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Sentinel Sites Evaluation

Interim Report

December 2011

Closing
the Gap.

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
AIH	Australian Institute for Health and Welfare
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
APCC	Australian Primary Care Collaborative
CC	Care Coordination
CCSS	Care Coordination & Supplementary Services
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CtG	Closing the Gap
DGP	Division of General Practice
DoHA	Department of Health and Ageing
FTE	Full-time Equivalent
GP	General Practitioner
GPMP	General Practitioner Management Plan
H4L	Healthy for Life
HLW	Healthy Lifestyle Workers
ICDP	Indigenous Chronic Disease Package
IHPO	Indigenous Health Project Officer
IUIH	Institute for Urban Indigenous Health
KAMSC	Kimberley Aboriginal Medical Services Council
KWHB	Katherine West Health Board Aboriginal Corporation
MSOAP-ICD	Medical Specialist Outreach Assistance Program—Indigenous Chronic Disease
NACCHO	National Aboriginal Community Controlled Health Organisation
NRT	Nicotine Replacement Therapy
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OH&S	Occupational Health and Safety
OW	Outreach Worker

PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
QAIHC	Queensland Aboriginal and Islander Health Council
QUMAX	Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People
RACGP	Royal Australian College of General Practitioner
RTC	Regional Tobacco Coordinator
SBO	State Based Organisation
SEIFA	Socio-Economic Index for Areas
SET	Sentinel Sites Evaluation Team
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 3

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 peoples.

- 'Aboriginal Health Sector' includes Aboriginal Health Services and NACCHO 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, nurse or Aboriginal Health Worker.

- 'General practice' refers to private General Practices.

- '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 ICDP 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 peoples' as used elsewhere in the report.

- 'National Framework' refers to the National Monitoring and Evaluation Framework which was developed to guide the ongoing monitoring and evaluation of the Indigenous Chronic Disease Package measures.

- 'Sentinel Site' refers to a geographically defined area which is the focus of 'place based' Sentinel Sites Evaluation activities.

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

Structure of the report

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

- The executive summary reflects the key messages emerging from the Sentinel Sites Evaluation to date.

- The main body of the report provides a comprehensive description of findings to date in relation to the key objectives of the Sentinel Sites Evaluation.

- The appendices contain more detailed information on the background, evaluation methods and analysis of the data presented in the main report.

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

1. Executive Summary

Implementation of the ICDP has progressed significantly since the previous reporting period, although a number of measures are still in early stages of implementation.

Tackling Smoking and Healthy Lifestyle: Recruitment to new positions funded under this priority area (Healthy Lifestyle Workers, Regional Tobacco Coordinators and Tobacco Action Workers) is becoming increasingly well established in the majority of sites. Recruitment and retention remains a particular challenge in remote sites. The deployment of the workers as teams was perceived to provide a positive support structure. There has been a diversity of services and programs emerging under this measure. There was limited awareness of the teams among DGP, General Practice staff, clinical staff and amongst community members. Stakeholders generally indicated that the positions have not been in place long enough and that teams were too thinly spread to expect an impact on smoking rates in the community. Consistent with the previous report, there was a high level of awareness among community members of health related behaviours. There is also evidence that an increasing proportion of clinicians believe there is increasing interest amongst Aboriginal and Torres Strait Islander clients to seek support to implement healthy lifestyle changes.

PBS Co-payment measure: There is a continuing high level of awareness of this measure among stakeholders, and positive perceptions of the information provided about the measure. The role of the Indigenous Health Project Officers (IHPOs) and Outreach Workers (OWs) in promoting the use of the measure has been positively regarded. There is an increasingly widely held perception that the PBS Co-payment has made medications more accessible, and that the improved access through removal of (or reduction in) cost is encouraging more regular attendance for health care, and is translating into improved adherence to prescribed medications. However, there is an emerging need for support for patients in medication management. Concerns continue to be expressed about the in-eligibility of non-Indigenous members of Aboriginal and Torres Strait Islander families, inability of hospital doctors to prescribe under the measure, lack of awareness of specialists of the measure, and ongoing concerns regarding the application of the 'at-risk' aspect of the eligibility criteria. Patients continue to report difficulty with identifying PIP registered practices and Health Service staff report difficulties with determining if non-regular clients are registered. There is an ongoing need for a system to allow staff to ascertain if clients are already registered for the PBS Co-payment. There continues to be evidence of a need to raise cultural awareness among some community pharmacists.

Higher utilisation costs for Medicare items: There continues to be an increase in claims for Medicare items for adult health assessments and follow-up items by Practice Nurses and Aboriginal Health Workers. Claims for follow-up items by Allied Health Professionals have shown a slower increasing trend. Numbers of claims for these items (particularly follow-up items) are low in relation to population numbers and known prevalence of chronic disease. There is room for significant increase in delivery of all three items. There has been an increase in the number of GP providers claiming adult health assessments. While the increase in absolute terms is small, the timing of the increase coincides with the introduction of the ICDP, and provides some evidence of impact of the ICDP.

PIP Indigenous Health Incentive: There is a continuing steady increase in General Practices registering for the PIP Indigenous Health Incentive, with substantial scope for further increases. In contrast, AHSs tended to sign on earlier and there has been a levelling off in the number of AHSs registering for the incentive during this reporting period, with relatively little scope for further increases. There is evidence that poorly developed clinical information systems are leading to the development of new stand-alone registers of PIP registered clients. There continues to appear to be a strong focus on registering clients, with relatively limited

emphasis on completing the requirements to claim Tier 1, and to a lesser extent Tier 2, payments. There were exceptionally low rates of Tier 1 payments being triggered nationally. While there is evidence of an increase in the understanding of requirements to receive the tiered payments, and clinicians report that the PIP Indigenous Health Incentive has enabled them to provide better care, there is little evidence of a shift to a more planned or coordinated approach to care in terms of uptake of GP Management Plans (GPMP) or Team Care Arrangements (TCA). The understanding of community members of what the PIP registration process is about continues to be very limited.

Care Coordination and Supplementary Services: Recruitment of the Care Coordinator positions has commenced in sites. There is evidence of efforts to ensure that the Care Coordination positions are complementing, and are coordinated with, positions with similar roles funded through other sources. Generally, the program roll-out is designed to accept referrals to Care Coordinators only from PIP Indigenous Health Incentive registered patients who are on a GPMP/TCA. In theory, this enables the Care Coordinator to be listed as a provider on the team care arrangement and to provide feedback to the GP through the TCA feedback process. In the one site where the service has been accepting referrals, the Care Coordinator was finding it difficult to ensure the referrals were being made with the relevant care planning documents and processes in place. The low rates of Tier 1 payments (which also require a GPMP or TCA) being made nationally[1] indicates that this experience in one site is likely to be experienced more widely as Care Coordination is implemented in other locations. The uptake of the Supplementary Services funding appears to have been limited, and there is ongoing uncertainty about how to use the funding (with particular concern regarding equitable allocation of funding for patients).

Increasing access to specialists and multidisciplinary team care: Recruitment for providers for the Urban Specialist Outreach Assistance Program (USOAP) and the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD) has progressed in the Sentinel Sites. A number of issues are emerging at this early stage of implementation, including concern about lack of coordination on the ground of outreach services and ongoing difficulties in ensuring patients turn up for scheduled appointments. An important limitation of the programs is the lack of support for follow-up investigations, procedures, aids or equipment, and continuing long waiting lists in public facilities and high costs in private facilities. There were also some concerns raised about barriers to referral by private General Practices. For USOAP, some stakeholders indicated that the focus should be on improving access to specialists in their usual facilities rather than getting specialists to see patients in primary care facilities.

Workforce Expansion and Support: Progress with recruitment of Outreach Workers (OW) in both the DGPs and AHSs, and of IHPOs based in the DGPs, is now well advanced. The OWs appear to be taking on diverse roles, depending on local needs. There are positive perceptions of the contributions being made by the IHPOs and the OWs, particularly in supporting improved access to primary care services, in raising awareness of the measures amongst providers and community members, and in contributing to improved identification of Aboriginal or Torres Strait Islander status among clients attending General Practices. There is some evidence that the intensity of the ICDP in terms of numbers of ICDP funded workers per population is related to the uptake of PIP registrations. The association is consistent with the important focus that the IHPOs and OWs have had on promoting uptake of PIP registrations through 2010. This evidence of impact of the ICDP workers is encouraging. In DGPs, there is emerging evidence that the new workers are becoming established as teams, and are also

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[1] DoHA reporting - In 2010, 31 000 patients were registered for the PIP Indigenous Health Incentive and of those, 1382 (4%) triggered a Tier 1 payment and 24 796 (80%) triggered a Tier 2 payment.

being integrated with existing teams within DGPs. The impact of the new workers appears to have been more marked where the establishment of teams has occurred. However, concerns were expressed in relation to uncertainty of the potential to extend positions beyond the current employment contracts, and this uncertainty is likely to impact on the effective functioning of these workers. In AHSs, some concern was expressed that the OWs were not well supported in their role, and the need for more effective support structures was highlighted by interviewees. Where OWs have had opportunities for peer support, it appears to have been beneficial. Strengthening of peer support arrangements is therefore a potential strategy for enhancing support for OWs.

Orientation for OWs was conducted in the majority of states and territories in the period covered by this report. The diversity of skills and experience of the recruited OWs, and the variation in timing of recruitment, continued to present challenges for the appropriate development and delivery of orientation packages. Overwhelmingly, the DGP sector viewed the orientation as inappropriate, because it was seen to be focused on work within the AHS sector. The issue of role diversity for the OWs is further complicated by the potential for the roles to change as other ICDP funded positions and programs become established and expectations change. There has not been strong uptake of the opportunities for individualised training. In this reporting period, an emerging issue was concern from some DGPs about commencing OWs on individualised training programs when, at this stage, contracts for the OWs employed in the DGPs end in June 2012.

Transition to Medicare Locals: There is significant concern within DGPs about how the transition to Medicare Locals will affect continuity of support for the ICDP and the employment of ICDP workers.

Integration across measures: There is some evidence of integration across measures, or collaboration of workers involved in different measures. However, it is evident that further strengthening of integration and collaboration across measures could bring significant additional benefits to the effective implementation of the ICDP in general.

Identification of Aboriginal and Torres Strait Islander patients with chronic disease in clinical information systems: Analysis of the clinical indicator data provided to the SSE team demonstrates the poor state of development of clinical information systems in many primary health care services. Underdeveloped clinical information systems place serious constraints on the effective implementation of a number of measures within the ICDP, specifically including any that require effective identification of Aboriginal and Torres Strait Islander clients of primary health care services, and those Aboriginal and Torres Strait Islander clients who have a chronic illness, or who have risk factors which predispose them to the development of chronic illness.

2. Introduction

The Sentinel Sites Evaluation (SSE) is one of a number of evaluations relevant to the Indigenous Chronic Disease Package (ICDP). The Department of Health and Ageing (DoHA) contracted Menzies School of Health Research to undertake a place based monitoring and formative evaluation of the ICDP through the SSE, in order to gather early observations on the progress of the ICDP implementation.

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, 3) expansion of the Aboriginal and Torres Strait Islander workforce and increased capacity of the health workforce to deliver effective care.[2]

The SSE has been designed to address the program logic (and associated evaluation questions) of the ICDP as described in the National Monitoring and Evaluation Framework (herein referred to as the 'National Framework').[3] This National Framework was developed by Urbis in a separate process to the SSE, through extensive consultation with key government and non-government stakeholders, and reflects the information that was available on the policy rationale and expected outcomes of the ICDP at the time of the development of the framework (early 2010).

This report provides a summary of the findings of the SSE up to December 2011.

Evaluation findings are presented in relation to each of the ICDP measures, and in relation to themes under each measure.

Our intention with this and subsequent reports is to make a constructive contribution to the effective implementation of the ICDP, with the aim of maximising the potential benefit for the Aboriginal and Torres Strait Islander peoples of Australia. We expect the information presented in this and other reports to be useful for early identification of problems and to guide refinement of further implementation (and evaluation) of the ICDP at national and local levels.

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[2] DoHA, For more information on the ICDP: Closing the Gap-Tackling Indigenous Chronic Disease [website], (accessed 1 November 2011).
[3] Urbis, ICDP Monitoring and Evaluation Framework [website], (accessed 11 February 2013).

3. Indigenous Chronic Disease Package

The ICDP 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 health outcomes.

Initiatives under the ICDP focus on improving the capacity of primary health care services to more effectively manage chronic disease among Aboriginal and Torres Strait Islander peoples. The initiatives are being delivered through a range of Aboriginal and non-Aboriginal Health Services, including Aboriginal Community Controlled Health Organisations, state and territory government Aboriginal specific Health Services, General Practices and other government and non-government organisations that provide primary health care to Aboriginal and Torres Strait Islander peoples.

The ICDP is made up of three priority areas, with a number of specific measures within each priority area (Table 1). It is being managed across seven divisions of the Department of Health and Ageing (DoHA), with the Office of Aboriginal and Torres Strait Islander Health (OATSIH) having a key role in overall coordination and governance.

Table 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	$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 [website], (accessed 11 February 2013)

4. Sentinel Sites Evaluation

The aim of the SSE is 'to provide place-based monitoring and formative evaluation of the ICDP'. The 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.

The SSE thus aims to provide early observations on the progress of the implementation of the ICDP. The broad scope of the ICDP, emphasis on providing regular six monthly reports on progress of implementation in selected sites and the primary focus on monitoring implementation at the local level, mean the SSE will not provide a comprehensive evaluation of the overall program.

The SSE has been implemented in three stages:

Stage 1: Eight sites were established in 2010. The first evaluation of developments in relation to the stage 1 sites was presented in the *Sentinel Sites Evaluation Interim Report: December 2010.*

Stage 2: Ten further sites were established by early 2011, bringing the total number of sites to eighteen. The first evaluation of developments in the eighteen stage 1 and stage 2 sites was presented in the *Sentinel Sites Evaluation Interim Report: June 2011.*

Stage 3: Six additional sites were established in the middle of 2011. This third evaluation report of ICDP implementation therefore covers a total of twenty-four stage 1 and 2 sites, for the period up to December 2011.

As for previous reports, the exact period covered for different types of data might differ as a result of when data were made available. These timeframes are specified in relation to each data type in Chapter 6 of this report.

This report is structured around the three priority areas in the ICDP. Based on data available within the timeframes for this report, we have used methods designed to address the program logics (and associated evaluation questions) and have analysed the state of implementation of the ICDP against these program logics for each of the individual measures and against the ICDP-wide program logic. We present the findings against each of the indicators identified in the National Framework that are relevant to the SSE, within the limitations of currently available data. We thus provide an assessment of the state of implementation of each measure, and for the ICDP overall, in relation to the extent to which the intended outcomes were achieved (relative to the state of implementation), as specified in the program logics (see Appendix A).

The information presented in this report builds on the information presented in the two previous reports and will be further developed in subsequent reports.

The large number of indicators in the National Framework, and the qualitative nature of many of these indicators, result in a lengthy document.

Ethical oversight

DoHA established an Ethics Advisory Group to provide advice on the ethical conduct of the ICDP evaluation, including the SSE. The Ethics Advisory Group reviewed key Sentinel Sites documents covering the evaluation processes and methods during September and October 2010, provided advice on the refinement of methods and project materials, and advised that they were satisfied the SSE methods comply with relevant ethical standards and legislative requirements.

Due to the lack of ongoing availability of some members of the Ethics Advisory Group, DoHA has been considering alternative options for the provision of ethical oversight of the evaluation. The DoHA has approached the chair of the DoHA ethics committee regarding the provision of ongoing oversight of the SSE.

The DoHA and the Menzies SSE team regard the provision of appropriate ethical oversight of the project as a priority issue, and are working together address this issue.

5. Sentinel Sites

The location of Sentinel Sites was decided by DoHA in consultation with the Aboriginal 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.

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:

- coverage areas of workers placed through the ICDP, to facilitate the program administrative data reported by these workers being comparable with data from other sources

- 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

ability to maintain a level of consistency between sites in terms of numbers of Aboriginal and Torres Strait Islander peoples resident in the site, and numbers of key service provider organisations (such as Divisions of General Practice and Aboriginal Health Services), while at the same time recognising the wide diversity of settings in which Aboriginal and Torres Strait Islander people live.

Establishment of the Sentinel Sites was dependent on the agreement of the key stakeholder organisations (the Aboriginal Health Service and the Division of General Practice) in each location to participate in the SSE.

Figure 1: Location of Sentinel Sites

Figure 1 shows the distribution of Sentinel Sites across each of the Australian states and territories and distribution across remote, regional and urban areas.

There are three types of Sentinel Sites: tracking, enhanced tracking and case study. The key difference between the three site types is the scope of data collection processes. Case study sites are involved in more intensive local data collection processes relative to tracking and enhanced tracking sites, in which only routinely collected data are analysed. The case study sites are depicted as the 'black dots' in Figure 1.

The number of Aboriginal and Torres Strait Islander people in each site ranges from less than 800 in one regional location to over 12 000 in an urban location, with the proportion of the total population being as high as 76% in one remote site and as low as 2% in one urban site.

The key stakeholder organisations in each site were identified through consultation with DoHA and generally include an Aboriginal Health Service (AHS) and a Division of General Practice (DGP). In one site there is no active involvement of a DGP, and in another site there are two AHSs. Two urban sites include two DGPs as key stakeholder organisations.

Sentinel Sites are not typical of Australia in general in terms of availability of primary health care services. The Sentinel Sites all have at least one Aboriginal Health Service, and selection was to some extent based on where ICDP investment was occurring relatively early and/or was more intense. The presence of an Aboriginal Health Service may influence patterns of utilisation of private General Practices.

The particular conditions in the Sentinel Sites have implications for interpretation of findings from the Sentinel Sites and the relevance of these findings to the rest of Australia.

Detailed site descriptions are available in Appendix B.

5.1. Brief site descriptions

See Table 2 and Appendix B for more information on the characteristics of the Sentinel Sites.

Remote sites:

Katherine West

The Katherine West site in the Northern Territory covers the region of Katherine West. The region extends south and west from outside the town of Katherine to the border of Western Australia. Katherine West is one of twenty-nine 'Remote Service Delivery Sites'.[4] The total population of the site is about 2800. Aboriginal and Torres Strait Islander people make up about 76% of the total population of the site.

The Katherine West Health Board Aboriginal Corporation (KWHB) is a community controlled organisation and is the only key stakeholder organisation in this site. The nearest Division of General Practice office is in Darwin, 300 kms to the north of Katherine. There are no private GPs in the Katherine West region. The DGP has a limited (if any) role in the Katherine West site, and for this reason is not involved as a key stakeholder organisation in the site. The Katherine West site will be included in the area covered by the single Northern Territory Medicare Local.

KWHB operates seven Health Services in remote communities and small towns within the region. Programs and services are managed from the Health Board office in the town of Katherine. Under existing service arrangements, Specialists Outreach NT provides specialists assistance for site residents. There is a regional hospital in Katherine and a tertiary level hospital in Darwin.

Pharmaceuticals are supplied through the special arrangements to supply Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services through Section

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[4] Australian Government, Remote Service Delivery [website], (accessed 11 February 2013).

100[5] of the *National Health Act 1953* (S100) in the KWHB region. KWHB receives funding under the Healthy for Life program.

The community of Lajamanu is the focus of community consultations and interviews with local Health Service staff. Lajamanu is approximately 500 kms from the town of Katherine. Community focus groups were held in Lajamanu in the previous evaluation cycle. No community focus groups were held in Katherine West during the current reporting period.

East Pilbara

The East Pilbara site is located within the Pilbara region of Western Australia. The site covers the SLA of East Pilbara, which extends north of the town of Newman to the coast and east to the border of the Northern Territory. The site includes the town of Newman and several remote Aboriginal communities. The total population of the site is about 6500. Aboriginal and Torres Strait Islander people make up about 22% of the total population of the site.

Both the AHS (Puntukurnu Aboriginal Medical Service) and the DGP (Pilbara Health Network) are key stakeholder organisations. The administrative office of the AHS is in the town of Newman, and the DGP office is in Karratha. The area covered by the Pilbara Health Network includes the towns of Karratha, Roebourne, Dampier and Port Hedland, and a total population of almost 50 000. The East Pilbara site will be included in the area covered by the Kimberley Pilbara Medicare Local.

Newman is almost 1200 kms north of Perth and lies on the Great Northern Highway. The town has a population of about 5000 people and is a mining service and tourism centre. While Karratha is one of the closest major service centres to Newman, it is about seven hours by road from Newman and lies well outside the site boundary.

The site includes a hospital and one private General Practice in Newman. This practice is part of a network of General Practices, mostly based in mining towns in WA. There are larger hospitals in Karratha and Port Hedland, and major referral hospitals in Perth.

The AHS provides services to the community of Jigalong and to three other clinics in the outlying communities of Parnngurr, Punmu and Kunawarritji. Jigalong lies about 165 kms east of Newman and has a population of approximately 300 people. The AHS staff includes a full-time GP, who resides in Jigalong and provides a visiting service to the outlying communities within an area of approximately 90 000 square kilometres. The AHS does not provide any clinical services in the town of Newman.

Pharmaceuticals are supplied under S100 arrangements in East Pilbara.

Community focus groups were held in Jigalong, and in Parnpajinya Community on the outskirts of Newman.

Derby

The Derby site is within the West Kimberly area of Western Australia and includes the town of Derby. The town has a population of approximately 3000 people and lies about two hours drive to the east of Broome. The site comprises one SLA which covers a large and sparsely populated region extending to the west of King Sound, east to Fitzroy Crossing, north to the coast and south beyond the Great Northern Highway. The total population of the site is about 6500. Aboriginal and Torres Strait Islander people make up about 62% of the total population of the site.

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[5] DoHA, Aboriginal Health Services - Section 100 - Frequently Asked Questions [website], (accessed 11 February 2013).

Both the AHS (Derby Aboriginal Health Service) and the DGP (Boab Health Services, formerly Kimberly Division of General Practice) are key stakeholder organisations. The DGP office is located in Broome, which is outside the site boundary. The area covered by the DGP has a population of over 30 000 people and extends from Broome to the Northern Territory border. In addition to Broome and Derby the DGP area includes the towns of Kununurra, Halls Creek and Wyndham. The new ICDP related positions based at the DGP are largely focused on the town of Broome, and the DGP plays a limited role in the Derby site.

The Derby site will be part of the area covered by the Kimberley Pilbara Medicare Local.

The AHS provides services to all town residents (Indigenous and non-Indigenous) and through outreach clinics in seven remote communities along the Gibb River Road. The hospital has a clinic that provides services to residents and tourists. This clinic has recently been granted a section 19(2) exemption that allows it to claim Medicare, despite being on hospital grounds. Derby is a base for the Royal Flying Doctor Service (RFDS). The RFDS work closely with the AHS and hospital. There are no other GPs in the site. In addition to the hospital in Derby, there is a hospital in Broome (outside the site boundary).

The AHS is a member of Kimberley Aboriginal Medical Services Council (KAMSC), which provides some additional support services. The AHS provides most of the specialist, outpatient and allied health clinics at the Health Service facility, and runs a transport service for clients.

