practice in relation to the prevention, early identification and management of chronic disease for Aboriginal and Torres Strait Islander people.	The data available through the SSE does not provide clear evidence on this indicator, mainly because the evaluation did not measure increased professional knowledge, and it was difficult to determine whether identified examples of good practice had improved as a direct result of the ICDP. Examples of improved practice in chronic disease prevention, detection and management in some Sentinel Sites that <i>may</i> be attributed to the ICDP were increased recognition by some providers of the need to take a population health approach; efforts to improve systems for identification of Aboriginal and Torres Strait Islander patients; improved practice in relation to timely review of GPMPs/TCAs through dedicated resources provided through ICDP incentives payments; improved cultural safety in many General Practices.
The ICDP workforce is retained and developed within funded services.	Retention of ICDP workforce has generally been good, with difficulties with retaining staff experienced in relatively few sites and organisations, and limited evidence that recruitment to new positions was impacting negatively on existing positions in the health sector.

17.3.2. KEY FINDINGS

This section synthesises the key findings of the SSE in relation to implementation of the overall ICDP at site level.

The ICDP as a system-level intervention

A systems approach was implicit in the design of this complex program, particularly in its framing as a ‘package’ of measures. Our approach viewed the package from a systems thinking perspective, seeking to analyse the multiple relationships and interactions among the measures and the way they affect and interact with each other to become a package of measures to enhance and provide a quality chronic disease prevention and care.

Overall, we found that while the ICDP is (appropriately) framed as a ‘package’, there appears to be a relative lack of emphasis on supporting the development and implementation of the measures to ensure the measures function in a complementary way. This was evident at DoHA level with apparent lack of well functioning structures to support complementary development and implementation across DoHA Divisions. Lack of appropriate emphasis on complementary development and implementation of measures was also evident in relation to State funded CtG initiatives.

The lack of complementary development and implementation at these high levels then flows through to regional levels where there are a variety of fundholder arrangements for different measures, and to local site level for organisations that are involved in the coordination and delivery of primary care services. This is reflected partly in lack of clear structures and processes to encourage engagement of ICDP related workers across measures (conferences, training and networking opportunities), although there was evidence in some sites where local or regional organisations have taken the initiative in promoting such engagement. There was a patchy and generally limited understanding amongst key stakeholders at the local level of the scope or the complementary nature of the ICDP measures. This was further complicated by variable levels of engagement and cooperation between the General Practice and the AHS sectors at the local and regional level.

Complimentarily development and implementation of measures was most evident at the site and service levels, where Health Services interpreted and adapted measure implementation to suit local service delivery structures and contexts.

There is a clear need for stronger emphasis at multiple levels of the system to ensure the measures work more effectively as a package.

Realist analysis of mechanisms, enablers and constraints for implementation of the overall ICDP at a site level

We have described the higher-level context-mechanism-outcome configurations that appear to be most relevant to achievement of the general aims of the ICDP. Understanding ‘what works for whom under what conditions’ for the ICDP overall is important in informing future policy directions and resource investment.

In terms of the mechanisms needed for effective implementation, we found that systems approaches were effective in developing and engaging the health workforce and in developing and optimising chronic disease service delivery systems. Best practice chronic disease care particularly emphasises

integration of patient services, therefore complementarity and coordination of programs, systems and services was, as expected, very important to quality service delivery (as perceived by community members and providers). Partnering and mobilisation within and across organisations to achieve common ICDP goals was required, and the fostering of complementary linkages between programs, activities and services. Engagement of primary health care organisations with ICDP measures and their utilisation within existing systems was required, as was orientation to Aboriginal community needs, openness to re-orienting service delivery approaches, and ability to create increased demand for services by Aboriginal and Torres Strait Islander people. The alignment of providers' core values with best practice in Aboriginal primary health care was another mechanism that supported effective ICDP implementation.

We found that the influences on constraints and enablers to activating the identified mechanisms were varied and were structural/systemic, administrative, relational, physical, individual/behavioural, socio-cultural and economic, with particular dimensions present in individual sites and circumstances. As indicated in the section 17.2 above, we found that local context greatly affected implementation of the ICDP as a whole, contexts were extremely varied across sites and Health Services, and specific local contexts were more significant influences on ICDP implementation than geographic location, although geographic location was associated with some contexts.