Pharmaceuticals are supplied under S100 arrangements. The AHS receives Healthy for Life funding.[6]

Barkly

The Barkly site includes the town of Tennant Creek, located on the Stuart Highway approximately 500 kms north of Alice Springs and 1000 kms south of Darwin.

The site includes the SLA of Tennant Creek (which includes the town and immediate surrounds), as well as the Elliot District. The town of Tennant Creek has a population of about 3300 people and the town of Elliot has a population of several hundred people. Both towns are located on the Stuart highway (Elliot is about 250 kms north of Tennant Creek). These towns service the pastoral industry of the Barkly region. Aboriginal and Torres Strait Islander people make up about 53% of the total site population. The broader Barkly region covers a large area extending east to the Queensland border and to the west of the Stuart highway. The total population for the Barkly region is about 8000 people.

The key stakeholder organisations for the site include the DGP (General Practice Network NT, with the closest office based in Alice Springs) and the AHS (Anyinginyi Congress Aboriginal Corporation, located in Tennant Creek). The Barkly site will be included in the area covered by the single Northern Territory Medicare Local.

The AHS provides an outreach service to several communities in the region. A health facility at the Royal Flying Doctor Service in Tennant Creek also provides primary health care services to residents and visitors through a fly-in/ fly-out GP service, established several years ago to address the lack of a resident private GP.[7] There is a small public hospital in Tennant Creek, with the next closest hospitals being in Alice Springs and Darwin. Several communities in the region are served by NT government run health clinics (Elliott, Ali Curung, Canteen Creek and Epenarra).

The AHS receives Healthy for Life funding. Pharmaceuticals are supplied under S100 arrangements.

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[6] DoHA, Healthy for Life [website], (accessed 11 February 2013).
[7] Royal Flying Doctor Service, Tennant Creek General Practice [website], (accessed 11 February 2013).

Regional sites:

Tamworth

The Tamworth site lies in northern NSW, approximately 420 kms from Sydney and 280 kms inland from Port Macquarie. The site covers two SLAs which include the town and surrounding areas. Tamworth has a population of almost 50 000 and also services several thousand people living in the surrounding region. The total population of the site is approximately 54 000. Aboriginal and Torres Strait Islander people make up about 7.0% of the total population of the site.

Both the AHS (Tamworth Aboriginal Medical Service) and the DGP (North West Slopes Division of General Practice) are key stakeholder organisations and are located in Tamworth. The DGP covers a population of over 60 000 people. The Tamworth site will be part of the area covered by the New England Medicare Local.

There is a hospital located in Tamworth. The AHS is auspiced by the DGP and services a region within an approximate 70 kilometre radius of the town. In addition, the DGP is the managing entity for a not for profit Health Service with a large allied health workforce on site.

There are several private General Practices, however at the time of the evaluation visit Tamworth was classed as a district of GP workforce shortage[8] and most Health Services, including the AHS, have had their books closed to new clients for several years. The chronic shortage of GPs impacts on the availability of healthcare to the population of the area. The waiting period for appointments for existing patients is up to two weeks.[9]

The DGP manages a Healthy for Life program. The AHS participates in the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX[10]) program.

A funding agreement was executed in May 2011 with North West Slopes Division of General Practice for refurbishment of a property for use as a medical facility in Tamworth. The refurbishment has commenced.

The community focus groups were held in Tamworth.

Bairnsdale

The Bairnsdale site covers the East Gippsland SLA and is located within the East Gippsland region of Victoria. The SLA includes the town of Bairnsdale and several smaller towns. Bairnsdale has a population of about 12 000 people, and the total population of the SLA is approximately 25 000. Aboriginal and Torres Strait Islander people make up about 3.0% of the total population of the site.

The DGP (East Gippsland Primary Health Alliance, formerly the East Gippsland Division of General Practice) covers a larger area, which has a population of about 85 000 people and includes the towns of Sale to the west of Bairnsdale and Orbost to the east. The DGP office is in Bairnsdale. The Bairnsdale site will be included in the area covered by the Gippsland Medicare Local.

Both the AHS (Gippsland and East Gippsland Aboriginal Co-operative Ltd) and the DGP are key stakeholder organisations for the site.

There is one regional hospital and two private General Practices located in the site. A number of GPs from private General Practices also consult from the AHS. Bairnsdale was not

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[8] DoHA, Doctor Connect [website], (accessed 1 November 2011).
[9] DoHA, North West Slopes DGP Annual Report 2009-2010 [website], (accessed 11 February 2013).
[10] DoHA, QUMAX [website], (accessed 11 February 2013).

considered to be a District of Workplace Shortage for GPs at the time of the evaluation visit. However, focus group discussion indicated that waiting times for non-urgent GP appointments at private practices and the AHS vary from one to four weeks.

The AHS has QUMAX funding and is part of an established regional consortium for the state based Aboriginal Health Promotion and Chronic Care Partnership Initiative[11] and for Healthy for Life.

Community focus groups were held in Bairnsdale.

Port Augusta

The Port Augusta site straddles the head of the Spencer Gulf, about 320 kms north of Adelaide. The site comprises one SLA covering the town of Port Augusta, and includes a population of approximately 14 000 people. Aboriginal and Torres Strait Islander people make up about 17% of the total site population.

Whyalla, the third largest city in South Australia (after Adelaide and Mount Gambier) with a population of over 20 000 lies about 75 kms to the south west.

The key stakeholder organisations are an AHS (Pika Wiya Health Service Aboriginal Corporation) and the DGP (Flinders and Far North Division of General Practice), both based in the town of Port Augusta. The DGP covers a large area extending to the north with a total population of about 30 000 people. The Port Augusta site will be covered by the Country North SA Medicare local.

The AHS recently transitioned from being a state managed service to a community controlled Health Service. The AHS runs four clinics located in Port Augusta, Davenport, Copley and Nepabunna. The site is also serviced by private General Practices. A high proportion of international medical graduates are placed in Port Augusta[12], and there is a history of partnerships between the AHS and the DGP for program delivery.[13] The town hospital has an existing visiting specialist service.

The AHS participates in the Healthy for Life Program and QUMAX.

Community focus groups were held in Port Augusta.

Cairns

The Cairns site covers the area between the Kuranda State Forest and the coast, from the sugar town of Gordonvale (population about 5000, and about 23 kms to the south of the city of Cairns) to the beach resort of Palm Cove (25 kms to the north of Cairns). The city of Cairns has a population of over 100 000. The site area covers one Statistical Subdivision comprising seven SLAs. The total population of the site is approximately 120 000. Aboriginal and Torres Strait Islander people make up about 8% of the total site population.

The key site stakeholder organisations are the AHS (Wuchopperen Health Service Limited) and the DGP (Far North Queensland Rural Division of General Practice), both based in Cairns. The Cairns site will be part of the area covered by the Far North Queensland Medicare Local.

Within Cairns there are a number of large primary health care services, including a GP super clinic, a twenty-four hour medical centre and private General Practices. Some of these services provide allied health care services as well as primary medical care. There are three hospitals located within the site, including Cairns Base Hospital, which is an important referral centre for

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[11] Aboriginal Health Promotion and Chronic Care [website], (accessed 1 November 2011).

[12] DoHA, Flinders and Far North Division of General Practice Annual Report 2009-2010 [website], (accessed 12 February 2013).

[13] Flinders and Far North Division of General Practice [website], (accessed 1 November 2011).

North Queensland. While the AHS has its main premises in the site it also operates a clinic outside the Sentinel Site, at Atherton.

The AHS participates in the Healthy for Life Program and QUMAX.

Dubbo

The Dubbo site includes the city of Dubbo, the town of Wellington, and the surrounding rural areas. The town of Dubbo lies 400 kms to the north west of Sydney and is a major road and rail freight hub. The city has a population of about 40 000 and services a larger region with a population of about 130 000. Wellington (population approximately 5000) is about 40 kms to the southeast of Dubbo. The site covers three SLAs. The total population of the site is approximately 46 000. Aboriginal and Torres Strait Islander people make up about 11% of the total site population.

Two AHSs (Thubbo Aboriginal Medical Co-operative Ltd & Wellington Aboriginal Corporation Health Service), and the DGP (Dubbo Plains Division of General Practice) are located in the site. These three organisations are the key stakeholder organisations. The Dubbo site will be covered by the Western NSW Medicare Local.

In addition to the two AHSs, an 'Indigenous owned not for profit community managed organisation' [a General Practice] delivers care targeting Aboriginal and Torres Strait Islander clients.

Until recently, Dubbo was classed as a district of GP workforce shortage. Wellington is currently a district of workforce shortage.[14] There are two hospitals within the site. One is the major hospital for the region.

Both AHSs participate in the Healthy for Life Program and QUMAX.

Swan Hill/Mildura

The Swan Hill/Mildura site includes the cities of Mildura (approximate population 30 000) and Swan Hill (approximate population 10 000) and the town of Robinvale (approximate population 2200). Mildura is a regional city and a major agricultural centre that services northwest Victoria and small towns and communities across the Murray River in NSW. The site covers five SLAs in the northwest corner of Victoria, including a large rural area between the Murray River and the South Australian border. The total population of the site is about 70 000. Aboriginal and Torres Strait Islander people make up about 3.2% of the total site population.

There are three AHSs and one DGP in the site. Two of the AHSs (Swan Hill Aboriginal Health Service & Mildura Aboriginal Corporation Inc) and the DGP (Mallee Division of General Practice), are key stakeholder organisations.

The three AHSs and three hospitals primarily service the three main cities/towns and surrounding communities. One of the AHSs is situated with the Aboriginal Corporation, which has an auspice role with one of the other AHSs. In addition to servicing people in northwest Victoria, the AHS in Mildura and other Health Services provide care to NSW residents from across the Murray River.

The DGP is located in Mildura. The area currently covered by the DGP will be part of the area covered by the Lower Murray Medicare Local, which will include the northwest corner of Victoria and the southwest corner of NSW. Part of the site area (including the town of Swan Hill) will be covered by the Loddon-Mallee-Murray Medicare Local.

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[14] DoHA, Doctor Connect [website], (accessed 16 November 2011).

There are a number of private General Practices. Privately operated GP super clinics have opened within the last year in Swan Hill and Mildura. An e-health network, "Argus", connects GPs, the DGP, AHS, hospital and community Health Services in Mildura.

Each AHS participates in the Healthy for Life Program (under a consortium) and two AHSs participate in the QUMAX program.

Geraldton

The Geraldton site includes the city of Geraldton, and covers one SLA. Geraldton is located about 420 kms north of Perth in the Mid West region of Western Australia. The city is an important centre for mining, fishing, agriculture and tourism. The estimated population of the city is almost 40 000. However, the population of the Geraldton SLA is about 20 000. Aboriginal and Torres Strait Islander people make up about 10% of the total population of the site.

The AHS (Geraldton Regional Aboriginal Medical Service), and the DGP (Midwest General Practice Network) are key stakeholder organisations, and both are located in the city of Geraldton. The Geraldton site will be covered by the Goldfields Midwest Medicare Local. This Medicare Local will cover a vast area of WA, extending from the west coast to the NT and South Australian borders, north to the Pilbara and south to the south coast of WA, but will exclude the southwest corner of WA.

Based within the site are one AHS and a large private General Practice that provides after hours care. There are two hospitals within the site.

The AHS participates in both the Healthy for Life Program and QUMAX.

Darwin

The Darwin site includes the city of Darwin, covering the Darwin Statistical Sub-Division. The Statistical Sub-Division has an estimated population almost 70 000 and includes 30 SLAs. The site does not include the city of Palmerston (which lies about 20 kms to the south of Darwin city centre) or any of the rural area surrounding Darwin. The greater Darwin area (including the areas referred to above) has a population of over 100 000. Aboriginal and Torres Strait Islander people make up about 9.4% of the total population of the site.

The AHS (Danila Dilba Health Service) is located within the site, while the DGP (General Practice Network NT) has an office in both Darwin and Alice Springs and leads and coordinates a Territory-wide Primary Health Care Network. Both the AHS and the DGP are the key stakeholder organisations in the site. The Darwin site will be included in the area covered by the single Northern Territory Medicare Local.

In addition to the AHS, there are numerous private General Practices, and one public and one private hospital located within the site. There is also a Community Health Centre which services an Aboriginal community located on Aboriginal land within the bounds of Darwin city. This community has a resident population of about 400 people. There is a GP super clinic in the city of Palmerston. The AHS based in Darwin runs a 'family clinic' in Palmerston, in addition to outreach services within the site boundary. As Darwin is the major centre for remote and rural communities across the Top End, health care services provide for many Aboriginal and Torres Strait Islander people who reside outside the site boundary, and for people visiting Darwin.

The AHS participates in both the Healthy for Life program and QUMAX.

Hobart

The Hobart site covers a large part of Greater Hobart, including a population of about 190 000 people. The site incorporates seven SLAs. Aboriginal and Torres Strait Islander people make up about 2.9% of the total population of the site.

Both the AHS (Tasmanian Aboriginal Centre Inc) and the DGP (General Practice South) are key stakeholder organisations. The area covered by the DGP falls within the area that will be covered by the single Tasmanian Medicare Local.

The AHS is co-located with the NACCHO affiliate office. There are numerous private General Practices and a new GP super clinic recently opened within the site. Three hospitals, including a major public hospital, are located in the site.

The AHS participates in both the Healthy for Life program and QUMAX.

Grafton

The Grafton site is located on the Mid North Coast of New South Wales, over 600 kms north of Sydney and about 340 kms south of Brisbane. The site covers the city of Grafton and the surrounding rural area, including a total population of about 23 000 people. The city has an estimated population of approximately 18 000 people. The site is defined geographically by the Grafton SLA of Clarence Valley. Aboriginal and Torres Strait Islander people make up about 5.4% of the total population of the site.

Both the AHS (Bulgarr Ngaru Medical Aboriginal Corporation) and the DGP (Mid North Coast Division of General Practice) are key stakeholder organisations. The area covered by the DGP includes a population of about 140 000 people, and includes Coffs Harbour. The DGP falls within the area that will be covered by the North Coast NSW Medicare Local.

There is one AHS, a GP super clinic and about five other General Practices within the Grafton site. A regional hospital is located in the site.

The AHS participates in the QUMAX program and is part of a Healthy for Life consortium with other Aboriginal Medical Services located on the north coast of NSW.

A funding agreement was executed in mid 2011 with Bulgarr Ngaru Aboriginal Corporation for a health administration facility at Grafton, as part of the ICDP capital works funding.

Gladstone

The Gladstone site in Queensland covers the city of Gladstone and the surrounding rural area, including a population of about 45 000 people. The site covers three SLAs. The city of Gladstone has a population of almost 30 000 people and lies approximately 550 kms north of Brisbane and 100 kms southeast of Rockhampton. The city is a major port and agricultural and mining service centre. Aboriginal and Torres Strait Islander people make up about 3.2% of the total site population.

The AHS (Nhulundu Wooribah Health Organisation) and the DGP (Capricornia Division of General Practice) are key stakeholder organisations.

Within the site there is one AHS and a number of private General Practices. There is a GP super clinic and a public hospital in Gladstone.

The DGP office is based in Rockhampton (outside of the site boundary). The DGP covers a population of about 160 000 people, and includes the cities of Gladstone and Rockhampton, a number of smaller centres and a large rural area. The area covered by the DGP will be included in the Central Queensland Medicare Local.

The AHS participates in the QUMAX program.

Kalgoorlie

The Kalgoorlie site in Western Australia includes the city of Kalgoorlie and a large remote area extending from Kalgoorlie to the South Australian border. The site is defined by the two SLAs

of Kalgoorlie/Boulder Part A and Part B. The city has a population of about 28 000 people (approximately 99% of the total site population), and lies about 600 kms east of Perth and about 400 kms north of Esperance (population about 10 000). Kalgoorlie is a major mining centre. Aboriginal and Torres Strait Islander people make up approximately 7.5% of the total population of the site. The neighbouring SLA to the west includes the town of Coolgardie (population <1000) and has a total population of about 4000 people who may access services in Kalgoorlie.

The DGP (Goldfields Esperance General Practice Network) and the AHS (Bega Garnbirringu Health Services Aboriginal Corporation) are key stakeholder organisations and are located within the site boundary. The DGP covers a vast area of WA, extending from the coast in the south (including the town of Esperance) to north of Kalgoorlie and east to the WA/NT and WA/SA borders. The area covered by the DGP will be part of the Goldfields Midwest Medicare Local.

In addition to the AHS, there are a number of private General Practices and a regional hospital within the site. The AHS provides outreach services to remote communities.

The AHS participates in the Healthy for Life program.

Urban sites:

Brisbane South

The Brisbane South site covers a large area of metropolitan Brisbane to the south and west of the city centre, and includes a total population of about 300 000 people living in forty-five SLAs and one state suburb. Aboriginal and Torres Strait Islander people make up about 1.6% of the total population of the site.

The DGP (Brisbane South Division of General Practice) and the AHS (Inala Indigenous Health Service) are key stakeholder organisations and are located within the Brisbane South site. The site spans the boundary between the Metro South and West-Moreton Oxley Medicare Locals.

The AHS is a major health service provider to Aboriginal and Torres Strait Islander people within the site. There are also many private General Practices. The Institute for Urban Indigenous Health (IUIH) has a service support, development and coordination role across south east Queensland. There are a number of ICDP positions allocated to the IUIH, whose area of responsibility includes the region within which the Brisbane South site is located. A care coordination service is provided through state funding. There are four hospitals within the site, one of which is a public hospital. Two private hospitals and one public hospital are within close proximity but outside the site boundary.

The AHS participates in the Healthy for Life program.

Community focus groups were held in the suburb of Inala.

Campbelltown

The Campbelltown site lies in South Western Sydney, approximately 50 kms southwest of the Sydney central business district. The site covers two SLAs with a total population of about 145 000, of whom 2.7% are Aboriginal or Torres Strait Islander.

The DGP (Sydney South West GP Link Ltd, formerly known as MacArthur Division of General Practices Ltd), and the AHS (Tharawal Aboriginal Corporation) are key stakeholder organisations and both are located in the city of Campbelltown. The site will be covered by the South Western Sydney Medicare Local.

There is one AHS and a number of private General Practices located within the site. A non government organisation just outside the site boundary provides a brokerage service that can be utilised by Aboriginal and Torres Strait Islander patients from within the site[15]. The DGP employs a large team of dieticians and exercise physiologists. A large care coordination team, funded through NSW Health[16], is based at the DGP. There are two hospitals within the site.

The AHS participates in the QUMAX program.

Community focus groups were held in Campbelltown.

Newcastle

The Newcastle site covers the urban areas and the inner regional areas of greater Newcastle. The site encompasses one Statistical Subdivision, comprising nine SLAs, with a total population of about 500 000 people. The city itself is situated about 160 kms north of Sydney and has a population of almost 300 000 people. Aboriginal and Torres Strait Islander people make up about 2.5% of the site population.

The DGP (GP Access, previously known as the Hunter Urban DGP) and the AHS (Awabakal Newcastle Aboriginal Cooperative Ltd) are located within the site boundary and are key stakeholder organisations. Part of the site (the SLA of Cessnock, with a population of about 50 000, 3.6% Aboriginal or Torres Strait Islander) lies within the boundaries of a neighbouring DGP, the Hunter Rural DGP. This area will be covered by the Hunter Rural Medicare Local, while the majority of the site will be covered by the Hunter Urban Medicare Local.

In addition to the AHS, there is a GP super clinic and a number of private General Practices within the site boundary. There are nine hospitals within the site.

The AHS is participating in the QUMAX program.

Elizabeth

The Elizabeth site comprises a suburb of northern Adelaide of the same name. The site covers eight SLAs with a total population of about 126 000, 2.2% of whom are Aboriginal or Torres Strait Islanders. Adelaide itself is a city of 1.2 million people, with about 1.2% being Aboriginal or Torres Strait Islanders.

Both the DGP (Adelaide Northern Division of General Practice) and the AHS (Nunkuwarrin Yunti of South Australia Inc) are key stakeholder organisations.

The AHS in the Elizabeth site is a satellite clinic of a large AHS in Adelaide. There are also numerous private General Practices, a GP super clinic and two hospitals within the site. In close proximity, but outside the site boundary, is a government Health Service that offers a range of clinical, allied, specialist and community services used by many site residents. This hospital-based health service is located in Gawler.

The AHS participates in both the Healthy for Life and QUMAX programs.

Logan/Woodridge

The Logan/Woodridge site covers the outer suburbs to the south of the city of Brisbane (and is adjacent to, and south of, the Brisbane South site). The site covers 17 SLAs with a total population of about 175 000. Aboriginal and Torres Strait Islander people make up about 2.5% of the total site population.

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[15] Marumali [website], (accessed 11 February 2013).
[16] NSW Health, Chronic Disease Management Program [website], (accessed 11 February 2013).

The key stakeholder organisations include a DGP (South East Primary Health Care Network), an AHS (Aboriginal & Torres Strait Islander Community Health Service), and the Institute for Urban Indigenous Health. The AHS is based close to the Brisbane CBD and outside the site boundary, but has operated a health centre in the Logan area for some years. It has recently expanded its services with the opening of a new facility within the site. There are a number of private General Practices and one public hospital within the site boundary.

The DGP is based within the site. The area covered by the DGP will become part of the Greater Metro South Brisbane Medicare Local.

The AHS participates in both the Healthy for Life and QUMAX programs.

Community focus groups were held in Woodridge.

North Lakes/Caboolture

The North Lakes/Caboolture site extends from the northern suburbs of Brisbane city into the rural area to the north, including the town of Caboolture. The town is approximately 44 kms north of Brisbane CBD and has a population of almost 50 000. The site covers 15 SLAs and has a total population of about 220 000, 2.2% of whom are Aboriginal or Torres Strait Islander.

Two DGPs (Moreton Bay General Practice Network and GP Partners) are involved as key stakeholder organisations, one located within the site boundary. The Institute for Urban Indigenous Health is also a key stakeholder organisation.

The area covered by this site will be covered by the Moreton Bay Branch Network (Metro North Brisbane) Medicare Local.

The Institute for Urban Indigenous Health recently set up an AHS clinic in the site. Prior to this there was no AHS. A GP super clinic is being established in the site. There are two public hospitals and two private hospitals within the site boundary.

Dandenong

The Dandenong site in Victoria is located south-east of Melbourne and covers 10 SLAs in the Dandenong, Frankston and Mornington Peninsula areas. The Greater City of Dandenong and the City of Frankston each have a population of about 130 000 people. These two major outer urban centres are between 30 and 40 kms from the Melbourne CBD. Part of the site is rural, but is an area of urban growth. The total population of the site is approximately 580 000, 0.5% of whom are Aboriginal or Torres Strait Islander.

Two DGPs (Dandenong and Casey General Practice Association & Peninsula GP Network) and one AHS (Dandenong and District Aboriginal Cooperative Ltd) are key stakeholder organisations for the site. The site will include the entire area of the Frankston-Mornington Peninsula Medicare Local and the western part of the South Eastern Melbourne Medicare Local.

The AHS is based in Dandenong and operates an outreach clinic in the north east of the Mornington Peninsula. There are four public hospitals, a GP super clinic, five private hospitals and many private General Practices within the site boundary.

The AHS participates in the QUMAX program.

Canberra

The Canberra site covers the Australian Capital Territory, including eight Statistical Sub-Divisions (one hundred and fourteen SLAs) and has a total population of about 320 000. Aboriginal and Torres Strait Islander people make up about 1.2% of the total site population. There are about 50 000 people within the Queanbeyan Statistical Sub Division which lies

adjacent to the ACT border, many of whom access services in the ACT. Aboriginal and Torres Strait Islander people make up about 2.3% of the total population of the Queanbeyan Statistical Sub-Divisions.

Both the DGP (ACT Division of General Practice) and the AHS (Winnunga Nimmityjah Aboriginal Health Service) are key stakeholder organisations and are located within the site. The DGP covers the whole of the ACT – this is the same area that will be covered by the ACT Medicare Local. Within the site are numerous private General Practices, a GP super clinic and four hospitals.

The AHS has been participating in the Healthy for Life program and QUMAX.

Table 2: Sentinel Site characteristics

Case Study Sites

Site	Stage	State	Rurality[a]	Aboriginal and Torres Strait Islander population	Total population	Proportion[b]	Workforce allocation per 10 000 people[c]	Key stakeholder organisations
Katherine West	1	NT	Remote	2126	2795	76.1%	9.4	AHS
Port Augusta	1	SA	Regional	2303	13 874	16.6%	2.7	AHS, DGP
Brisbane South	1	Qld	Urban	4768	302 382	1.6%	4.5	AHS, DGP
East Pilbara	2	WA	Remote	1429	6543	21.80%	5.3	AHS, DGP
Tamworth	2	NSW	Regional	3710	53 595	6.9%	2.2	AHS, DGP
Bairnsdale	2	Vic	Regional	764	25 368	3.0%	18.2	AHS, DGP
Campbelltown	2	NSW	Urban	3834	143 076	2.7%	5.9	AHS, DGP
Logan/ Woodridge	3	Qld	Urban	4376	173 269	2.5%	9.9	AHSx2, DGP

Enhanced Tracking Sites

Site	Stage	State	Rurality[a]	Aboriginal and Torres Strait Islander population	Total population	Proportion[b]	Workforce allocation per 10 000 people[c]	Key stakeholder organisations
Cairns	1	Qld	Regional	9558	122 234	7.8%	1.2	AHS, DGP
Newcastle	1	NSW	Urban	12 285	493 466	2.5%	2.9	AHS, DGP
Dubbo	1	NSW	Regional	5147	45 964	11.2%	2	AHS x 2, DGP
Derby	1	WA	Remote	4031	6507	61.9%	2.3	AHS, DGP
Swan Hill/Mildura	1	Vic	Regional	2238	70 452	3.2%	9.5	AHSx2, DGP
Elizabeth	2	SA	Urban	2777	126 717	2.2%	7.7	AHS, DGP
Barkly	3	NT	Remote	1770	3333	53.1%	0.9	AHS, DGP
Darwin	2	NT	Regional	6233	66 291	9.4%	6.4	AHS, DGP

Tracking Sites

Site	Stage	State	Rurality[a]	Aboriginal and Torres Strait Islander population	Total population	Proportion[b]	Workforce allocation per 10 000 people[c]	Key stakeholder organisations
Geraldton	2	WA	Regional	1836	18 916	9.7%	5.3	AHS, DGP
Hobart	2	Tas	Regional	5413	189 637	2.9%	3.2	AHS, DGP
Grafton	2	NSW	Regional	1238	22 812	5.4%	5.5	AHS, DGP
Gladstone	3	Qld	Regional	1481	45 626	3.2%	4.6	AHS, DGP
Kalgoorlie	3	WA	Regional	2135	28 423	7.5%	3.8	AHS, DGP
North Lakes/ Caboolture	3	Qld	Urban	4682	216 349	2.2%	2.7	AHS, DGPx2
Dandenong	3	Vic	Urban	2996	581 191	0.5%	11.7	AHS, DGPx2
Canberra	2	ACT	Urban	3847	323 326	1.2%	5.2	AHS, DGP

[a] See Appendix C for rurality classifications .

[b] Proportion of the total population who identify as Aboriginal and Torres Strait Islander.

[c] Data are based on the whole DGP as this is the coverage of the OW and IHPO workers based in the DGP. Workforce allocation/recruitment data are based on information provided by DoHA for OWs based in the AHS and IHPO and OW based in the DGP for reporting period 2 (these data are for a period up to 25 February 2011). Report 2 workforce data are used as these are more aligned with the period covered by the administration data [MBS, PBS and PIP] for this report.

Source: Australian Bureau of Statistics, Census, 2006.

6. Overview of Evaluation Methods

The SSE design is based on the National Framework developed to guide the ongoing monitoring and evaluation of the ICDP measures.[17] The data required to report on indicators relevant to the SSE are derived from five main sources: routine Medicare data; program administration data; stakeholder interviews; community focus groups, and; clinical indicators from primary health care information systems, quality improvement or other systems used to report on clinical indicators.

The key difference between the three types of Sentinel Sites (tracking, enhanced tracking and case study sites) is the intensity of the evaluation process. Figure 2 illustrates the different evaluation methods used for the different site types:
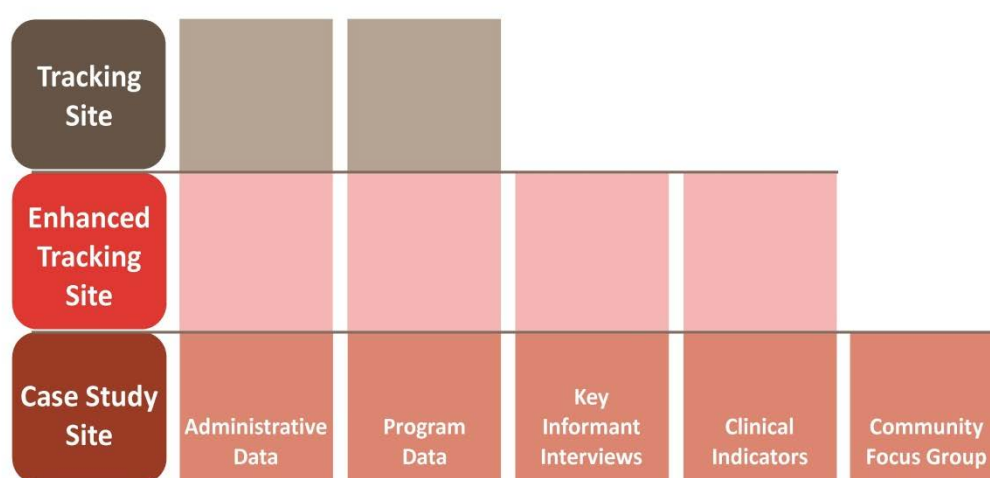
Figure 2: Sentinel Sites evaluation processes

For tracking sites, only administrative data and program data are collated, analysed and reported.

For enhanced tracking sites, administrative data and program data are enhanced by data collected through annual stakeholder interviews and group information sharing sessions. The purpose of interviews and information sharing sessions is to gain deeper understanding of the patterns being seen in the administrative data and additional depth of information about emerging themes. Health Services may also provide clinical indicator data.

For case study sites, interviews with key stakeholders at local and regional levels and community focus groups are conducted in addition to the data collection processes used for tracking and enhanced tracking sites. Data from case study sites provide more in–depth understanding of the implementation and impact of the ICDP at a local level, and complements the administrative and program data available from all sites.

Site specific feedback is provided to local stakeholder organisations involved in the SSE, consistent with Aboriginal and Torres Strait Islander research values and providing early opportunities for locally initiated systems improvements.

It should also be noted that a number of specific ICDP measures were still undergoing development, or were in preliminary stages of implementation, and would not have had an impact at a local level during the period covered by this report.

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[17] Urbis, ICDP Monitoring and Evaluation Framework, September 2010 [website], (accessed 11 February 2013).

As explained in the introduction, the limited number of Sentinel Sites across Australia and the stage of implementation of the evaluation provide early indication of emerging issues in ICDP implementation. For the purpose of developing appropriate responses, further investigation may be required to assess the scale and significance of identified issues.

Details about the SSE approach and methods are included in other documentation provided to DoHA during the process of developing and refining the evaluation methods and tools; specifically, the 'MBS, PBS, PIP data analysis technical paper'.

6.1. Administrative data

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 was 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 peoples.[18]

Pharmaceutical Benefit Scheme Co-payment measure

The Pharmaceutical Benefit Scheme (PBS) Co-payment measure was introduced on 1 July 2010. PBS administrative data are not presented in this report following a new process of data extraction being agreed upon with the Department and a reschedule of the data extraction. Future reports will cover this reporting timeframe.

The uptake of the PBS Co-payment measure is much lower in remote Sentinel Sites than other Sentinel Sites, and other urban and regional parts of Australia because the S100 supply arrangements (S100) operate in remote and very remote Australia, where the PBS Co-payment measure is generally less relevant. Remote area Aboriginal and Torres Strait Islander Health Services participating in the S100 can provide PBS medicines to their clients at no cost to the patient and without the need for a normal PBS script.

This would be expected to lead to an underestimate of the uptake of the PBS Co-payment in the rest of Australia. In the June 2012 SSE report both Sentinel Sites and the rest of Australia will be broken down by rurality in a comparable way. This will enable a more detailed analysis of trends that enables the presence of the S100 for access to medicines through remote area Aboriginal and Torres Strait Islander Health services to be taken into account.

Medicare Benefits Schedule data

A number of Medicare Benefits Schedule (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. In this report, MBS data are presented for the period March 2009 - May 2011. For the purposes of the SSE, March 2009 - February 2010 is defined as a 'baseline' period.

Practice Incentives Program Indigenous Health Incentive

The Practice Incentives Program (PIP) Indigenous Health Incentive was introduced in March 2010. In this report, data are presented for the period March 2010 - May 2011.

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

6.2. Program data

The program administrative data used for the SSE are 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 is 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.

For this SSE report, general implementation and site specific data were requested for all ICDP measures excluding B4 and C5.

In general, information on measure implementation was provided to SSE as at the 30 June 2011. However, specific updates were obtained from DoHA and through evaluation team interviews through to November 2011 (see specific measures for details). For example all ICDP workforce data were cumulative and current to 30 June 2011 but later findings are also included.

Some site specific measure data were sourced from the fundholder contractual reporting. Thus the time frames differed:

- The MSOAP-ICD activity data covered 1 July 2010 - 30 June 2011.

- The USOAP data were based on the first progress reports covering the program from the beginning to 31 December 2010 and 28 February 2011 depending on the organisational agreement.

- Data from the Division of General Practice 6 month report covered 1 July 2010 - 31 December 2010, a timeframe significantly earlier than the reporting period for this report.

Where appropriate, the SSE has drawn on publicly available information to further expand the measure implementation description. We have 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.

6.3. Stakeholder interviews

Stakeholder interviews were held in the eight case study sites and five enhanced tracking sites. In total, 195 individuals were consulted in this reporting period. The information gathered during interviews reflected the situation in each Sentinel Site visited in this reporting period, up to the time the data were collected. Appendix D outlines the interviews conducted by type and number in both site types.

Case study sites

Interviews were conducted to gain insight into stakeholder awareness and perceptions of issues relevant to the implementation of the ICDP. Specific interview forms were designed to meet the needs of different types of stakeholders, such as specific ICDP funded roles/positions, managers and clinicians.

Interviews were held in case study sites in the months of August-October 2011. A total of one hundred and forty six interviews were conducted in eight case study sites (see Table 3). Sixty-

five interviews were done in urban sites, fifty in regional sites and thirty-one in remote sites. In this reporting period, interviews were predominately conducted face-to-face [72% (105/146)], or over the phone [27% (39/146)]. Only 2% (2/146) were self-completed.

Table 3: Number of interviews held in case study sites, by reporting period and rurality

Rurality	Report 1	Report 2	Report 3
Overall	46	102	146
Urban	17	35	65
Regional	18	49	50
Remote	11	18	31

Note: For SSE Interim Report 1 there were three case study sites; SSE Interim Report 2, seven case study sites; SSE Interim Report 3, eight case study sites.

Enhanced tracking sites

In depth interviews were conducted with stakeholders in five enhanced tracking sites in this evaluation period. The purpose of interviews was to gain further insight into the factors contributing to different patterns of uptake of adult health assessments, follow-up items, registrations for PIP Indigenous Health Incentive and PBS Co-payments. Feedback sessions were organised with key stakeholder organisations and follow-up interviews were held with key informants to gain further understanding of the factors behind variation between sites.

Forty-nine individuals were interviewed in the enhanced tracking sites during the months of September - October 2011.

6.4. Community focus groups

Seventeen community focus groups were held in seven case study sites in the months of August - October 2011. A total of one hundred and sixty-one individuals participated, compared to eighty-three individuals in the previous reporting period (Table 4). The number of participants per group ranged from four to fifteen, with an average of nine per group.

Table 4: Trend in number of attendees at community focus groups held in case study sites, by rurality

Rurality	Report 1	Report 2	Report 3
Overall	66	83	161
Urban	11	21	66
Regional	20	36	67
Remote	35	26	28

Note: For SSE Interim Report 1 there were three case study sites; SSE Interim Report 2, seven case study sites; SSE Interim Report 3, eight case study sites.

The information gathered reflects the situation in each case study site up to the time the data were collected. Characteristics of community focus groups participants varied within and between sites. The interpretation of focus group data has been made with consideration of potential biases of different participant groups. Appendix E provides an overview of focus group profiles and participant numbers.

6.5. Clinical indicators

In this reporting period, fifty-three Health Services were requested to provide clinical indicator data for the purpose of the SSE. Of these, twenty-eight Health Services provided data: seventeen General Practices and eleven Aboriginal Health Services. As shown in Table 5 there has been an increase in the number of Health Services providing clinical indicators for each reporting period across service types. In this reporting period, additional emphasis was placed on working with the DGPs practice support teams to assist in data collection from private General Practices.

Table 5: Number of Health Services that were requested and provided clinical indicator data, by reporting period, and sector

Health Service Sector	Report 1 Requested	Report 1 Provided	Report 2 Requested	Report 2 Provided	Report 3 Requested	Report 3 Provided
Overall	12	4	28	13	53	28
General Practice	3	0	13	5	32	17
Aboriginal Health Service	9	4	15	8	21	11

Clinical indicator data were collected from Health Services during the months of August - November 2011. For some Health Services data were collected retrospectively and for varying timeframes, depending on existing arrangements for reporting and/or quality improvement systems.

6.6. Analysis of data, presentation of findings and evolution of the evaluation

Analysis of data is conducted in two phases, with an initial phase focused on analysis of data from each of the main data sources, followed by an analysis that draws together the data from different sources.

Phase 1 of data analysis

The main focus of analysis in phase 1 differs for each data source as follows:

- Administration data: focuses on uptake of MBS, PBS, PIP, trends in uptake, and differences in trends between different groups or between sites.

- Program data: focuses on understanding progress with implementation, differences between sites in different situations.

- Interview data: focuses on perceptions of ICDP related issues, trends in perceptions, differences in trends between different groups or between sites.

- Focus group data: focuses on community perceptions of ICDP related issues, trends in perceptions, differences in trends between different groups or between sites.

- Clinical Indicator data: focuses on availability and quality of clinical indicator data and, where availability and quality is adequate, on trends in clinical indicators over time and between different groups or between sites.

Phase 2 of data analysis

The second phase of analysis draws together data from each of the major data sources as relevant to the program logic and evaluation questions, as specified in the evaluation framework or in relation to themes that emerge during the evaluation and data analysis process.

Data analysis includes the use of triangulation whereby patterns of convergence and divergence in the data are identified by comparing results between different sources of data (e.g. between interviewees, between different types of sites and between individual sites, between interview and program data, between interview and data on trends in uptake, between program data and trends in uptake, etc), and between evaluation findings and the program logic.

Thus data analysis involves:

- multiple methods

- multiple data sources

- triangulation between data sources and between sites.

A number of other processes are used to ensure rigour in the evaluation process. These include:

- peer review of methods by the expert consultants on the team and through an expert ethical oversight committee

- purposive sampling of a range of key informants to ensure a diversity of relevant views are reflected in the data

- peer debriefing and support

- respondent validation through follow-up interviews and through feedback of findings to key stakeholder organisations and key informants, and

- iterative cycles of evaluation to progressively build and refine understanding of progress with, and impact on, the implementation of the ICDP.

Evolution and refinement of evaluation methods

Evaluation methods and approach to analysis are being refined throughout the evaluation to ensure that priority issues emerging over the course of implementation of the ICDP measures are appropriately addressed. As the implementation of the ICDP and of the SSE progresses, a more in-depth understanding of circumstances in case study and enhanced tracking sites will be developed; this will allow for more detailed analysis of cross site comparisons and more in-depth analysis of drivers and enablers of change, barriers to change, contextual factors and the validity of the program logic for each measure.

The development of relationships and trust with key stakeholders and informants in each site are essential for the development of in-depth understanding of the issues addressed in the evaluation. This will occur through feedback of site specific evaluation information and prolonged engagement over the course of the evaluation.

7. Clinical Indicators

7.1. Introduction

The National Evaluation Framework includes reference to the use of clinical indicator data for assessment of outcomes of the ICDP. The purpose of collection and analysis of clinical indicator data for the SSE is to provide an assessment of impact of the ICDP on clinical performance of primary health care services located in the Sentinel Sites and on clinical outcomes among Aboriginal and Torres Strait Islander people attending these services.

One of the following three processes was followed to obtain clinical indicator data from AHSs and General Practices in the Sentinel Sites:

- The DGPs were requested to provide contact details of General Practices that had an interest in Aboriginal health and/or that may be interested in providing clinical indicators for the SSE. The SSE team then contacted these General Practices with a request for them to provide the clinical indicators. The practices often required further support from the DGP staff (or advice from a member of the SSE team) to extract the clinical indicator data from their systems, before providing the data to the SSE team.

- The DGP, through their practice support teams, worked directly with General Practices that they identified as having an interest in Aboriginal health and/or being likely to be willing to provide clinical indicator data for the purpose of the SSE. The DGP staff extracted the clinical indicator data and provided these to the SSE team.

- The SSE team worked directly with the AHSs to obtain the clinical indicators.

In this reporting period there was more emphasis on working with practice support teams based within DGPs to either collect clinical indicators directly from General Practices or to provide contact details to the SSE team.

7.2. Ability of services to provide data

In this reporting period the SSE team focused on encouraging General Practices to provide the standard Australian Primary Care Collaborative (APCC)[19] reports that can be generated by the PEN CAT[20]. This audit tool has been made widely available to General Practices across Australia. These APCC reports contain a number of clinical indicators of relevance to the SSE.

However, through working with practice staff it became clear that many were not aware of the PEN CAT, or did not understand how it could be used to generate APCC reports. The active role of the DGP staff in supporting practices to generate the reports was therefore an important factor in the increased availability of clinical indicator data for the current cycle of the SSE.

The data were generated from a variety of sources within these Health Services, with the most common source in AHSs being Healthy for Life (H4L)[21] reports and the most common source in private General Practices being the standard reports generated by using the PEN CAT tool.

About half of the AHSs and of General Practices approached actually provided clinical indicator data. Even among AHSs that were involved in the H4L program it was apparent that, in a number of services, the clinical information systems were not adequately functional and/or there was limited capability amongst staff to use the clinical information systems to generate

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[19] Australian Primary Care Collaborative [website], (accessed 11 February 2013).
[20] Clinical Audit Tool [website], (accessed 11 February 2013).
[21] DoHA, Healthy for Life [website], (accessed 7 December 2011).

the H4L reports. Some staff reported 'making up the data' required for H4L reports, and others had limited confidence in the accuracy of the data included in H4L reports. Reservations about the quality of clinical information, and about the potential to provide data that was a fair reflection of clinical performance, appeared to be an important factor in services being unwilling or unable to provide clinical indicator data for the purpose of the SSE.

7.3. Characteristics of Health Services that provided clinical indicator data

The size of the Health Services in terms of their total numbers of clients, as well the number of clients identified as Aboriginal or Torres Strait Islander, varied widely between the Health Services that provided clinical indicator data, as did the number of clients on various disease registers. The focus of the analysis presented below is on diabetes and coronary heart disease (CHD) as these are among the most common and important chronic diseases, and the identification of people with these conditions on clinical information systems appeared to be more advanced than for other conditions.

Data from AHSs and General Practices are presented separately below because of generally wide differences in numbers and proportions of Aboriginal and Torres Strait Islander clients between these two types of services, and general differences in terms of relative focus on care for Aboriginal and Torres Strait Islander people. The differences are reflected in Table 6 and in further discussion of the findings of the analysis of clinical indicator data reported below.

The data in Table 6 show that the majority of AHSs that reported clinical indicator data:

1. had significant numbers of clients identified as Aboriginal and Torres Strait Islander people

2. had a higher proportion of clients identified as Aboriginal and Torres Strait Islander than the proportion of Aboriginal and Torres Strait Islander people in the site population

3. had more than ten Aboriginal and Torres Strait Islander clients on their diabetes and coronary heart disease (CHD) registers.

In contrast, the above three points apply only to a minority of the General Practices that reported clinical indicator data. It is important to note that the General Practices that were approached to provide clinical indicator data for the SSE were identified by their local DGPs as having a relatively strong interest in, and orientation to, providing care for Aboriginal and Torres Strait Islander people. The data provided an indication of the relatively poor state of practice system development and the small number of clients identified as Aboriginal or Torres Strait Islander in the majority of General Practices, and therefore their limited potential for supporting provision of high quality chronic illness care for Aboriginal and Torres Strait Islander people in the communities where these General Practices are located.

Table 6: Characteristics of Health Services that provided clinical indicator data overall and by sector

Health Service Characteristics	General Practice	AHS	Total
No. of services requested to provide clinical indicator data	32	21	53
No. of services that provided clinical indicator data	17	10	27
No. of services with >50 clients identified as Aboriginal and/or Torres Strait Islander	10	10	20
No. of services with >100 clients identified as Aboriginal and/or Torres	7	10	17

Health Service Characteristics	General Practice	AHS	Total
Strait Islander			
No. of services with >200 clients identified as Aboriginal and/or Torres Strait Islander	5	10	15
No. of services where proportion of clients identified as Aboriginal and/or Torres Strait Islander is greater than proportion of Aboriginal and/or Torres Strait Islanders in site population	3	10	13
No. of services that report no. of clients on diabetes register	16	8	24
No. of services that report no. of clients on CHD register	16	9	25
No. of services with > 10 clients on the diabetes register	4	8	12
No. of services with > 10 clients on the CHD register	3	9	12

Aboriginal Health Services

Ten of the 21 AHSs approached to provide clinical indicator data actually provided clinical indicator reports. The AHSs that provided reports were located in ten different sites. One of the AHSs provided reports for four separate health centres in addition to a combined report for the four services. The combined report for this site was more comprehensive than the specific health centre reports, and the data from the combined report were therefore used for this report (i.e. the four health centres will be counted as reflecting data from one Health Service).