The wide variation highlighted the importance of well functioning systems within services and sites. The services and sites where ICDP policies and programs worked well were mostly those that were functioning in relation to chronic illness management and care prior to the ICDP, where there was capacity and readiness to optimise the additional resources available through the ICDP, and where measures could be integrated into existing well functioning service systems. Five of the seven mechanisms identified as necessary for effective implementation of the overall ICDP relate in a relatively direct way to the state of development, and capacity to utilise, systems thinking or service systems. Analysis of data relating to different measures consistently identified the difficulties posed by use of locum staff and high staff turnover – this is an ongoing reality within the contemporary Health Service environment, which further emphasises the need for well functioning, widely understood information systems with consistent approaches to training the workforce in the effective use of these systems. This issue is reinforced by the data on clinical indicators (see Appendix E), which shows the inconsistency of capacity of clinical information systems to extract consistent meaningful data for the purpose of monitoring and reporting purposes.

Some enablers that appeared to work across a number of mechanisms were clear information, guidelines, communication and processes about the ICDP; management and leadership commitment (e.g. to vision, implementation, appropriate workforce development); organisational stability; cultural competency and values (e.g. staff cultural competency, culturally appropriate services, structures and processes for community/patient participation and health literacy), commitment to best practice, professional experience and local knowledge.

Constraints that worked across several mechanisms (other than systems related constraints described above) were limited service capacity to engage; diverse and complex delivery contexts; workforce limitations and development issues (e.g. shortage of skilled workers, required skill sets, mentoring and training capacity); inability to make linkages (e.g. between services and community, staff, organisations, measures); inability to change (approaches, attitudes, procedures).

Current investment is heavily oriented to operate through Medicare funding channels. As raised above, many of the services most in need of development, and services providing care to the populations most in need of improved access to high quality care, are not able to benefit from funding that is dependent on having system and service capability to provide and bill for Medicare related items. This means that

the funding channelled through these incentives provides benefit to the most developed services, with relatively little benefit to those services or populations most in need of improved systems and access to quality care.

17.3.3. POLICY CONSIDERATIONS

This section identifies key policy considerations emerging from the SSE findings, in relation to the overall ICDP:

- a) Consider greater investment in shifting practice of existing workers. The skills of the health care workforce need to be expanded to meet the complexities of delivery of best practice chronic disease management and care¹⁹⁶. This need has important implications for training of the existing workforce, as well as the pre-qualification training of the future health workforce.
- b) Consider greater investment in enhancing capability of less developed services. Investment should be specifically designed to provide benefit to services and populations that are most in need of improved access to high quality care for prevention and management of chronic disease.
- c) Use new investment to complement ICDP related financial incentives through Medicare, rather than increase the financial incentives through this channel. This approach has greater potential to improve the quality of chronic disease care.
- d) Focus investment on promoting development of local service capability in providing high quality preventive and chronic illness care, including development of local service systems, and in development of hard and soft capabilities.¹⁹⁷
- e) Consider stronger and more strategic investment in development of clinical information systems within primary health care services in both AHSs and General Practices to support their effective application in chronic illness care and the ability of Health Service staff to use these systems to evaluate and improve the quality of chronic illness care. This needs to be done in a way that ensures these systems and the data that are generated by these systems are valued by the Health Service staff. Related to this investment is the need for monitoring and reporting to have greater focus on service and systems improvement. Development of clinical information systems will support implementation of a number of measures within the ICDP, specifically including any that require effective identification of any Aboriginal and Torres Strait Islander patients of primary health care services, as well as any Aboriginal and Torres Strait Islander patients who have a chronic illness or who have risk factors which predispose them to the development of chronic illness.
- f) Focus investment on a limited number of General Practices that have a strong orientation to providing care for Aboriginal and Torres Strait Islander people rather than spreading investment across all General Practices, many of which have few Aboriginal and Torres Strait Islander patients and relatively little interest or potential to improve quality of care for significant numbers of Aboriginal and Torres Strait Islander people.

¹⁹⁶ As identified by WHO 2005, in Preparing a health care workforce for the 21st century: the challenge of chronic conditions, WHO Geneva.

¹⁹⁷ Tsey K, McCalman J, Bainbridge R & Brown C 2012. Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.