Source of reports

Six services provided H4L reports. One of these six services also provided NT Key Performance[22] reports and one provided additional self-generated data. One service provided One21seventy[23] audit reports, one service provided an NT KPI report only, one provided an APCC report from the PEN CAT, and one provided a Queensland Aboriginal and Islander Health Council (QAIHC) indicator report from the PEN CAT.

Regular clients

Of these ten services that provided clinical indicator reports, nine reported the number of clients on the clinical information system identified as regular clients (see Figure 3). Eight could report the number of regular clients identified as Aboriginal and Torres Strait Islander and for those eight the range was between 69% and 96% (numbers of regular clients ranged from 714 to 6804; three services had less than 1000 regular clients, four had between 2000 and 4000, and one had over 4000). Most of these services appeared to be using the definition of 'regular client' as used in the Healthy for Life Program, but the consistency of the application of this definition among the services that provided clinical indicator data was not clear.

Between 4% and about 30% of regular clients of these AHSs appeared to be neither Aboriginal nor Torres Strait Islander, or did not have their Indigenous status recorded.

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[22] NT Aboriginal Health Key Performance Indicator Information [website], (accessed 7 December 2011).
[23] One21seventy [website], (accessed 12 February 2013).
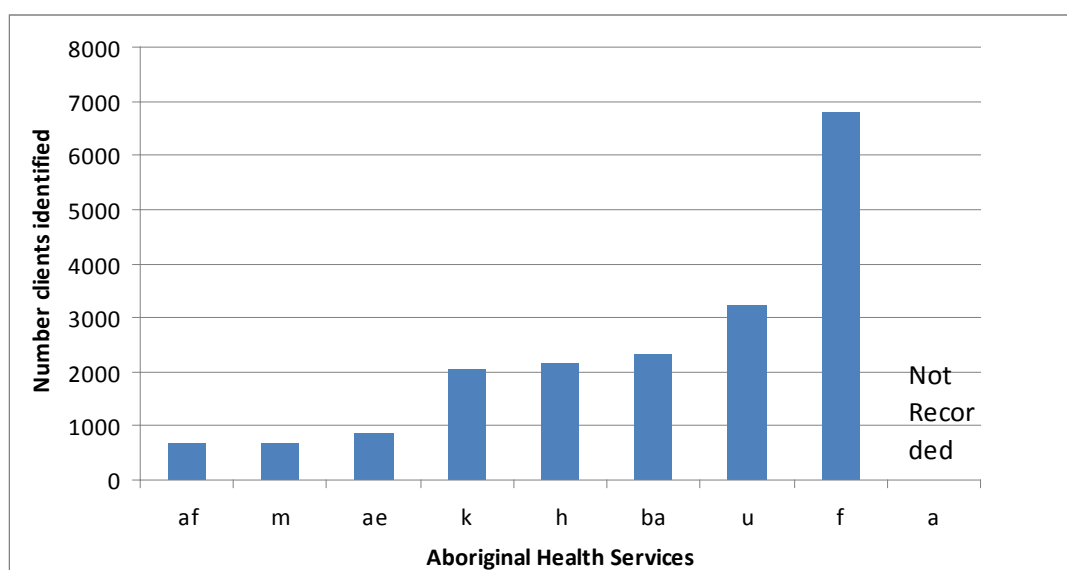
Figure 3: Number of clients on the clinical information system identified as Aboriginal and Torres Strait Islander for each Aboriginal Health Service.

Two of the AHSs that reported number of regular clients in this reporting period also reported clinical indicator data in the previous reporting period.

- For one AHS the number of regular clients reported for the current reporting period was almost 500 clients (about 12% of the client population) less than for the previous reporting period.

- For the other AHS, the number of regular clients was almost 200 clients (about 2.5% of the client population) more than for the previous reporting period. Interestingly, this AHS also reported the number of clients identified as Aboriginal and Torres Strait Islander for the current and previous reporting cycles, and (in contrast to the reported number of regular clients) the reported number of Aboriginal and Torres Strait Islander clients was exactly the same for each reporting cycle.

The changes in the number of regular clients may reflect real changes in the number of regular clients using these services, and/or updating the clinical information system to more accurately reflect current regular clients, and/or a change in the definition or improved application of the existing definition of 'regular client'. Change in the number of regular clients reported by one service over two consecutive reporting rounds, with no change in the number of clients identified as Aboriginal and Torres Strait Islander, highlights the likelihood of imperfections in the reported data, and the consequent need to interpret the findings of analysis of these data with caution.

Diabetes register

Eight of the AHSs reported the number of Aboriginal and Torres Strait Islander people on the diabetes register. The number of Aboriginal and Torres Strait Islander people on the diabetes register as a percentage of all Aboriginal and Torres Strait Islander regular clients ranged from 6.2% to 20.5%, with the average for these eight AHSs being 13.3%. These figures are within the range of prevalence estimates of diabetes in Aboriginal and Torres Strait Islander people.[24] The number of clients on the diabetes register ranged from 44 to 756 (Figure 4).

The wide range in published prevalence estimates makes it difficult to estimate whether the proportion of clients on the diabetes register is a fair reflection of the population prevalence. However, the range in the proportion of clients included on the diabetes register is likely to reflect, to some extent, differences in screening, diagnosis and recording of diagnosed clients on the diabetes register. These differences are also evident in relation to CHD in AHSs and in relation to both diabetes and CHD in General Practices.
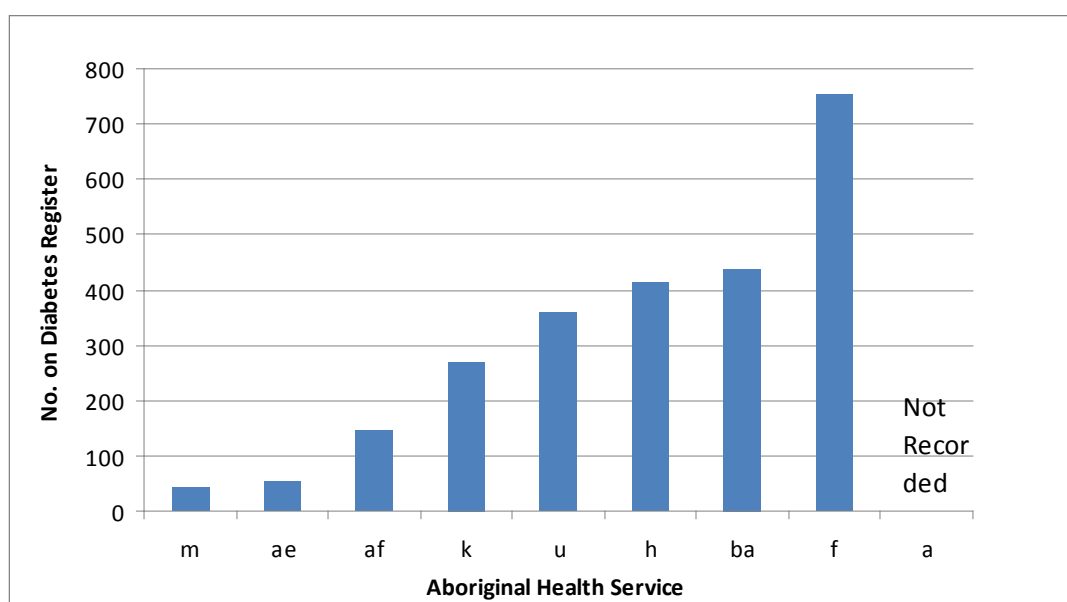
Figure 4: Number of Aboriginal and Torres Strait Islander people on the diabetes register in Aboriginal Health Services

One of the AHSs that reported the number of people on the diabetes register in this reporting period also reported the number in the previous reporting period. The number of people on the service's diabetes register in the current evaluation cycle was almost 120 clients (about 17% of the total number of Aboriginal and Torres Strait Islander clients on the service diabetes register) more than for the previous cycle. This increase may reflect new diagnoses and/or improved recording and completeness of the diabetes register.

An analysis of the diabetes clinical indicator data from the eight AHSs that had more than ten clients on their diabetes register is included below. However, the analysis should be regarded as being for illustrative purposes only as these services cannot be regarded as representative of AHSs more widely and there are serious limitations in the quality of the data reported.

Coronary Heart Disease register

Nine of the AHSs reported the number of Aboriginal and Torres Strait Islander people on the CHD register. The percentage of Aboriginal and Torres Strait Islander people on the CHD

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[24] Minges, K.E., Zimmet, P., Magliano, D.J., Dunstan, D.W., Brown, A., Shaw, J.E., 'Diabetes prevalence and determinants in Indigenous Australian populations: A systematic review', Diabetes Research and Clinical Practice, August 2011 (Vol. 93, Issue 2, Pp 139-149).

register as a percentage of all Aboriginal and Torres Strait Islander regular clients ranged from 1.8% to 6.4%, with the average for the eight AHSs for which this proportion could be calculated being 3.2%. This is higher than published estimates of the prevalence of CHD among Aboriginal and Torres Strait Islander people.[25] The number of clients on the CHD register ranged from 15 to 318 (Figure 5).
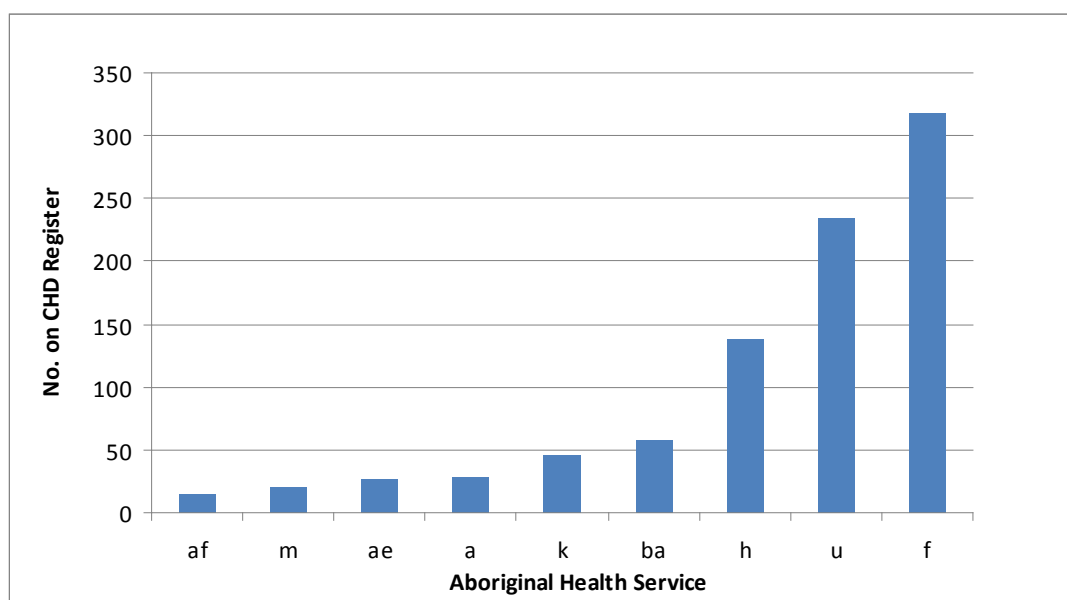
Figure 5: Number of Aboriginal and Torres Strait Islander people on the CHD register in Aboriginal Health Services

One of the AHSs that reported number of clients on the CHD register in this reporting period also reported on this number in the previous reporting period. This is the same AHS that reported number of clients on the diabetes register for both reporting periods. The number of regular clients reported for the current reporting period was almost 20 clients (about 6% of the total number of Aboriginal and Torres Strait Islander clients on the CHD register) less than for the previous reporting period. This may reflect updated and improved recording of current CHD diagnoses on the diabetes register.

An analysis of the CHD clinical indicator data for the AHSs that had at least ten clients on the CHD register is included below. However, the analysis should be regarded as being for illustrative purposes only, as these services cannot be regarded as representative of AHSs more widely and there are serious limitations in the quality of the data reported.

Limitations of the clinical indicator data provided by the AHSs

While several AHSs provided clinical indicator data for at least ten clients on their diabetes and CHD registers, the AHSs cannot be regarded as representative of AHSs in the Sentinel Sites or for Australia more widely. The fact that clinical indicator data were provided by less than half of AHSs within Sentinel Sites, and that only a proportion of the AHSs that provided any data appear to have disease registers through which they could identify clients with diabetes or CHD, indicates that these are a selective group of AHSs. The selection bias in relation to AHSs that provided data is an important limitation of the clinical indicator data. Any further analysis of the clinical indicator data from the AHSs needs to be interpreted in the context of these limitations.

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[25] Australian Institute of Health and Welfare, Penm E (2008) *Cardiovascular disease and its associated risk factors in Aboriginal and Torres Strait Islander peoples 2004-05*. Australian Institute of Health and Welfare, Canberra.

General Practices

Seventeen General Practices provided clinical indicator reports. These 17 practices were in ten different Sentinel Sites. Sixteen of the General Practices provided Australian Primary Care Collaborative (APCC) reports generated from the PEN CAT tool and one was generated from the practice information system by practice staff.

Almost all practices had the PEN CAT tool installed on their computer systems, but the staff in a considerable number of practices did not know how to use the tool. It was necessary to talk practice staff through the use of the tool in order to generate the APCC report that contains the required clinical indicators, or for the practice support teams within the DGP to assist the practice staff with the data extraction.

Practices that provided APCC reports were generally not actively participating in the APCC, but were rather using the APCC report function on the PEN CAT tool in order to generate the clinical indicator for the specific purpose of the SSE.

Regular clients

All except one General Practice provided data on the number of regular clients of the practice.

The number of regular clients in each practice ranged between 1640 and 39 625. Five practices had less than 5000 regular clients, six practices had between 5000 and 10 000 regular clients, four between 10 000 and 20 000 and one had over 20 000.

Six of the General Practices that reported data for the current reporting period also reported the number of regular clients for the previous reporting period. For three of these practices the number reported for this reporting period varied by less than 10% of the number reported in the previous reporting period. For the other three practices, there were marked differences between the number of regular clients reported for this round and the previous round – between 65% and 330% difference.

The number of regular clients identified in the practice information system as Aboriginal and Torres Strait Islander ranged from 18 to 797 (Figure 6). Ten of the 17 General Practices had more than 50 clients identified as Aboriginal and Torres Strait Islander, seven had more than 100, and five had more than 200 (Table 6). Most practices seem to be identifying only adults as Aboriginal and Torres Strait Islander. For all except two practices, the total reported number of regular clients identified as Aboriginal and Torres Strait Islander was the same as the number reported to be aged 15 years or more.
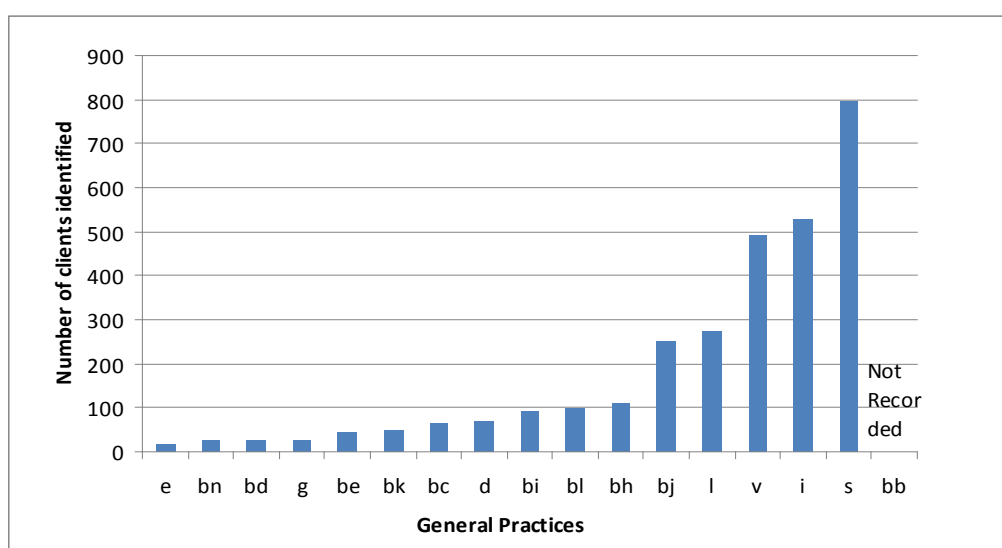
Figure 6: Number of clients on the patient information system identified as Aboriginal and Torres Strait Islander for each General Practice

As a proportion of all regular clients, the range for those identified as Aboriginal and Torres Strait Islander was from 0.3% to 6.8%. For three 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. In other words, for the majority of practices (13/16) Aboriginal and Torres Strait Islander people made up a smaller proportion of regular clients than the proportion of the total site population who were identified as Aboriginal and Torres Strait Islander.

The six General Practices that reported data on number of regular clients for the current and previous reporting periods also reported on number of clients identified as Aboriginal and Torres Strait Islander for each of the reporting periods. For three of these General Practices the number reported for this reporting period varied by less than 10% of the number reported in the previous reporting period (two of these three were different to the three that reported reasonably consistent numbers of regular clients over the two reporting periods). For the other three practices, the reported number of clients identified as Aboriginal and Torres Strait Islander was markedly higher for this reporting period compared to the previous reporting period – more specifically, the increase in numbers for each practice were:

- 12 (75% increase over number reported in the previous reporting period)

- 18 (58% increase over number reported in the previous reporting period)

- 297 (128% increase over number reported in the previous reporting period).

These increases are likely to reflect a combination of improved identification and (probably to a lesser extent) new Aboriginal and Torres Strait Islander clients attending these practices.

Diabetes registers

Sixteen of the 17 General Practices reported the number of clients identified as Aboriginal and Torres Strait Islander on the diabetes register. The numbers range between 0 and 63 per General Practice (see Figure 7). Most practices (12/16) had six or fewer patients identified as Aboriginal and Torres Strait Islander on the diabetes register. Four practices had ten or more patients identified as Aboriginal and Torres Strait Islander on the diabetes register.

The number of Aboriginal and Torres Strait Islander people on the diabetes register, as a percentage of all Aboriginal and Torres Strait Islander regular patients ranged from 1.4% to 11.5%, with the average for the sixteen practices being 5.3%. This figure is close to the lower limit of the range of prevalence estimates of diabetes in Aboriginal and Torres Strait Islander people.[26] For the four practices with ten or more Aboriginal and Torres Strait Islander clients on the diabetes register, the number of Aboriginal and Torres Strait Islander people on the diabetes register as a proportion of all clients identified as Aboriginal and Torres Strait Islander on the practice client list was 6.3%. As for the figure provided above for all sixteen practices, this figure is also close to the lower limit of the range of prevalence estimates of diabetes in Aboriginal and Torres Strait Islander people.

By way of comparison, for the fourteen practices that provided relevant data, the number of *all* people on the diabetes register as a percentage of *all* regular patients, ranged from 1.3% to 7.6%, with the average for the 14 practices being 3.3%. This is lower than national surveys of prevalence of self-reported diagnosis of diabetes in the general population (4.4%).[27]

These findings suggest that diabetes registers are not being well maintained for regular clients of these practices in general, or for regular Aboriginal and Torres Strait Islander clients. In addition to the points made above regarding limited identification of Aboriginal and Torres Strait Islander clients in these practices and/or the clients identified as Aboriginal and Torres Strait Islander in these practices not being representative of the general Aboriginal and Torres Strait Islander population, the apparent deficiency in diabetes registers presents further limitation on the use of clinical indicator data provided by General Practices for the purpose of assessing impact of the ICDP on clinical performance or outcomes.
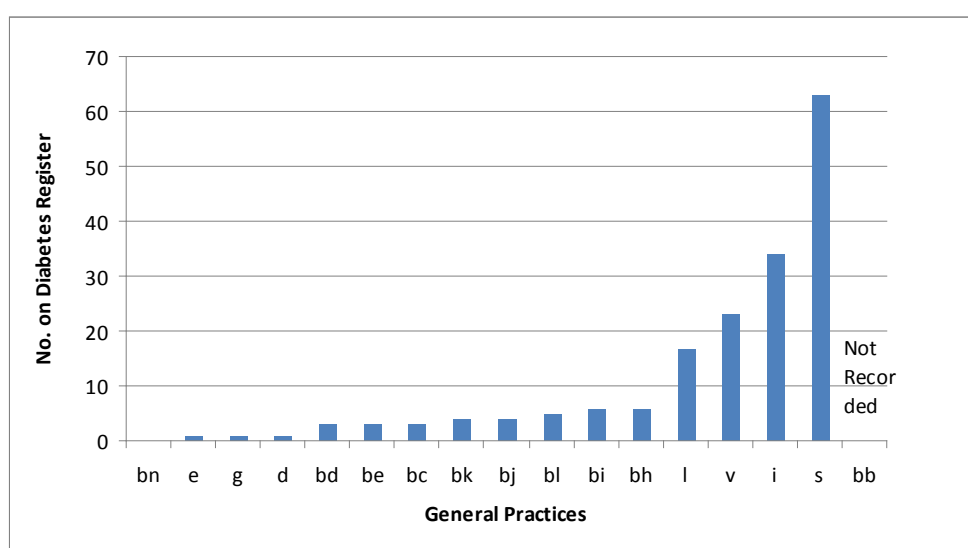
Figure 7: Number of Aboriginal and Torres Strait Islander people on diabetes registers for each General Practice

Four practices reported the number of Aboriginal and Torres Strait Islander clients on their diabetes register for both the current and previous reporting periods. Two of these practices reported they had less than ten Aboriginal and Torres Strait Islander clients on the register in the current reporting period (although one of these practices reported they had over 60 Aboriginal and Torres Strait Islander clients on the register in the previous reporting period).

[26] Minges, K.E., Zimmet, P., Magliano, D.J., Dunstan, D.W., Brown, A., Shaw, J.E., 'Diabetes prevalence and determinants in Indigenous Australian populations: A systematic review', *Diabetes Research and Clinical Practice - August 2011* (Vol. 93, Issue 2, Pp 139-149).
[27] AIHW 2011. Diabetes prevalence in Australia: detailed estimates for 2007-08. Diabetes series no. 17. Cat. no. CVD 56. Canberra: AIHW [website], (accessed 28 November 2011).

For the other two practices, the reported number of Aboriginal and Torres Strait Islander clients on the diabetes register was higher for this reporting period compared to the previous reporting period – more specifically, the increase in numbers for each practice were 3 (21% increase over number reported in the previous cycle) and 20 (140% increase over number reported in the previous cycle). These increases are likely to reflect a combination of improved identification of known clients with diabetes as Aboriginal and Torres Strait Islander and (probably to lesser extent) new diagnoses of diabetes among regular clients of these practices who are known to be Aboriginal and Torres Strait Islander.

An analysis of the diabetes clinical indicator data from the four General Practices with ten or more Aboriginal and Torres Strait Islander patients on their diabetes registers in the current reporting period is included below. The analysis should be regarded as being for illustrative purposes only as these services cannot be regarded as representative of General Practices more widely and there are serious limitations in the quality of the data reported.

CHD register

Sixteen of the 17 General Practices reported the number of clients identified as Aboriginal and Torres Strait Islander on the CHD register (Figure 8). The numbers range between 0 and 21 per practice. Most practices (12/16) had three or fewer Aboriginal and Torres Strait Islander clients on the CHD register. Three practices had ten or more Aboriginal and Torres Strait Islander clients on the CHD register.

The number of Aboriginal and Torres Strait Islander people on the CHD register as a percentage of all Aboriginal and Torres Strait Islander regular clients ranged from 0% to 7.1%, with the average for the sixteen practices being 2.3%. While this average figure is higher than prevalence estimates of CHD in Aboriginal and Torres Strait Islander people, the majority of practices have fewer Aboriginal and Torres Strait Islander people diagnosed with CHD than would be expected in relation to the population prevalence of CHD among Aboriginal and Torres Strait Islander people (1.2%).[28] The small number of Aboriginal and Torres Strait Islander clients in most of these practices is a limitation on making meaningful comparison with population estimates of CHD. For the three practices with ten or more Aboriginal and Torres Strait Islander clients on the CHD register, the number of Aboriginal and Torres Strait Islander people on the CHD register as a proportion of all clients identified as Aboriginal and Torres Strait Islander on the practice client list was 2.8%.

By way of comparison, for the fourteen practices that provided relevant data, the number of *all* people on the CHD register as a percentage of *all* regular patients ranged from 0.3% to 3.9%, with the average for the 14 practices being 1.8%. The high proportion of Aboriginal and Torres Strait Islander clients diagnosed as having CHD compared to all regular clients is consistent with the higher prevalence of CHD among Aboriginal and Torres Strait Islander people compared to the non-Indigenous Australian population.

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[28] Australian Institute of Health and Welfare, Penm E (2008) *Cardiovascular disease and its associated risk factors in Aboriginal and Torres Strait Islander peoples 2004-05*. Australian Institute of Health and Welfare, Canberra.
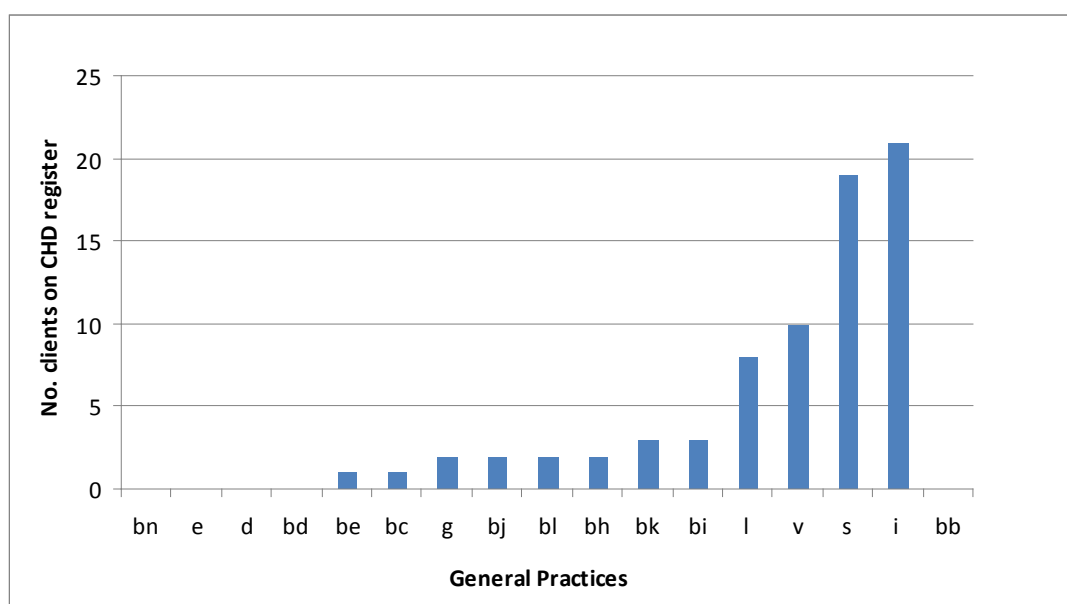
Figure 8: Number of Aboriginal and Torres Strait Islander people on the CHD register for each General Practice

Four practices reported the number of Aboriginal and Torres Strait Islander clients on their CHD register for both the current and previous reporting periods. Three of these practices reported they had less than ten Aboriginal and Torres Strait Islander clients on the register in the current reporting period (although one of these practices reported they had almost 60 Aboriginal and Torres Strait Islander clients on the register in the previous reporting period – the same practice that reported similar figures for the diabetes register). For the other practice, the reported number of Aboriginal and Torres Strait Islander clients on the diabetes register was higher for this reporting period compared to the previous reporting period – more specifically, the increase in numbers for this practice was 2 (11% increase over number reported in the previous reporting period). The reasons for this increase are likely to be similar to the reasons for the increase in numbers on the diabetes register as described above.

An analysis of the CHD clinical indicator data from the three General Practices with ten or more Aboriginal and Torres Strait Islander clients on their CHD registers is included below. The analysis should be regarded as being for illustrative purposes only as these services cannot be regarded as representative of General Practices more widely and there are serious limitations in the quality of the data reported.

Limitations of the clinical indicator data provided by General Practices

In the context of these practices being identified by the DGPs in the Sentinel Sites as practices with a strong interest and/or involvement in providing care for Aboriginal and Torres Strait Islander people, the under-representation of Aboriginal and Torres Strait Islander people among the regular practice clients suggests that:

- Aboriginal and Torres Strait Islander people attending these practices are not consistently being identified as Aboriginal and Torres Strait Islander on the practice information systems and/or

- the Aboriginal and Torres Strait Islander people attending these practices tend to be a small relatively select group of people within the local Aboriginal and Torres Strait Islander population.

In either case, the clinical indicator data from the majority of these practices are likely to be subject to significant selection bias and the data cannot be considered to be representative of Aboriginal and Torres Strait Islander people in the site population. Furthermore, the practices that provided clinical indicator data cannot be regarded as representative of General Practices in the Sentinel Sites or for Australia more widely. The selection bias in relation to practices that provided data, and in relation to the records from which clinical indicator data could be obtained, is an important limitation of the clinical indicator data.

In addition to the points made above regarding limited identification of Aboriginal and Torres Strait Islander clients in these practices and/or the clients identified as Aboriginal and Torres Strait Islander in these practices not being representative of the general Aboriginal and Torres Strait Islander population, the small number of Aboriginal and Torres Strait Islander patients on the diabetes and CHD registers for most of these practices, and the low proportion of regular Aboriginal and Torres Strait Islander clients on the diabetes register relative to the prevalence of diabetes among Aboriginal and Torres Strait Islander people, provides further indication of selection bias in relation to the representativeness of clients on the practice registers. This presents limitations on the use of clinical indicator data provided by General Practices for the purpose of assessing the impact of the ICDP on clinical performance or outcomes for diabetes and CHD. Any further analysis of the clinical indicator data needs to be interpreted in the context of these limitations.

State of development of primary care clinical information systems

For a range of reasons relating to quality of data and representativeness of data, in addition to difficulties of attributing causality, it is not appropriate to use available clinical indicator data for the purposes of assessing the impact of the ICDP on clinical performance or on clinical outcomes. However, the data provided on clinical indicators described above provide some important insights into the state of development of clinical information systems in AHSs and in General Practices that have been identified as being interested in providing care to Aboriginal and Torres Strait Islander people.

There is some evidence of Health Services (particularly AHSs) using excel spreadsheets to manage the patient registration process for the PIP Indigenous Health Incentive. Interview data suggests that practice staff are not using disease registers to identify clients for the incentive, or for flagging clients on recall and reminder systems, due to the poor state of development and/or utilisation of disease registers and clinical information systems more generally. Rather than working to improve the functioning of disease registers, there has been an emphasis on the development of additional systems (such as excel spreadsheets) to meet specific needs in relation to the ICDP (particularly in AHSs). This underdevelopment of systems may be contributing to the low trigger rates for Tier 1 payments, as the development of GP Management Plans and Team Care Arrangements are challenging to undertake in the context of an acute presentation and often require the client to be recalled – which is not happening as a result of proliferation of new specific systems and fragmentation of clinical information.

7.4. Analysis of Clinical Indicator data

Aboriginal Health Services

The indicators that were most commonly reported by the eight AHSs (and the number of services that reported each indicator) are listed below:

- proportion of clients with type 2 diabetes who have a current GP Management Plan (MBS 721) (8)

- proportion of clients with type 2 diabetes who have a current Team Care Arrangement (MBS 723) (6)

- proportion of clients with type 2 diabetes who have had a HbA1c test recorded in the past 6 months (7)

- proportion of clients with type 2 diabetes who have had a HbA1c test in the past 6 months and have a reading of ≤7% (6)

- proportion of clients with type 2 diabetes who have had a HbA1c test in the past 6 months and have a reading of ≥10% (6)

- proportion of clients with type 2 diabetes who have had blood pressure recorded in the past 6 months (6)

- proportion of clients with type 2 diabetes who have had a blood pressure test in the last 6 months who had a reading of ≤130/80 (6)

- proportion of clients with CHD who have a current GP Management Plan (MBS 721) (8)

- proportion of clients with CHD who have a current Team Care Arrangement (MBS 723) (6)

- proportion of clients with a current and complete health check MBS 715 (8).

The mean of the values reported for each of these indicators, and for the other indicators reported by at least one of the eight AHSs, are reported in Appendix G.

On average, about 45% of clients with diabetes in each of these AHSs were reported to have a current GP Management Plan (MBS 721) (range 15%-73%), with a similar proportion reported to have a current Team Care Arrangement (MBS 723) (range 14%–70%). On average, about one quarter (23.4%) of clients in each of these AHSs were reported to have a current and complete health check (MBS 715) (range 8%-48%).

For all indicators that were reported by more than one AHS there was a wide range in the values reported by different AHSs.

General Practices

For the purposes of the SSE, data from General Practice have only been analysed if there were more than 100 Aboriginal and Torres Strait Islander patients identified on their patient information system. Seven General Practices met this criterion. The findings below are based on these seven General Practices.

The indicators most commonly reported by General Practices tended to be limited to specific clinical indicators, and no General Practices reported the proportion of clients who had a current GP Management Plan (MBS 721) or a current Team Care Arrangement (MBS 723). However, all four General Practices reported the proportion of clients who had a current and complete health check MBS 715.

The General Practices tended to report clinical indicators relating to CHD more than those relating to diabetes. All four General Practices that had ten or more Aboriginal or Torres Strait Islander clients in their diabetes register reported that all of these clients had a record of an HbA1c in the past 12 months and all clients with diabetes or CHD had their smoking status recorded. For all other indicators that were reported by more than one General Practice there was a wide range in the values reported by different practices.

General limitations on interpretation of the clinical indicator data

Interpretation of the analysis of the clinical indicator data provided by services for the purpose of assessing quality of care is limited by a number of factors, including:

- the small number and selective nature of the Health Services that provided indicators

- the wide range in the values for various indicators reported by different Health Services - more than can be expected by variations in the characteristics of different service populations. Examples of indicators with wider variation than might reasonably be explained by natural variation between service populations include:

  - proportion of clients who are smokers (range 16% to 55% in AHSs and 28% to 57% in General Practices; 18% to 48% for clients with diabetes in General Practices and 10% to 63% for clients with CHD in General Practices)

  - proportion of clients who are overweight/obese (overweight range 8% to 24% for clients with diabetes and 6% to 32% for all clients in AHSs; obese range 9% to 40% for all clients in AHSs)

  - proportion of clients who have their BP controlled at ≤130/80 (range 39% to 74% for clients with diabetes in AHSs and 10% to 29% for clients with CHD in General Practices).

There were also wide variations between the values of other process indicators (for example recording of HbA1c and BP within specified timeframes) that were reported by different services. The wide variation in these indicators between services (and over time within the same service) has been described by previous research. This variation is due to a wide range of factors in the health centre operating environment as well as the broader context in which the health centre is operating. Programs such as the ICDP are therefore only one of a wide range of (often inter-related) influences that might impact on trends in clinical indicators over time. It is very difficult to isolate the impact that the ICDP may have had on any observed trends in clinical indicator data from the impact of other factors, particularly where clinical indicator data are only available for a small number of highly selected services.

Comparison of clinical indicators for AHS and General Practices

Validity of comparisons of the values of indicators reported by AHSs and General Practices is limited by the same general factors identified above, and by the differences in the specifications of reported indicators (for example the timeframe for recorded HbA1c). Nevertheless, it is worth noting that for indicators where at least three AHSs and at least three General Practices had reported the same indicator, the average values of the indicators reported by the AHSs were similar to the average values reported by the General Practices (Appendix G).

Analysis of reported values for the current and previous evaluation cycle

The validity of analysis of differences in reported values between the current and previous reporting periods is also limited by the factors identified above, in addition to changes over time in the quality of the information systems used to generate the clinical indicator data, changes over time in the ability of Health Service staff to use clinical information systems to generate the required reports, changes over time in the completeness of recording of Aboriginal and/or Torres Strait Islander status and in completeness of inclusion of clients on disease registers. The limitations resulting from the small numbers of services that have reported clinical indicators as described above are exacerbated by the even smaller number of services that have reported specific indicators consistently over the two reporting periods. With these limitations in mind, we can make the following observations:

GP Management Plans, Health Checks and recording of smoking status

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have a current GP Management Plan (MBS 721) for both round two and round three, there was an increase of between 6% and 42%. These three AHSs also reported increases in the proportion of clients with CHD who have a current GP Management Plan of 7%, 6% and 1% respectively.

- For the two General Practices that reported the proportion of clients with a current and complete health check MBS 715, there was an increase of 3% and 17% respectively for each practice.

- For the two General Practices that reported the proportion of clients with type 2 diabetes who have had their smoking status recorded in the past 12 months, there was an increase of 36% and 50% respectively for each practice.

Diabetes and CHD care delivery

- For the two General Practices that reported the proportion of clients with type 2 diabetes who have had an HbA1c test recorded in the past 12 months, there was an increase of 14% and 36% respectively for each practice. The one AHS that reported values for this indicator showed an increase of 12%.

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have had an HbA1c test recorded in the past 6 months, there was an increase of 0.3%, 12.1% and 21.7% respectively.

- For the two General Practices that reported the proportion of clients with type 2 diabetes who have had a blood pressure recorded in the past 12 months there was a *decrease* of 36% and 12% respectively for each practice. The one AHS that reported values for this indicator showed a *decrease* of 5%.

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have had a blood pressure recorded in the past 6 months, there was an increase of 6%, 8% and 35% respectively.

Intermediate outcomes

- For the two General Practices that reported the proportion of clients with type 2 diabetes who have had an HbA1c test in the past 12 months and have a reading of ≤7%, there was a *decrease* of 19% and 21% respectively for each practice. This needs to be interpreted in the light of these two practices increasing the proportion of clients who were reported to have had an HbA1c in the past 12 months from 65% and 85% respectively to 100% for both practices. The one AHS that reported values for this indicator showed an increase of 1.4%.

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have had an HbA1c test in the past 6 months and have a reading ≤7%, there was a change of 0.7%, -0.3% and 2.6% in each AHS respectively.

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have had an HbA1c test in the past 6 months and have a reading ≥10%, there was a *decrease* of 3.3%, 0.7% and 39.6% respectively.

- For the three AHSs that reported the proportion of clients with type 2 diabetes who have had a blood pressure test in the last 6 months who had a reading ≤130/80 there was a change of 7%, -2% and -7% respectively.

For all other indicators there were less than three AHSs or less than two General Practices that reported data for both reporting periods.

From the above data on changes in values of indicators over time it appears that for the services that reported indicators in both reporting periods, the general pattern is of a trend to an increase in the proportion of Aboriginal and Torres Strait Islander clients who are recorded as having received some specified services in both General Practices and in AHSs, and a positive trend in recording of smoking status in General Practice. However, for indicators that reflect intermediate outcomes, the pattern in General Practices is mixed, with a decrease in the proportion of clients with good control of diabetes – probably reflecting an increase in the inclusion of clients with poor control being clearly identified as Aboriginal and Torres Strait Islander and/or being included on the diabetes register; in contrast, the pattern in the AHSs was more positive, with a decrease in the proportion of clients with very poor control (HbA1c ≥10%). For the reasons described above in the section on general limitations on interpretation of clinical indicator data the extent to which the ICDP may have contributed to any observed trends is unclear.

Summary

The most important issue emerging from this analysis of the clinical indicator data is the evidence on the poor state of development of clinical information systems, and the lack of ability of Health Service staff to effectively use such systems. The poor state of development and use of clinical information systems, and the consequent lack of clinical indicator data of reasonable quality, places serious constraints on the value of the clinical indicator data for the purpose of assessing impact of the ICDP on clinical performance and clinical outcomes - as was the intended purpose of the clinical indicator data reflected in the National Framework. The findings reported here demonstrate the serious inadequacies in the potential for currently available clinical information systems to provide meaningful data on the impact of the ICDP.

More importantly, the poor state of development of clinical information systems places serious constraints on the effective implementation of a number of measures within the ICDP, specifically including any that require effective identification of any Aboriginal and Torres Strait Islander clients of primary health care services, as well any Aboriginal and Torres Strait Islander clients who have a chronic illness, or who have risk factors which predispose them to the development of chronic illness.

It is clear that there is a need for stronger and more strategic investment in development of clinical information systems within primary health care services–both AHSs and General Practices–to support their effective engagement 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.

The quality of the clinical indicator data in these systems is critically dependent on the engagement of Health Service staff with the clinical information systems and with the data that can be generated by these systems. There is therefore a vital need for systematic approaches to support such engagement of Health Service staff. It is a critical requirement that, in addition to development of user-friendly information systems, such approaches include training of clinicians, managers and administrative staff in the effective implementation and use of clinical information systems in a way that directly supports provision of high quality clinical care and provides value to the local clinical and management staff. There are continuous quality improvement models that are well suited to meet this need, including models that have been designed to meet the specific needs of Aboriginal and Torres Strait Islander primary health care services. It is notable that the two AHSs that have provided the most consistent and useful clinical indicator data for the SSE to date have engaged proactively in the use of systematic continuous quality improvement approaches.

We recommend that in the next reporting period there should be a shift in the focus of the evaluation relating to clinical indicators to a focus on providing a better understanding of the enablers and barriers to effective clinical information systems to support chronic illness care for Aboriginal and Torres Strait Islander people in AHSs and in general, and how clinical information systems could be strengthened in a way that will support effective implementation of the ICDP.

8. ICDP Workers: Recruitment, Training and Impact

There are a number of issues related to recruitment to new ICDP funded positions that are relevant to a number of positions funded through different measures. In order to avoid repetition these more general issues are addressed in this section, rather than in each of the separate chapters relating to specific measures. The information in this section is drawn from interviews with managers [CEOs, deputy CEOs, program managers, and Indigenous Health Project Officers (IHPOs)].

Progress with recruitment

In this reporting period, managers were generally positive about the progress with recruitment of the ICDP workers (see Figure 9). Recruitment of IHPOs and OWs in DGPs, as previously reported has advanced relatively quickly. It is evident that the RTC, TAW and HLW positions are becoming increasingly well established in the majority of sites. However, some sites continue to have difficulty with recruitment and retention of staff for these positions.
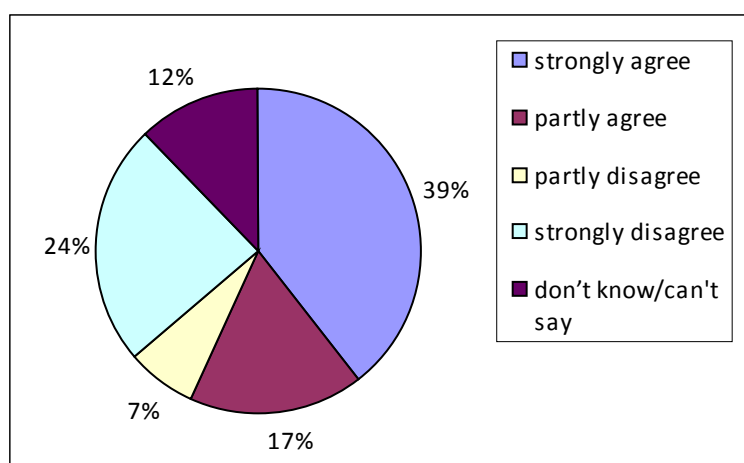
Figure 9: Managers' responses to the statement: 'Recruitment of the new ICDP workers is on schedule.' (n=42)

Perceptions over time

Fifty-six per cent (23/41) of interviewees strongly or partly agreed that 'recruitment to the new positions was on schedule'. This is an increase from 42% (16/38) in the previous reporting period.

Perceptions by rurality

Urban sites were more likely to agree that recruitment was on schedule, with 69% (11/16) partly or strongly agreeing to the statement, compared to 42% (5/12) in the previous reporting period. Regional and remote sites had 54% (7/13) and 42% (5/12) strongly or partly agreeing to the statement respectively. Similar to the previous reporting period, remote sites have generally been experiencing more difficulties with recruitment.

Perceptions by sector

There was a marked difference in responses between the GP and the AHS sectors, with 39% (7/18) of interviewees in the AHS sector, compared with 70% (16/23) for General Practice sector strongly or partly agreeing with the statement on progress with recruitment being on schedule (see Table 7). As previously reported, recruitment to positions based in the DGPs has generally advanced more quickly than in the AHS sector.

Preparedness of the primary health care sector

Less than a half [40% (17/42)] of interviewees strongly or partly agreed with the statement that *'the primary health care sector was well prepared for the new ICDP positions'*. This was an increase from 24% (9/42) in the previous reporting period.

Perceptions by rurality

For remote sites, the proportion of respondents agreeing with this statement tended to be lower than for urban and regional sites [25% (3/12)], compared to 56% (9/16) and 36% (5/14) for urban and regional sites respectively]. This is in contrast to the previous reporting period where interviewees in regional sites tended to be least likely to agree with this statement [13% (2/15)].

Perceptions by sector

Interviewees from the General Practice sector [48% (11/23)] were more likely to agree that 'the primary health care sector was well prepared for the new ICDP positions' than those in the AHS sector [32% (6/19)] (Table 7).

Adequacy of infrastructure

Forty per cent (17/42) of interviewees in this reporting period [compared to 24% (9/38) previously] strongly or partly agreed with the statement that *'the infrastructure was adequate to accommodate the new workforce'.*
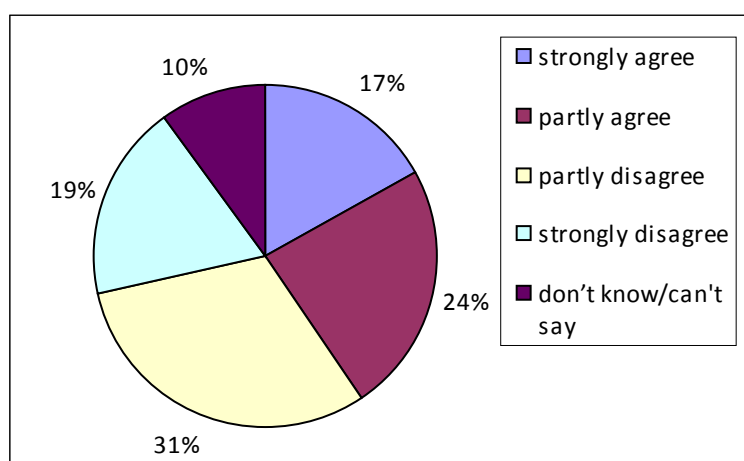
Figure 10: Managers' responses to the statement: 'Infrastructure was adequate to accommodate new workforce.' (n=42)

Perceptions by rurality

While comparisons by rurality are limited by small numbers, there was some sign of an increase in agreement among interviewees in remote sites that infrastructure is adequate [18% (2/11) in last reporting period to 33% (4/12) in this reporting period]. However, respondents in remote site continued to be less likely to agree to this statement than those in urban [38% (6/16)] or regional sites [50% (7/14)]. Concerns about lack of infrastructure in remote sites was also evident in quotes from managers about challenges in regards to housing in remote sites.

Perceptions by sectors

There was also a difference between sectors in perceptions of adequacy of infrastructure, with 52% (12/23) of managers in the General Practice sector strongly or party agreeing that infrastructure was adequate to accommodate new workforce compared to 26% (5/19) in the Aboriginal health sector (Table 7). There were a number of comments from the Aboriginal

health sector about challenges providing space for the new workforce in both regional and remote settings.

Training provided to ICDP Workers

In this reporting period managers were expressing mixed perceptions, about the training provided to the ICDP workers (see Figure 11). When asked to respond to the statement: '*training provided to ICDP workers has equipped them with skills to fulfil roles'*, the majority either strongly or partly agreed [52% (22/42)]. However, 22% (9/21) of respondents indicated that they 'don't know/can't say'. These responses were generally because the staff had not been able to access the training, and therefore were unable to comment if it had equipped them to fulfil roles. In addition, 26% (11/42) strongly or partly disagreed with the statement.
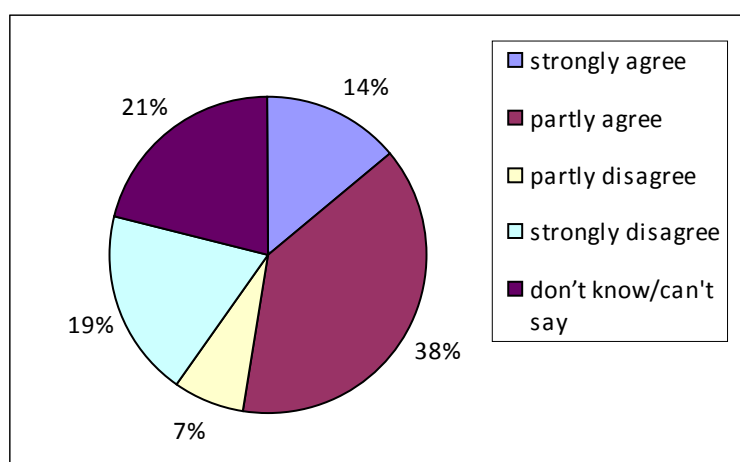
Figure 11: Managers' responses to the statement: 'Training provided to ICDP workers has equipped them with skills to fulfil their roles.' (n=42)

Perceptions over time

Over the three reporting periods there has been an increase in the number of interviewees strongly or partly agreeing to the statement '*training provided to ICDP workers has equipped them with skills to fulfil roles'*. In December 2010, 6% (2/18) partly or strongly agreed compared to 32% (12/38) in the June 2011 reporting period and 52% (22/42) in the current reporting period. This is consistent with more ICDP workers being recruited to roles in Sentinel Sites, and training being delivered and accessed as implementation progresses, and is a positive reflection on the training provided to the new ICDP workers in general.

Perceptions by rurality

In the previous reporting period, the perception that the training had provided ICDP workers with the skills to fulfil their roles was most common among respondents in remote sites. The overall increase in this perception since the previous reporting period is entirely due to a shift in perceptions in regional and urban sites, with an increase from 33% (5/15) in the previous reporting period to 79% (11/14) in regional sites and from 17% (2/12) to 38% (6/16) in urban sites. In remote sites 45% and 42% of respondents in the previous and current reporting cycles respectively, agreed with the statement that the training had provided workers with the skills to fulfil their roles. Access to training for remote sites presents challenges with staff not being able or willing to travel to large centres to access training.

Perceptions by sector

There was a notable difference in perceptions of the training between respondents from the General Practice sector and the AHS sector, with 65% (15/23) in the General Practice sector agreeing that the training had equipped the ICDP workers with necessary skills compared to

37% (7/19) in the AHS sector (Table 7). Despite this, comments from the General Practice sector about the orientation provided for Outreach Workers indicated that they felt that it was not designed or delivered in a way that met the needs to Outreach Workers based in Divisions of General Practice. Perceptions of the orientation provided for OWs are discussed further in the chapter on Measure C1.

Impact of ICDP related positions on redistribution of the workforce

As more ICDP related positions were being filled in the Sentinel Sites, there were more managers who felt able to comment on the statement *'there has been a negative impact on other programs or workforce groups from the employment of new workers'* than in the previous reporting period. In the previous reporting period 29% of those who responded indicated 'don't know/can't say' compared with only 10% this reporting period (see Figure 12). There was an increase in perceptions of a negative impact on other programs or workforce groups, with 40% (17/42) either strongly or partly agreed with the statement, compared to 13% (5/38) in the previous reporting period. Despite this increase in the proportion of respondents who stated there had been a negative impact, relatively few strongly agreed with this statement and half of the respondents did not believe there had been a negative impact.
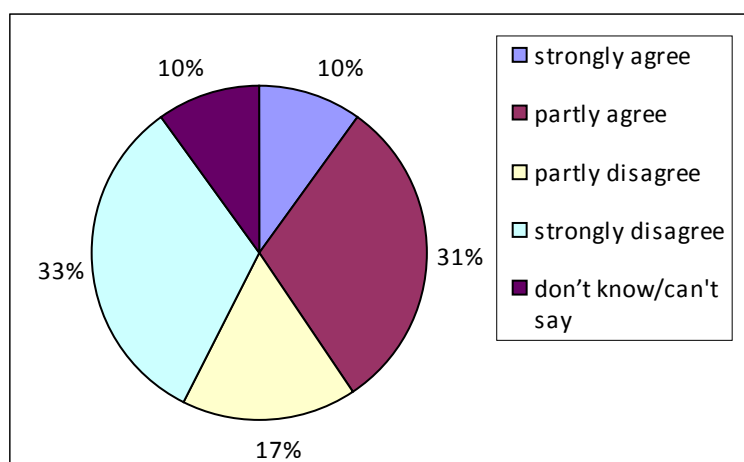
Figure 12: Managers' responses to the statement: 'There has been a negative impact on other programs or workforce groups from the employment of the new workers.' (n=42)

Perceptions by rurality

The increase in perceptions of a negative impact was evident in urban, regional and remote sites, but was most noticeable in regional sites, with 50% (7/14) in this reporting period agreeing with the statement there had been a negative impact compared to 13% (2/15) in last reporting period.

Perceptions by sector

The perceptions of a negative impact of the new positions on existing programs were evident in both the General Practice and the AHS sector, with between one third and one half of respondents in both sectors agreeing with the statement on negative impact [9/19 in the Aboriginal health sector and 8/23 in the General Practice sector (Table 7)].

In the previous reporting period, interviewees indicated continuing concern, among some stakeholder groups, about the current or potential negative impact on other organisations when staff left existing roles to move into newly created positions. In this reporting period, comments and statements indicated that new positions were impacting on the existing workforce as more ICDP funded workers were being recruited.

Table 7: Managers' perceptions of recruitment and training of new ICDP workforce (% who responded 'strongly agree' or 'partly agree'), by sector

Interview statements	Aboriginal Health Sector[a]	General Practice Sector[b]
Training provided to ICDP workers has equipped them with skills to fulfil roles.	37% (n=19)	65% (n=23)
Recruitment of new ICDP funded positions is on schedule.	39% (n=18)	70% (n=23)
There has been a negative impact on other programs or workforce groups from the employment of the new workers.	47% (n=19)	35% (n=23)
The primary health care sector was well prepared for the new ICDP positions.	32% (n=19)	48% (n=23)
Infrastructure was adequate to accommodate new workforce.	26% (n=19)	52% (n=23)

[a] Aboriginal Health Sector includes Aboriginal Health Services and NACCHO state/territory affiliates.
[b] General Practice Sector includes Division of General Practices and Division State Based Organisations.
Note: n = number of people who responded to statement. Included in the denominator are the respondents who indicated 'don't know/can't say'.
Managers interview used, see Appendix D for listing of interview types and respondent types.

Complementary/conflicting programs

Similar to the previous reporting period, 64% (44/69) of interviewees indicated that there are other policies and programs adding to, or complementing, the effectiveness of the ICDP. There was little difference in perceptions on this issue between respondents in urban, regional or remote sites.

Similar to the previous reporting period, 21% (14/66) believed there were other programs or policies that were constraining or having a negative impact on the potential effectiveness of the ICDP. There were marked differences on this issue between urban, regional and remote sites, with respondents in remote sites most likely to indicate that there were perceptions of conflicting programs (4%, 24% and 39% respectively in urban, regional and remote sites indicated there were conflicting programs).

Further information on complementary or contradictory programs in relation to specific measures is included in the chapters on specific measures where relevant. There was little information available from interviewees on how or why programs were enhancing or constraining implementation of various measures, and these questions will be explored further in future reports.

Linkages with other ICDP workers

Sixty-eight per cent (17/25) of people who are in newly funded ICDP positions (such as Regional Tobacco Coordinators, Tobacco Action Workers, Healthy Lifestyle Workers, Outreach Workers or Care Coordinators) reported that they were working with others in ICDP funded positions. This was similar to the previous reporting period in which 5/6 respondents reported that they were working with other ICDP workers. There has been an emphasis of working in teams within sectors for example the Regional Tackling Smoking and Healthy Lifestyle teams and the IHPOs, OWs and Care Coordinators in DGP. ICDP workers generally viewed having a team structure as offering support. Responses indicated there is further work that can be undertaken in establishing links between teams across sectors. This could commence at a high level initially through NACCHO state affiliates and State Based Organisations.

Analysis of impact of the ICDP

The relationship between variables that (to some extent) reflect impact of the ICDP intervention and the intensity of the intervention in terms of number of ICDP workers (per 10 000 Aboriginal and Torres Strait Islander people in the population) was examined using uni-variate descriptive statistics. We also examined associations between the variables that reflect impact of the ICDP intervention and key contextual variables for each site.

The Impact variables examined were:

- number of health assessments in March-May 2011 per 100 Aboriginal and Torres Strait Islander people in the site,

- the relative and absolute difference between the number of health assessment per 100 Aboriginal and Torres Strait Islander people in March-May 2011 and baseline levels of health assessments in the site,

- number of PIP Indigenous Health Incentive registrations in 2010 per 100 Aboriginal and Torres Strait Islander people in the site,

- number of Tier 1 payments in 2010 per 100 Aboriginal and Torres Strait Islander people in the site, and

- number of Tier 2 payments in 2010 per 100 Aboriginal and Torres Strait Islander people in the site.

The types of ICDP workers included in the analysis included IHPOs in DGPs and OWs in DGPs and AHSs, as these are the workers whose roles relate most directly to the impact variables identified above. Because ICDP workers based in the DGPs have responsibility across the DGP rather than for specific Sentinel Sites, the calculation of numbers of workers per population is based on numbers of Aboriginal and Torres Strait Islander people in the DGP where the site is located, rather than population of the site.

Contextual variables examined were:

- *Socio-Economic Index of Disadvantage for Areas* (SEIFA) average for the Sentinel Site (based on the average SEIFA for all postcodes included in the Sentinel Site),

- Per cent of solo practices in the DGP where the site is located,

- GP to population ratio in the DGP where the site is located.

The SEIFA index was included in the analysis to determine if socio-economic conditions in the site might have an influence on impact of the ICDP as reflected by the various impact variables included in the analysis. Similarly, the per cent of solo practices in the DGP where the site is located was included in the analysis to determine if potential impact of the ICDP may be affected by having a large proportion of solo practices. The percentage of solo practices also provides a proxy measure of the relative proportion of small practices as opposed to larger practices in the DGP. The GP to population ratio is included to measure the density of service provision in each area.

There was a significant correlation between the number of ICDP workers per 10 000 Aboriginal and Torres Strait Islander people aged over 15 years and the number of PIP registrations in 2010 per 100 Aboriginal and Torres Strait Islander people (r=0.42, p=0.04, Figure 13). No other correlations between the intensity of the intervention (as reflected by number of ICDP workers

per population) or any of the other impact variables (numbers of adult health assessments, Tier 1 or Tier 2 payments) were statistically significant. There were also no statistically significant correlations between any of the impact variables and the contextual variables identified above.

The results provide some evidence that the intensity of the intervention as measured by numbers of workers is related to the uptake of PIP registrations. However, we cannot rule out the possibility that this association is the result of confounding, and that some other factor may be driving this association. However, none of the key contextual variables tested to date appear to be confounders. The PIP Indigenous Health Incentive is a new program and there was a lack of pre-existing data on which sites were likely to achieve better uptake. This suggests that the observed association between the intensity of the intervention and PIP registration is unlikely to be due to reverse causation, that is, workers being placed in sites where PIP Indigenous Health Incentive uptake was likely to be high.

The limited number of sites and the lack of good data on potential confounding factors limits the potential for more sophisticated quantitative analysis. Nevertheless, the association described above is consistent with the important focus that the IHPOs and OWs have had on promoting uptake of PIP registrations through 2010, and the evidence of impact is encouraging.
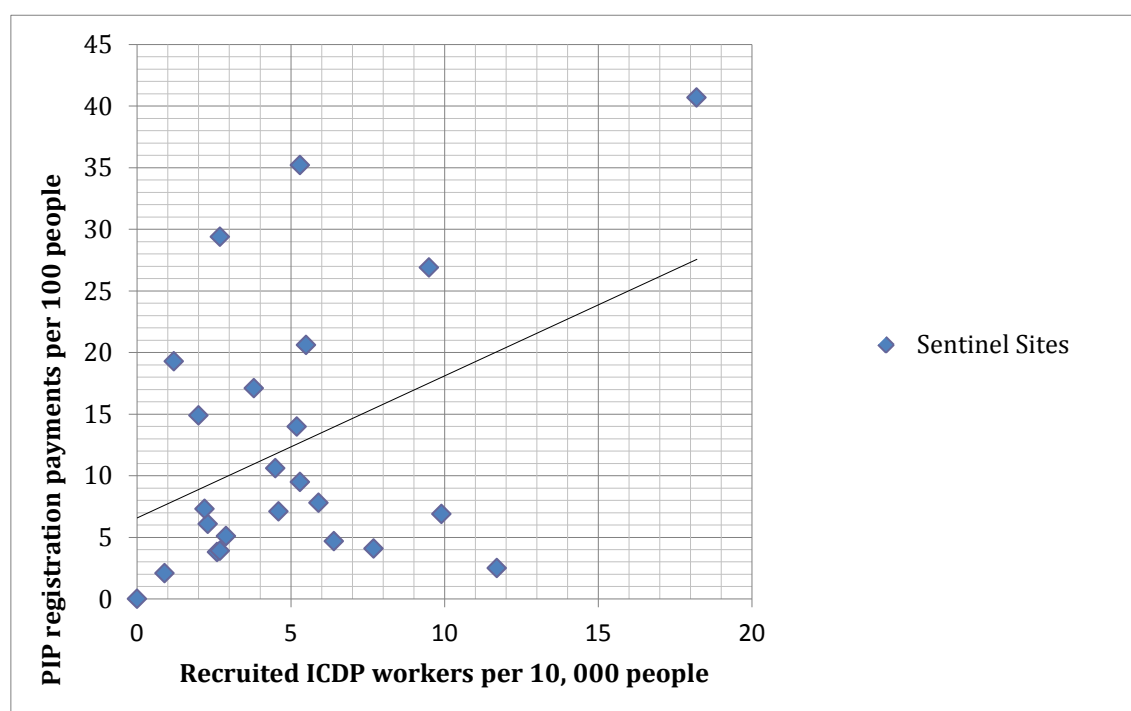
Figure 13: PIP Indigenous Health Incentive registration payments per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in 2010 in relation to number of ICDP workers (IHPOs in DGP and OWs in DGP and AHSs) per 10 000 Aboriginal and Torres Strait Islander people in the DGP where the site is located

Summary

There was a positive shift in perceptions of progress with recruitment, the preparedness of the primary care workforce for the ICDP positions, the adequacy of infrastructure, and the impact of training on the skills of the new workers since the previous reporting period. In contrast, and probably related to increased recruitment to new ICDP funded positions, there was an increase in perceptions of a negative impact on other programs resulting from the employment of ICDP funded workers.

Workers in ICDP positions continued to work with others in ICDP funded positions, with emphasis on working in teams for increased support. There is scope for linkages between teams in different sectors (AHS and DGP).

Respondents in the General Practice sector, and in urban and regional sites, tended to be more positive than those from the AHS sector and from remote sites, on most of these issues.

There was a common perception (overall and across remote, regional and urban sites) that there were other policies and programs complementing the effectiveness of the ICDP, and a relatively uncommon perception that other programs or policies were constraining or having a negative impact on the effectiveness of the ICDP.

There was a significant correlation between the number of ICDP workers per 10 000 Aboriginal and Torres Strait Islander people and the number of PIP Indigenous Health Incentive registrations in 2010 per 100 Aboriginal and Torres Strait Islander people. The results suggest that the intensity of the intervention, as measured by numbers of workers, is related to the uptake of PIP registrations, and that the IHPOs and OWs have played an important role in promoting uptake of PIP registrations.

9. National Action to Reduce Indigenous Smoking Rates (*Measure A1*) & Helping Indigenous People Reduce Their Risk of Chronic Disease (*Measure A2*)

9.1. Description of measure

Measures A1 and A2, under the 'Tackling Chronic Disease Risk Factors' priority area of the ICDP, have a significant workforce implementation and training component. The measures have been addressed together in this SSE report as the new workforce is deployed in teams with a regional approach to program planning and implementation.

The 'National Action to Reduce Indigenous Smoking Rates' measure (A1) funds a new network of Regional Tobacco Coordinators (RTC) and Tobacco Action Workers (TAW) to work with Aboriginal and Torres Strait Islander communities to reduce the number of people smoking. Dr Tom Calma has been appointed to lead this initiative as National Coordinator. The workforce will implement a range of community-based smoking prevention and cessation support activities tailored to local Aboriginal and Torres Strait Islander communities. Existing workers such as nurses and Aboriginal health workers will be trained in brief interventions. Enhancements will be made to Quitline to become more accessible and appropriate for Aboriginal and Torres Strait Islander people. Social marketing messages will be delivered. [29]

Through measure A2, Healthy Lifestyle Worker (HLW) positions are being established around Australia to help people reduce the lifestyle risk factors that contribute to preventable chronic disease and to refer people at risk, or with an established chronic disease, to Health Services. The Healthy Lifestyle Workers (HLWs) will work to improve nutrition and physical activity for individuals, families and communities. They will refer people who they identify as being at risk of developing a chronic disease and those with existing disease to appropriate health services where necessary. [30] The positions are non clinical.

The roll out of the workforce to support these two measures began in 2010-11. Redesign of the workforce element of these measures resulted in them being deployed in teams to create a more concentrated effort in each region (herein referred to as 'Regional Tackling Smoking and Healthy Lifestyle teams'). [31] The team members will undertake programs of learning and development. [32]

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[29] DoHA, National Action to Reduce Smoking Rates Factsheet [website], (accessed 21 November 2011).

[30] DoHA, Helping Indigenous Australians to Reduce Their Risk of Chronic Disease – Factsheet [website], (accessed 12 February 2013).

[31] DoHA, Annual Progress Report on the Australian Government's Contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes [website], (accessed 21 November 2011).

[32] TAW and HLW aiming for Certificate II (initially as entry level), III or higher, and RTC leading to Certificate IV. DoHA, Healthy Lifestyle Workers, Tobacco Action Workers and Regional Tobacco Coordinator Job Descriptions.

9.2. Program logic for Measure A1

As specified in the National Framework the following outputs and early results in relation to measure A1, and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- Regional Tobacco Coordinators and Tobacco Action Workers would be recruited.

- The training for these workers would be well received and well regarded.

- Enhanced or new smoking cessation services and programs would be designed and delivered.

Expected early results for years 2-4:

- Health professionals have better access to smoking cessation resources, services and materials to support their own cessation attempts.

- Participating services are smoke free workplaces or implementing smoke free policies.

- Individuals and communities in contact with measure A1 are more aware of health risks associated with smoking, more aware of resources available to help them quit or cut back and more inclined to seek assistance as part of quit attempts.

9.3. Program logic for Measure A2

As specified in the National Framework the following outputs and early results in relation to measure A2, and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- The occupancy rate for healthy lifestyle worker positions is high.

- Training provides the necessary skills and information to deliver A2.

- There are strong participation rates for A2 activities.

Expected early results for years 2-4:

- Primary health care services involved in A2 are able to offer more support for Indigenous Australians with or at risk of chronic disease.

- Participants in A2 activities have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean.

9.4. State of implementation

The following information was provided by DoHA on the state of implementation of measure A1 and A2 at a national level as at 12th August 2011 (relevant to the SSE):[33]

- There are twenty-one Regional Tackling Smoking and Healthy Lifestyle teams funded, with another nineteen teams to be funded in 2011-2012. The first preference has been

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[33] DoHA, A1/A2 update, 12 August 2011 (personal communication).

for each team to be hosted by an AHS, but it can be another suitable organisation. Hosting of workers in AHSs is not intended to prevent the teams conducting activities in a range of settings across the region.

- In December 2010 an induction training workshop was held in Canberra for current Regional Tackling Smoking and Healthy Lifestyle workers and other relevant people. The induction training had two streams: 'Talkin' Up Good Air' training and 'Smoke Check' brief intervention training, and; 'Living Stronger' training.

- Teams can access up to $100 000 each to undertake programs and community development activities of a non-clinical nature. Each team puts in a plan to be assessed by DoHA before approval. The money can be applied for in increments.

- The organisations employing the teams are also funded to supply Vocational Education and Training opportunities to the workers under this measure. Each organisation has to develop an individualised training plan which takes into account pre-existing education and experience for each worker.

- All organisations with funding allocation for these measures have been provided with a Healthy Lifestyle tool kit. The tool kit is a starting pack for the workforce, designed to be built on by the funded organisation. The contents of the kit were determined by a reference group and include training and reference materials, such as 'Talking Up Good Air', developed by the Centre for Excellence in Indigenous Tobacco Control, and the 'Healthy, Deadly and Strong' toolkit, developed by the Australian Indigenous Healthinfonet.

- DoHA has encouraged the organisations hosting the Regional Tackling Smoking and Healthy Lifestyle teams to apply to DoHA for Healthy Community Days funding and grant funding available through the Local Community Campaigns program.

Quitline services are to be enhanced to be more accessible and provide more appropriate services to Aboriginal and Torres Strait Islander people.[34] In the previous reporting period, DoHA advised that most of the Quitline funding agreements were in place. Through a search of Quitline websites and newsletters some activities relating to this strategy have been identified in Victoria and Queensland (no other state information was available):

- Quit Victoria has recently developed an Aboriginal Quitline Service and employed Aboriginal Quitline Specialists and an Aboriginal Liaison Officer to encourage and support Aboriginal smokers to utilise Quitline. Referral to the Aboriginal Quitline Service is being encouraged by the provision of information to the AHSs and Community Health Services in Victoria.

- The Queensland Health SmokeCheck - Indigenous Smoking Program, which delivers training, materials and programs to health providers working with Aboriginal and Torres Strait Islander people, has undertaken the Quitline Enhancement project for Queensland.[35]

- The project involves stakeholders such as Queensland Aboriginal & Islander Health Council (QAIHC), Health Contact Service (Quitline), and the Alcohol, Tobacco and Other Drugs Branch in the Preventative Health Directorate, Queensland Health.

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[34] DoHA, National Action to Reduce Smoking Rates Factsheet [website], (accessed 21 November 2011).
[35] Queensland Government, SmokeCheck – Indigenous Smoking Program [website], (accessed 21 November 2011).

- Some strategies for the project include:

    - recruitment of Aboriginal & Torres Strait Islander telecounsellors

    - initiating and maintaining a culturally welcoming and supportive environment at Quitline

    - delivering cultural competence training for Quitline staff

    - building cultural competence into quality assurance and professional frameworks

    - developing culturally appropriate pamphlets and literature for use by Quitline staff when engaging with Aboriginal & Torres Strait Islander clients.[36]

- The Quitline Enhancement project team report that, following months of engagement and consultation, they have progressed to the next phase of enhancing the cultural competence of Quitline staff and are developing culturally appropriate resources and materials for the Quitline service.[37]

- Quit Victoria and Queensland Health have been delivering training that could potentially have impact in some Sentinel Sites: [38,39]

    - Aboriginal Educator training, Bairnsdale, Vic

    - Peninsula Health Educator training, Dandenong site, Vic

    - Aboriginal Educator training, Katherine, NT

    - Pharmaceutical Society of Australia's smoking cessation and pharmacy training, Mildura, Vic

    - SmokeCheck workshops, Nhulundu Health Service and Aboriginal and Torres Strait Islander Health, Gladstone Hospital, Gladstone, Qld

    - SmokeCheck workshops, Brisbane, Qld.

- The Commonwealth funded 'Break the Chain' advertisements are being broadcast on TV, and published in print. The advertisements aim to contribute to halving the smoking rate of Aboriginal and Torres Strait Islander people through a higher level of personal acknowledgement of the health impacts of smoking. The campaign supports quit attempts and promotes strategies to avoid relapse among quitters. Related materials for health professionals are being offered through the website.[40]

Contractual activity reports from organisations funded with Regional Tackling Smoking and Healthy Lifestyle teams were received by DoHA for the December 2010-June 2011 period. Of

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[36] Queensland Government, Aboriginal & Torres Strait Islander Smoking Prevention Team Newsletter First Edition 2011 [website], (accessed 21 November 2011).

[37] Aboriginal & Torres Strait Islander Smoking Prevention Team Newsletter Winter Edition 2011 Queensland Government [website], (accessed 22 November 2011).

[38] QUIT Victoria, The Human Touch, September 2011. e-newsletter for QUIT educators.

[39] Queensland Health [website], (accessed 12 February 2013).

[40] Australian Government Quit now [website], (accessed 22 November 2011).

the fifteen organisations /services in Sentinel Sites with funding allocations, only ten reports were provided to DoHA. The data received varied in type and detail and did not provide an adequate basis to make comparisons between sites. Two of the sites were case study sites, but due to the early stage of development of their teams at the time of reporting they provided very little information on the activity of the teams.[41]

Five of the ten reports received outlined the types of local tobacco cessation and healthy lifestyle sessions being delivered, as:[42]

- community events which have been attracting large numbers of people, including events in remote sites

- smoking cessation and healthy lifestyle programs being run over several weeks

- targeted group activities (men, women, youth, antenatal) and events at various locations such as school and sporting venues

- cooking and walking groups established.

Of the ten funded organisations that reported, five reported that training had been undertaken with the Regional Tackling Smoking and Healthy Lifestyle team and four described the training as:[43]

- brief intervention training by SmokeCheck and the Asthma Foundation

- QUIT educator training

- smoking symposiums by the Centre for Excellence in Indigenous Tobacco Control

- attending conferences that related to tobacco use – particularly to smoke free workplaces.

One report stated that smoking cessation and brief intervention training had been undertaken by other health professionals such as nurses, Aboriginal Health Workers and drug and alcohol workers.

9.5. Findings from Sentinel Sites

Notes on collection and analysis of data

Interviews were conducted in six case study sites where the workforce had been partly or fully recruited, with key informants who would be expected to have some knowledge of the Regional Tackling Smoking and Healthy Lifestyle teams. Interviews in the enhanced tracking sites provided additional information on implementation of this measure.

Community focus groups discussed their perceptions of lifestyle risk factors and the health risks associated with smoking, their perceptions and awareness of the local smoking cessation and lifestyle modification services and programs, and their perceptions of change since the previous reporting period. The findings reported are based on focus group discussions in seven case study sites.

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[41] DoHA, A1 A2 site reports, 30 June 2011.
[42] DoHA, A1 A2 site reports, 30 June 2011.
[43] DoHA, A1 A2 site reports, 30 June 2011.

Progress with recruitment to the Regional Tackling Smoking and Healthy Lifestyle teams

Table 8 presents the allocation and recruitment findings from two sources; the DoHA reported allocation and recruitment as at 30 June 2011, and the findings of evaluation visits that occurred between August -October 2011. There are some disparities between the two data sources. In some sites the DoHA report indicated a position as filled, while the evaluation visit found it to be vacant (or vice versa). This is likely to be due to changes that occurred between the time the data was provided to DoHA and the evaluation visit. Data reported below on the number (and %) of positions filled are based on findings at the evaluation visit.

Table 8 shows that of the 58 positions allocated to organisations in the regions in which the Sentinel Sites are located, 40 (69%) positions were filled at the time of the evaluation visits. Six positions had been filled since the previous report for March -May 2011, however one of the recently recruited positions has since become vacant. Two further positions were shortly to become vacant. Of the sixteen vacancies, ten had never been filled. Assessment of overall progress with recruitment to the positions in Sentinel Sites for this reporting period has been that 12/14 (86%) of RTC positions, 9/15 (60%) of TAW positions and 19/29 (66%) of HLWs positions were filled.

Table 8: Recruitment and retention data for measure A1 and A2 workforce by Sentinel Site

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
Case study sites	Katherine West	remote	Katherine West Health Board	1 x TAW	0	Recruitment commenced, Not yet filled
				1 x RTC	1	Position filled in August 2011[a]
				2 x HLW	0	Recruitment commenced, Not yet filled
	Port Augusta	regional	Country Health South Australia	1 x TAW	0	Recruitment commenced, Not yet filled
				1 x RTC	0	Recruitment commenced, Not yet filled
				2 x HLW	0	Positions not yet filled recruitment commenced[d]
	Campbell-town	urban	Tharawal Aboriginal Medical Service	1 x TAW	0	Position filled- recently vacant[a]
				1 x RTC	1	Position filled -about to be vacant[a]
				2 x HLW	2	Positions filled – one about to be vacant[a]
	Tamworth	regional	Tamworth Aboriginal Medical Service	1 x TAW	0	Recruitment commenced, Not yet filled
				1 x RTC	1	Position filled August 2011[c]
				2 X HLW	0	Recruitment commenced, Not yet filled
	East Pilbara	remote	Puntukurnu Aboriginal Medical Service	1 x TAW	0	Position filled -recently vacant[a]
				1 x RTC	0	Position filled but staff on extended leave – recently vacant[a]
				2 X HLW	1	1 position filled since previous report –recently vacant
	Brisbane South	urban	Institute for Urban Indigenous Health [d,e]	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled
	Logan/ Woodridge	urban	Institute for Urban Indigenous Health [d,e]	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
Enhanced tracking sites	Derby	remote	Kimberley Aboriginal Medical Services Inc (West)[d]	1 x TAW	0	Previously filled, now vacant, recruitment under way
				1 x RTC	1	Position filled
				2 x HLW	1	Both positions previously filled, one now vacant and recruitment under way
	Swan Hill/ Mildura	regional	Mildura Aboriginal Corporation Inc	1 x TAW	1	Position filled
				1x RTC	1	Position filled
				2 X HLW	2	Positions filled
	Cairns	regional	WuChopperen Health Service	1 x TAW	1	Position filled
				1 x RTC	1	Position filled – have had one changeover since initial recruitment[a]
				2 x HLW	2	Positions filled
	Newcastle	urban	Awabakal Newcastle Aboriginal Cooperative Ltd	1 x TAW	1	Position filled since previous report
				1 x RTC	1	Position filled since previous report
				2 x HLW	0	Recruitment commenced, Not yet filled
	Darwin	regional	Danila Dilba Health Service	1 x TAW	1	Position filled
				1 x RTC	1	Position filled since previous report
				2 x HLW	2	Positions filled
Tracking sites	Kalgoorlie	regional	Bega Garnbirringu Health Services Aboriginal Corporation	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled
	Dandenong	urban	Dandenong & District Aboriginal Cooperative	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled
	North Lakes /Caboolture	urban	Institute for Urban Indigenous Health [d,e]	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
	Gladstone	regional	Nhulundu Wooribah Indigenous Health Organisation	1 x TAW	1	Position filled
				1 x RTC	1	Position filled
				2 x HLW	2	Positions filled
	Canberra	urban	Winnunga Nimmityjah Aboriginal Health Service	1 x TAW	1	Position filled
				1 x HLW	1	Position filled

[a] Updates made on evaluation visit findings.

[b] DoHA reports the position as filled, On evaluation visit and further follow-up the HLW position could not be identified and will be considered not filled for this report.

[c] DoHA, A1/A2 personal communication, 12 August 2011.

[d] DoHA, Report on National ICDP workforce, 30 June 2011. The workers may be based in an organisation that lies outside of the Sentinel Site, and/or within an organisation other than the DGP or AHS identified for the site.

[e] Hon Warren Snowdon MP, New Primary Health Care Services for South-East Queensland Aboriginal and Torres Strait Islander Communities [website], (accessed 12 February 2013). The Institute for Urban Indigenous Health have one team listed for areas of Brisbane. The same workers are attributed for 3 Sentinel Sites. At evaluation visits it was identified that the organisation has more staff working in trainee positions. A second healthy lifestyle team was funded for the region in October 2011.

Note: Table excludes seven sites: Dubbo, Bairnsdale, Geraldton, Elizabeth, Grafton, Hobart and Barkly, as there are currently no measure A1 and A2 positions funded in these areas.

While the allocated ICDP positions include responsibility for the Sentinel Site, they may cover an area that extends beyond the Sentinel Site boundaries.

Full-time Equivalent (FTE).

Source: DoHA, Report on ICDP workforce, 30 June 2011 unless specified by footnotes.

Recruitment Overall

Seventeen of the twenty-four Sentinel Sites have measure A1 and A2 workforce investment; three remote; seven regional; seven urban (three of the urban sites are in an area covered by the same organisation and A1 and A2 workforce). The funding approach has been to allocate a Regional Tackling Smoking and Healthy Lifestyle team, initially comprising of 4 staff- 1 RTC, 1 TAW and 2 HLWs (Canberra excepted) to work in particular locations. The teams will expand in the second and third years with the addition of one more TAW each year. Our observations show that the way services allocate these positions and the approach taken to the work differs between locations.

Recruitment by Geographic Region

Five of the seven urban sites have full recruitment (noting that three sites are covered by one team). The one organisation covering three sites has had stable employment and has taken on trainee positions to expand its reach. This organisation now has additional funding for further positions to cover their region.[44] Of the urban sites without full recruitment, one is establishing its first team with 2/4 positions filled and the other (which previously had a full team) has lost one staff member and is about to lose two more.

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[44] Hon Warren Snowdon MP, New Primary Health Care Services for South-East Queensland Aboriginal and Torres Strait Islander Communities [website], (accessed 12 February 2013).

Of the seven regional sites that had been allocated positions, five have full recruitment. The two sites with vacancies have had recruitment issues throughout the Sentinel Sites Evaluation. The majority of the regional sites have been successful with recruitment and retention.

The three remote sites have vacancies. One site has had difficulty with recruiting staff, however one position was recently filled. The other two sites have previously had full teams, but both have now lost staff; one with 2/4 staff remaining and the other about to lose three staff at the time of the evaluation visit.

Recruitment by case study site

Seven case study sites have been allocated Regional Tackling Smoking and Healthy Lifestyle teams; two remote, two regional, and three urban (one organisation covering two sites). The following positions had been recruited in the case study sites; four RTCs, one TAW and five HLWs. Only one urban team was complete.

Challenges to recruitment

Chapter 8 of the report provides information on recruitment to ICDP funded positions in general. Where recruitment difficulties were raised, the commonly reported reasons for delays or difficulty included a small pool of suitably skilled people to draw upon, especially in the remote and regional sites.

A number of sites indicated that they staggered the recruitment process in order to recruit to the RTC position, with the aim of first creating a support structure. The time taken for staggered recruitment had delayed the recruitment to TAW and HLW positions. This was an important factor in Katherine West, which is the site where recruitment was less advanced compared to other sites.

In Katherine West, recruitment to the position of TAW was delayed due to difficulties in finding a non-smoking applicant with suitable qualifications and experience. Though it is not a position requirement from DoHA that the workforce be non-smokers, the organisation felt that the person in the position should lead by example. This was generally not raised as an issue in other sites.

> *'There is a perception it is hard to recruit Aboriginal people that don't smoke or lead a healthy lifestyle to these positions. There is a feeling that they would not be able to do the job due to lack of credibility within community. There are HLW employed who do smoke but they are just not allowed to at work. Generally the TAW positions are to be filled by someone who doesn't smoke and these are really hard to fill because of community expectations. It also is a barrier to people applying.'* (Interview, NACCHO affiliate)

Limited infrastructure to accommodate staff in the office was noted by interviewees in a regional and a remote site. Recruitment in the regional site had been delayed due to not being able to accommodate new staff; this site has been granted capital works funding for a new building which, when completed, should alleviate the problem. The remote site expressed concerns about availability of housing for staff.

The impact on other programs or workforce groups as a result of newly funded Regional Tackling Smoking and Healthy Lifestyle team positions

Responses from managers to a statement that referred specifically to the impact of the RTC and TAW positions in drawing workers away from other important health programs showed that:

- As recruitment was more advanced in this reporting period, interviewees were less likely to respond 'don't know/can't say' – 42% (11/26) in this reporting period compared to 57% (12/21) in the previous reporting period.

- Of those who felt they could make an assessment of the impact on the workforce of other programs, the majority (11/15) strongly disagreed with the statement that there had been a negative impact, and a few partly disagreed. Only one respondent agreed with the statement that there had been a negative impact. This is similar to the previous reporting period where only three agreed with this statement.

- This perception that there has been minimal impact on other programs or workforce groups due to the employment of the RTCs and TAWs is in contrast to the data collected for ICDP workers in general (reported above in Chapter 8) where 40% (17/42) of managers either strongly or partly agreed with the statement about there being a negative impact on other workforce groups and programs. This difference in perceptions related to the A1 and A2 workforce, compared to the ICDP workforce more generally, is possibly because the workers being attracted to the A1 and A2 positions are less likely to come from within the existing primary health care workforce in Aboriginal Health Services, possibly because they are non-clinical positions.

Structure of Regional Tackling Smoking and Healthy Lifestyle teams

The ways the Healthy Lifestyle teams have been structured has varied between sites:

- The Institute for Urban Indigenous Health (IUIH) has received funding for Regional Tackling Smoking and Healthy Lifestyle teams, but they are not covering the Sentinel Sites of Brisbane South or Logan/Woodridge at this stage because they are prioritising other areas within their boundaries.

- The Regional Tackling Smoking and Healthy Lifestyle team that has jurisdictional responsibility for Derby has the RTC based in Broome and the TAW in Derby, two hundred and twenty kilometres apart. In the West Kimberley, a HLW is based in each of Derby and Halls Creek (550 kilometres from Derby, 680 kilometres from Broome).

- In the East Pilbara site, the AHS has pooled the state and commonwealth Closing the Gap funding [in particular the HLW and Outreach Worker funding] to create three generalist positions and part funding for a reception position to assist with the sign up of patients.

Awareness of the Regional Tackling Smoking and Healthy Lifestyle teams generally

Consistent with the early stage of recruitment, there was limited awareness among interviewees of recruitment to the positions associated with the Regional Tackling Smoking and Healthy Lifestyle team. In response to the question *'are you aware of the following positions?'*:

- Fifty five per cent (35/64) of interviewees said they were aware of the RTC position. While differences in relation to remoteness of sites were relatively small, awareness in remote sites [60% (12/20)] and in urban sites [56% (15/27)] tended to be higher than in regional sites [47% (8/17)].

- Thirty-six per cent (23/64) were aware of the TAW position. Awareness tended to be higher in the urban sites [48% (13/27)] compared to remote sites [35% (7/20)] and regional sites [18% (3/17)].

- Forty –three per cent (26/60) were aware of the HLW position. Awareness tended to be higher in urban sites [59% (16/27)] compared to remote sites [40% (8/20)] and regional sites [15% (2/13)].

Recruitment in the urban case study sites was more advanced so it would be expected that there would be more awareness. Despite less advanced recruitment in remote areas, awareness of these new workers tended to be greater in remote locations than in regional locations, possibly because of the smaller and fewer networks in the remote environment. In addition, there was only one regional site with funding for a Regional Tackling Smoking and Healthy Lifestyle team, so awareness when compared to sites in remote and urban locations is expected to be lower.

In sites where positions have been newly recruited, workers were often in 'meet and greet' (or orientation) phase.

Clinicians based in the AHS in Campbelltown and East Pilbara expressed awareness of the positions. In Logan/Woodridge and Brisbane South there was minimal awareness of the Regional Tackling Smoking and Healthy Lifestyle team, even amongst clinicians based in the AHS. In these two sites, those clinicians in the AHS who were aware said that they knew of the positions but that the positions were not doing any work in the AHS within the site. This is consistent with the teams being focused on work in other parts of the region, rather than in the Sentinel Sites.

Community awareness of Regional Tackling Smoking and Healthy Lifestyle teams

There was minimal community awareness of the Regional Tackling Smoking and Healthy Lifestyle teams. In Campbelltown, the community focus groups expressed awareness of the Healthy Lifestyle Worker and of the 'Durali' campaign that supports people to quit smoking and runs health promotion activities. The community focus groups in Campbelltown also spoke about accessing an exercise group run by the AHS and spoke very highly of this program. In Brisbane South, the community focus group indicated that they had heard of the 'Deadly Choices' program that was operating in schools but questioned its effectiveness: *'I wonder if they listen?'* In Logan/Woodridge, the community focus groups indicated no awareness of the Regional Tackling Smoking and Healthy Lifestyle team and indicated that if they want support to quit smoking, or to modify their lifestyles, they would visit their GP to seek this support. In East Pilbara, community focus groups felt that there was no support to quit smoking from

dedicated workers and no lifestyle modification programs being delivered. This perspective is consistent with the way the funding has been used in the East Pilbara site and with the delays in recruitment and difficulties with retention of workers in the site.

Mainstream General Practice awareness of the Regional Tackling Smoking and Healthy Lifestyle teams

Clinicians based in General Practice were generally not aware of the Regional Tackling Smoking and Healthy Lifestyle teams. The teams appear not to have extended their reach to offering services and/or programs to the clients of General Practices in their regions.

There was only one mainstream clinician who indicated awareness of the new workforce associated with the Regional Tackling Smoking and Healthy Lifestyle team. This GP reported that he does not access their services but is aware they exist. The reason given for not accessing the services was that this type of counselling and support was provided within the practice; clinicians didn't feel the need to seek external support for patients. Apart from this one GP, no clinicians in mainstream General Practices in the case study sites (or in the enhanced tracking sites where General Practice clinicians were interviewed) where the new workers have been deployed showed any awareness of the new positions, with a typical response being *'I have not heard of any of the positions despite being just down the road.'* (Interview, GP, General Practice)

This lack of awareness of the HLW teams is consistent with information from interviews with the HLWs, where six out of the nine HLWs interviewed indicated that they 'don't know/cant say' when asked to respond to the statement '*local doctors often refer Aboriginal or Torres Strait Islander patients to the HLWs.*'

There is scope for the Regional Tackling Smoking and Healthy Lifestyle teams to engage more with General Practices in their region.

Regional Tackling Smoking and Healthy Lifestyle teams working with DGP and SBOs

The lack of engagement with mainstream General Practice was also evident in interviews with staff of the DGPs in various sites and staff of the SBOs who indicated that they were generally aware of the positions, but there had been minimal to no contact with these organisations in regards to planning the work of these teams.

> *'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 ACCHO [Aboriginal Community Controlled Health Organisation] sector to manage, but I don't think they must be established yet as we haven't heard anything about status or plans to integrate with other ICDP funded workers or how general practitioners will be able to access the services.'* (Interview, SBO)

One DGP went so far as to say that they were actively being excluded from discussions with the AHS about the positions.

Interviewees in the AHS in the Newcastle enhanced tracking site indicated that they were, at that stage, focusing on work within the AHS and were *'open to sharing but … busy at the moment with existing events and work at the AHS.'*

In the Swan Hill/Mildura enhanced tracking site, interviewees from the DGP indicated that the IHPO, OW and other positions (i.e. not funded through the ICDP) based in the DGP were running 16 week Healthy Lifestyle programs for Aboriginal communities in the site. The programs were being funded through the DGP using lifestyle modification funding. The DGP

had accessed the TAW based at the AHS to provide information to lifestyle program participants. Swan Hill DGP has also received state Closing the Gap funding for a Quit Facilitator and intends to employ an Aboriginal person for 3 days a week, for 36 weeks, to enhance the delivery of these programs.

There was no indication from any other Regional Tackling Smoking and Healthy Lifestyle teams that they are planning to link with the DGP or General Practices. There is scope to enhance the work being undertaken by the teams by linking with DGPs and SBOs, in order to share information on program development and to take advantage of possible synergies with other programs being run by the DGPs.

Support structures for new Regional Tackling Smoking and Healthy Lifestyle teams and deployment of new positions in teams

When asked if they agreed that *'The deployment of the RTCs, TAWs and HLWs as teams has provided a supportive environment for workers'*, 49% (20/41) of interviewees said that they didn't know or couldn't say. Almost all of the remaining respondents agreed with the statement, with most strongly agreeing [39% (16/41)]. This is consistent with the variable progress with implementation between sites and the variable level of engagement in different sectors. The majority (11/15) of the RTCs, TAWs and HLWs who were interviewed indicated that they strongly agreed that deployment as teams had provided a supportive environment. These data are strongly influenced by the perceptions of the team based in southeast Queensland, where the team appeared to be well established.

Having the workforce deployed in teams was seen by interviewees to encourage collaboration and to limit the potential for these staff to work in 'silos'.

In this reporting period, there was one site that had restructured the Regional Tackling Smoking and Healthy Lifestyle team as part of an organisational restructure. Rather than having the RTC manage the whole team, they incorporated the team under a manager with responsibility for all substance misuse programs. This is the second location where such an approach has been adopted. The team in this location covers an area that includes three sites: North Lakes/Caboolture, Brisbane South and Logan/Woodridge. The IUIH, which manages the team, has appointed a 'Preventative Health Manager' whose responsibilities include management of the Regional Tackling Smoking and Healthy Lifestyle team. This was logical within the organisational structure, as there were a number of pre-existing substance misuse programs. The restructure was made to enable synergies across the new team and other programs and teams, and also to allow the RTC to get on with coordination and implementation of the program, rather than having to focus on management issues such as organising recruitment. The RTC based at the IUIH was previously employed as the RTC at Cairns; the similar restructure in Cairns had commenced during his period of employment there.

> *'[The] role of the Regional Tobacco Coordinator is a coordination role but in the initial stages of the project had to take on a management role. We changed this structure to where the RTC now sits under the manager, so the coordinator can focus on coordinating the project rather than like first RTC having to do recruitment, reporting, managerial and HR type roles. It enhances the project as these guys can now get on with core business. It's an organisational approach for the future.'* (Interview, AHS)

> *'[The] structure of the team is helpful. There's a manager who manages the whole team so I can focus on the delivery of the program.'* (Interview, RTC)

There have been staggered recruitment processes to ensure mentoring and support structures and arrangements. This was done in Katherine West, where they recruited to the RTC position before recruiting to TAW and HLW positions. In Brisbane South, the TAW was recruited before the RTC, and commented that he '*felt lost in the healthy lifestyle team'* until the appointment of the RTC, adding that he now has 'more direction and focus.'

The team approach has provided a supportive structure and was considered positive by Regional Tackling Smoking and Healthy Lifestyle teams generally.

> *'Deployment in teams has opened the doors for other avenues as they have to cover such a large area with a small team, therefore it's an opportunity they can support each other because tobacco, nutrition, and physical [activity] all comes under health.'* (Interview, HLW)

In the previous reporting period in Campbelltown, there were a number of issues noted in regard to the management structure and uncertainty regarding the focus and priorities for the work program of the Regional Tackling Smoking and Healthy Lifestyle team . In this reporting round, members of the Campbelltown team have moved on to other work. Despite this, the program continues to the extent possible with vacant positions. There are plans for recruitment to vacant positions.

In sites where there is a plan and/or project with clear roles and responsibilities for individual workers (respondents in their respective sites were able to describe their role in these programs), the team approach appears to work well. This was evident in a number of sites, including Campbelltown ('Djurali' program); Brisbane South and Logan/Woodridge ('Deadly Choices' program); Cairns ('Our Space' smoke free workplaces & 'Living Strong' Programs).

AHSs often have pre-existing funding for substance abuse programs or chronic disease programs. There have been some challenges and success in integrating the teams, not only with external organisations, but also internally. It appears that where there is a manager with overarching responsibility to integrate teams, and it is not left up to the RTC, the teams become better integrated into the broader work of the organisation. It is evident that this approach has created some tension in some organisation, but the outcomes appear to have been generally positive:

> *'Other workers who were doing other programs now fall under ours. Feels like we are stepping on some toes. Some programs have been taken from one team to another. It's kind of re-structuring in the organisation. There were tension a little bit at the beginning in terms of roles and responsibilities, but now everyone is used to the fact that we are here now. Understanding that [we are] not stepping on toes, but getting out there and having partnerships between teams within the organisation. There are a lot of staff members within the teams with cross sectional skills are there for a long time and know the community very well. They are helpful in implementing the programs. It's important to have this partnerships and complementary to each other.'* (Interview, HLW)

The small number of sites with a full Regional Tackling Smoking and Healthy Lifestyle team established, and the limited time workers had been in the positions during the time covered by this report, means we cannot draw any firm conclusions regarding the extent to which these new workers are working effectively in teams. However, early indications from the available data are positive.

Networking with other Regional Tackling Smoking and Healthy Lifestyle teams

A number of the teams spoke about the value of networking with staff of other programs that have been established for some time. In Tamworth, where the RTC has just commenced, the RTC has made contact with colleagues in Campbelltown and Mildura to seek support to implement the program in Tamworth.

Effectiveness of the new Regional Tackling Smoking and Healthy Lifestyle teams

In response to the statement 'in the past six months, smoking rates amongst Aboriginal and Torres Strait Islanders appear to be declining due to the new support programs established by the TAWs and RTCs', 75% (24/32) of interviewees responded that they 'don't know/can't say'. This is consistent with the early stage of recruitment and implementation of these programs, and the uncertainty about whether the programs would be effective and/or the time they may take to be effective. Of those who did feel able to respond, five out of eight respondents disagreed that the smoking rates had been declining in the past six months. All of the (low number of) RTCs and TAWs indicated that they 'don't know/can't say', when asked to respond to this statement.

Similarly, 44% (14/32) respondents when asked to respond to the statement 'in the past six months, there has been an increase in smoking cessation resources and services available to Aboriginal and Torres Strait Islander people' indicated that 'they don't know/ can't say'. Again this is consistent with the early stages of recruitment and program implementation. The RTCs and TAWs were less likely to respond 'don't know/ can't say' and more likely to disagree with the statement than their managers.

In response to the statement 'the availability of support provided through the HLWs has led to more Aboriginal health checks, GP Management Plans or Team Care Arrangements', about half (16/34) of interviewees said 'don't know/can't say', and the rest tended to agree with the statement. However, clinicians tended to be less likely to respond 'don't know/cant say', less likely to agree and more likely to disagree than other respondents.

Eight of the nine HLWs felt that they had been able to introduce new ways to assist Aboriginal and Torres Strait Islander people who want to improve their health.

Interviewees were asked a number of questions regarding the impact of the new ICDP measures on availability of smoking cessation resources, smoke free workplace policies, developments of partnerships related to smoking cessation activities, knowledge and resourcing of the health workforce in relation to smoking cessation activities, and smoking rates in the population. As reported in the previous reporting period and as expected at this early stage of implementation, most respondents indicated they were not able to make an assessment of impact of the measures. Of those who felt they could provide a response regarding resources, partnerships, and knowledge of the health workforce, the majority tended to agree that there had been an impact. As expected at this early stage, they were less likely to agree there had been an impact on smoking rates among health workers or in the population. The situation with regard to perceptions of impact of this measure is very similar to the previous reporting period.

The SSE will continue to monitor trends in perceptions of potential impact, including differences in different types of sites or locations, and how this information can be used to inform ongoing implementation and refinement of the smoking cessation measures.

Geographic coverage

The relatively small number of positions in relation to the large geographic areas to be covered, and the scale of change required to achieve impact on health status, were again raised as issues in this reporting period. 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.

> *'This will be a challenge and I am sceptical of the impact the workers will make on a remote satellite clinic like [name of clinic].'* (Interview, NACCHO affiliate)

As noted above, there has been limited engagement with the General Practice sector, including through engagement with DGPs. This is partly due to the large area the workers are expected to cover and to the fact that they are focusing on supporting the Aboriginal Health Services. None of the Regional Tackling Smoking and Healthy Lifestyle teams spoke about their potential to support General Practice clients. Clinicians in some sites expressed interest in the possibility of referring patients to these teams for support, and in one site it was reported that patients were being referred to one of the HLWs who is a dietitian. However, the DoHA has indicated that the intended roles of these teams does not include receiving referrals from clinical services, and that if anything the intended role is the reverse – with these teams referring people to clinical and other services for support. Based on the evaluation findings from some sites it appears there may be a need to further communication to clarify the intended role of these teams in relation to referrals.

The large geographic area to cover has, as indicated above, required the teams to limit service delivery to particular parts of the area they are funded to cover.

> *'[For] all the team to cover a huge geographic area and Aboriginal and Torres Strait Islander population is a challenge. We didn't pick up resources under the package specifically for [site name] we picked up the resources for all of South East Queensland. I don't think what the community gets is enough in terms of Healthy Lifestyle resources.'* (Interview, AHS)

In Cairns, the focus of the Regional Tackling Smoking and Healthy Lifestyle team is on promoting smoke free workplaces, and their approach is initially to support Health Service workers to quit and then to enforce the smoke free workplace policy for workers and clients. Initial focus was on the AHS where they are based, and on extending their work to other AHSs in the region. They are using a 'train the trainer' model and linking with other AHSs in order to achieve wider impact across the large geographic area they are expected to cover.

> *'It is a huge area and if it's going to be achievable it will be long term. Linking with other AMSs as they are the ones that will have the reach into the communities and we will be communicating to the AHS [our] success in programs and policies. The health hub is the AHS, so [we] focus on work with the service rather than scatter gun through communities. Tap into the AHS, get their support and they will roll it out into the communities.'* (Interview, ICDP worker, AHS)

> *'Funding body needs to be aware that this is a rural and remote area we are dealing with, and yes, there are timeframes that we need to make sure that all achievable outcomes are achieved in that timeframe. Realistically though, it is so spread out - our area - that it takes a lot of time and effort to get there. The funding body needs to understand that a lot of the information needs to be designed again locally. Time,*

patience and cultural appropriateness are needed for programs to work and funders don't always understand this.' (Interview, ICDP worker, AHS)

'Geographical day: 8 or 9 hour drive to furthest point. If we are delivering a six to eight week smoking cessation program, need to go there and establish how to do it - networking. It is 9 hours to Melbourne from Canberra. Canberra to Sydney is a three hour drive. For us to go to a network meeting it is 5 or 6 hour drive. The other AHSs are really important as they are closer to the action, so we need to train the staff at the AMSs and let them deliver the service.' (Interview, ICDP worker, AHS)

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 [name] 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/or Torres Strait Islander people that are offered by the city council, state government and the Indigenous health peak body.

Satisfaction with training for the new workforce

All (12/12) of the TAWs, RTCs and HLWs agreed with the statement that *'the training has equipped me with the skills to fulfil my role.'* The teams based in Cairns and at the IUIH indicated that they had undertaken a skills assessment audit and then used this to develop a training plan for individual team members.

> *'Population health diploma [has been] commenced by both HLWs and this was identified through the training plan developed as part of the funding agreement.'* (Interview, ICDP worker, AHS)

The Regional Tackling Smoking and Healthy Lifestyle teams generally felt they were able to access training to give them skills to fulfil their roles. One team felt that access to training for HLWs was easy, but there had been some difficulties in access to training for supporting smoking cessation.

> *'We have been able to access huge amounts of training - we have been treated so well. Training is through Cox Inala. 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. QAIHC have been very helpful with promotion tools and Living Strong program. [We] have had some challenges looking for training focused on smoking cessation and the only one found is the Quit training through the Cancer Council. There is not a lot specifically focused on smoking*

> *cessation. Training is often down south. More localised training. More training [has]*
> *been available for HLWs, but not so easy to find [training] for tobacco workforce.'*
> (Interview, ICDP worker, AHS)

See Chapter 8 for more information on perceptions of training for ICDP workers in general.

The ICDP and other smoking cessation and healthy lifestyle initiatives

As reported previously, there is a number of pre-existing tobacco initiatives, at both state and national levels, occurring in tandem with the new ICDP funded measure. Interviewees commented on other funded (in particular state funded) initiatives focusing on tobacco more than initiatives focusing on other aspects of a healthy lifestyle.

In Western Australia in particular, it was noted that there is already a large investment of Closing the Gap funding at the state level to tackle smoking cessation for workers. Investment from both state and Commonwealth governments has caused some confusion and duplication of roles*.*

> *'The states had to come up with implementation plans on how they were going to*
> *spend their Close the Gap commitments before the Commonwealth had advised what*
> *they were going to do with the Commonwealth Close the Gap money. This is how the*
> *duplication has come about and the 'explosion of smoking workforce in WA.'*
> (Interview, SBO)

Not only are there pre-existing programs to work with externally but, as noted above, there have been some challenges integrating with internal AHS programs that often include pre-existing substance abuse and healthy lifestyle programs. In Cairns, the AHS addressed the challenge by integrating all existing substance abuse programs under the one management structure, along with the Regional Tackling Smoking and Healthy Lifestyle team.

As for the previous reporting period, interviewees and focus group participants were at times unable to say whether tobacco control initiatives they were aware of were funded and delivered through the ICDP Tackling Smoking measure, or through some other initiative.

The existence of a range of other initiatives relevant to smoking cessation in the Sentinel Sites will make it difficult to tease out the relative effect of different initiatives. As the Sentinel Sites Evaluation progresses, we will focus our efforts on understanding the extent to which the ICDP related tobacco cessation initiatives are adding value to existing programs and activities.

Impact of pre-existing smoking cessation and healthy lifestyle activities and programs

There was relatively limited reference to pre-existing or other smoking cessation and/or other healthy lifestyle activities or programs. Three of the eight HLWs interviewed indicated that there were pre-existing programs. These programs included:

- Healthy for Life Program activities[45] (also referred to in the previous reporting period)

- existing Medicare item numbers for preventive health checks

- other existing chronic disease programs at the AHSs

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[45] DoHA, Healthy for Life [website], (accessed 12 February 2013).

- TV commercials with messages aimed at reducing smoking among local Aboriginal and Torres Strait Islander people (developed by the AHS in Bairnsdale, where there is no funded Regional Tackling Smoking and Healthy Lifestyle team).

A number of factors may have contributed to the relatively limited reference by interviewees to pre-existing programs, including the relative scale of the new ICDP investment compared to previous initiatives, the focus of the SSE being on the ICDP related activities, and that many of the interviewees were relatively new to the sector and would have limited potential for exposure to pre-existing programs.

Design and delivery of smoking cessation and healthy lifestyle programs

The design and delivery of services and programs being developed by the Regional Tackling Smoking and Healthy Lifestyle teams is still, generally, at a relatively early stage, with recruitment to new positions still underway in some locations. However, it is evident that a number of different models are emerging in the Sentinel Sites where teams were, or were being, established.

Some examples of the diversity of models include:

Model 1: Campbelltown - Delivering lifestyle sessions and fruit and vegetable packs – a brightly painted ute bearing health promotion slogans is a major focus of the program (named 'Durali').

Model 2: Institute for Urban Indigenous Health (SE Qld) – Focusing on delivery of secondary schools programs (named 'Deadly Choices') and running Healthy Community Days.

Model 3: Cairns -- Focusing on smoke free workplace environments and supporting staff and community to quit smoking. The model in Cairns supports the team to work together rather than in 'silos'. They took the approach of promoting swapping smoking for healthy lifestyles, which brought the HLWs and TAWs together to form a team.

Model 4: East Pilbara – Pooling the state and commonwealth Closing the Gap funding to create several generalist positions in health promotion (whose work includes focus on smoking and healthy lifestyles), and using part of the ICDP funding for a reception position to assist with sign up of patients.

The generalist model in the remote context appears to be working well and there has been an increase in patient registrations for the PIP Indigenous Health Incentive in this remote site.

The program logic indicates that in the first year smoking cessation support programs are to be developed and delivered. In addition, DoHA provided job descriptions for both the RTC and TAW positions, which indicate that they are to '*Deliver smoking cessation and support programs, appropriate to the worker's qualification level, to Aboriginal and/or Torres Strait Islander people, and refer people to other health programs as appropriate*.' At this stage of implementation it appears that the focus has not been on delivering smoking cessation or support programs. The community focus group data clearly indicate that there is a need for support for quitting smoking, through development of group and individualised programs.

Vignette - Talking not telling

An urban Regional Tackling Smoking and 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'.*[46]

Partnerships

In response to the statement 'Partnerships were developed with other agencies to assist with the delivery and referral pathways of local stop smoking programs', respondents either indicated that they 'don't know/can't say' [49% (21/41)] or that they strongly or partly agreed [46% (19/41)].

There is additional scope, as identified in a previous section of report, to inform DGPs about the new teams and scope of their work. This may encourage partnerships and collaborations.

Vignette - Coordinating and Resourcing

A large, long established AHS in a capital city has used the Regional Tackling Smoking and Healthy Lifestyle team funding to build on existing programs. The result has been a well coordinated health promotion program that involves Tobacco Action Workers and the Healthy Lifestyle Workers in a range of activities aimed to raise community awareness of healthy choices, increase community engagement and link people with clinical services, including those that offer smoking cessation support and products. The service has a 'no smoking' workplace policy.

'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 Clinician)

Funds obtained through the Council of Australian Governments Indigenous Health Partnerships were used to buy a vehicle and a trailer filled with gym equipment. The Holden Ute, colourfully branded with healthy lifestyle messages, supports the work of the Regional Tackling Smoking and Healthy Lifestyle Team and other service staff in a practical way. It is used to support Koori boot camps and exercise programs, community cooking classes and kitchen programs, community garden projects, smoking cessation activities and delivery of fruits and vegetables to households.

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[46] 'Deadly' is used widely by many Aboriginal and Torres Strait Islander people to mean excellent or very good.

> *'It's one of the biggest things that we actually got for our [health promotion] Program. It does attract a lot of attention … It's hard not to see it.'*

Linking Regional Tackling Smoking and Healthy Lifestyle teams to clinical teams

The majority of the clinicians either disagreed (3/8) or indicated that they 'don't know/can't say' (2/8) when asked to respond to the statement '*I regularly refer Aboriginal and Torres Strait Islander patients to the new TAW to support patients in their attempts to quit smoking*'. The clinicians who agreed with the statement (3/8) were all from the Campbelltown AHS.

In Cairns, the Medical Director of the AHS and the Regional Tackling Smoking and Healthy Lifestyle team indicated that they wanted to do more work on developing links between their teams.

> *'[There is] more work to be done on linking with the other sections of Health Service such as tobacco and healthy lifestyle teams. Looking to develop systems to do this. They previously have functioned a little bit independently.'* (Interview, GP, AHS)

The Healthy Lifestyle Worker in one site is an allied health professional and it was felt that clinicians in the AHS were referring to the HLW more often as that worker was able to offer specific services rather than general advice and support. The HLW in this site also noted that generally the GPs were not referring to other types of services offered through the healthy lifestyle programs.

> *'Doctors refer to see patients one on one probably because I am an accredited [allied health professional] 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.'* (Interview, ICDP worker, AHS)

Vignette - Referral pathways

A large AHS in a regional site have found that having the Regional Tackling Smoking and 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.

A number of General Practices and AHSs provided clinical indicator data on smoking status. These data have serious limitations, which are described in Chapter 7. Ten AHSs and seventeen General Practices provided clinical indicator data. Data were only analysed for Health Services with over 100 Aboriginal and Torres Strait Islander patients identified on their clinical information system. Less than a third of the Health Services provided data on recording of smoking status. It is evident from the clinical indicator data provided that there is minimal recording of smoking status in clinical information systems. Enquiring about, and recording of, smoking status is an important first step in the implementation of brief interventions and smoking cessation measures.

It is interesting to note that there is a relatively high reported rate of completed GPMPs (8/10) and TCAs (6/10) within AHSs (see Appendix G), but low rates of reporting of smoking status, especially for diabetic clients.

Table 9: Clinical indicators provided by Health Services for Aboriginal and Torres Strait Islander people

Indicator	AHS Mean	AHS n	AHS Min	AHS Max	GP Mean	GP n	GP Min	GP Max
Proportion of all clients who have had their smoking status recorded in the past 12 months	75.5%	3	46.0%	100%	86.2%	4	66.3%	100%
Proportion of all clients who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	41.1%	3	15.6%	55.4%	40.8%	4	27.5%	57.1%
Proportion of clients with type 2 diabetes who have had their smoking status recorded in the past 12 months	53.1%	1	n/a	n/a	100%	4	100%	100%
Proportion of clients with type 2 diabetes who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	18.0%	1	n/a	n/a	34.2%	4	17.7%	47.8%

Note: n= number of services.
AHS = Aboriginal Health Services
GP = General Practice
n/a = Not applicable

Quitline

There were a number of community focus group participants who indicated that they were aware of Quitline. Despite this there is significant room for improvement in access to this service. A number of participants indicated that they had rung the Quitline but no one had got back to them. Interviewees in urban sites indicated that Quitline was being used by community members and that the Regional Tackling Smoking and Healthy Lifestyle teams were actively encouraging use of this service.

> *'Quitline have its clients, of whom 6% are Aboriginal and/or Torres Strait Islander – due to shame factor is not there, that is, their family do not know if accessing Quitline.'* (Interview, ICDP worker, AHS)

However, interviewees consistently indicated that this service was not being accessed by members of remote communities, due to language barriers and low phone ownership.

Existing awareness of risks and health related behaviours

Interviewees in all case study sites indicated that there was a high level of interest among patients attending Health Services to seek support to quit smoking. Similar to the two previous reporting periods, 56% (14/25) of clinicians either strongly or partly agreed with the statement that '*over the past six months there has been an increased interest from Aboriginal and Torres Strait Islander patients seeking support to quit smoking'.*

This suggests that the level of interest expressed amongst Aboriginal and Torres Strait Islander community members to seek support to quit smoking predates the introduction of the

Regional Tackling Smoking and Healthy Lifestyle teams. This, and other information presented above, indicates that the impact of the teams is minimal at a population level at this point. The minimal impact is due to the early stage of implementation of the work of these teams, and to the evidence that teams are not able to cover the large and diverse populations and service providers within the areas for which their organisations have a role, and the consequent need to target their activity in specific areas.

As for the previous reporting period, it is evident from community focus groups that there is a high and increasing level of community awareness across all sites that 'smoking is bad'. However, the data from the community focus groups generally did not indicate a deeper understanding of the ill effects and risks of smoking. However, it is important to note that a deeper understanding of ill effects and risks is not necessarily an important requirement for encouraging behavioural change.

The high level of awareness of the ill effects of smoking, and the generally positive perceptions of the interest in quitting, are a positive sign for the potential of the ICDP smoking measures to be taken up and to have an impact. The available data through the SSE are consistent with other data that point to the significance of this challenge in remote areas in particular.

All focus group discussions indicated a general level of awareness of what constitutes a healthy lifestyle. However, there were no or limited discussions that reflected an understanding about how lifestyle influences the risk of developing chronic disease. This level of community understanding is similar to that reflected in the previous two reporting periods.

Clinicians' views of community interest in health related behaviours

Clinicians in all case study sites were asked to respond to a series of statements regarding their perceptions of community interest in health related behaviours.

Clinicians indicated that '*there has been increased interest from patients to seek support to implement healthy lifestyle choices in the past 6 months*', with 65% (15/23) of clinicians either strongly or partly agreeing with this statement in this reporting period, compared with 39% (13/33) in the previous reporting period and 13% (2/16) in the period before this (Figure 14).
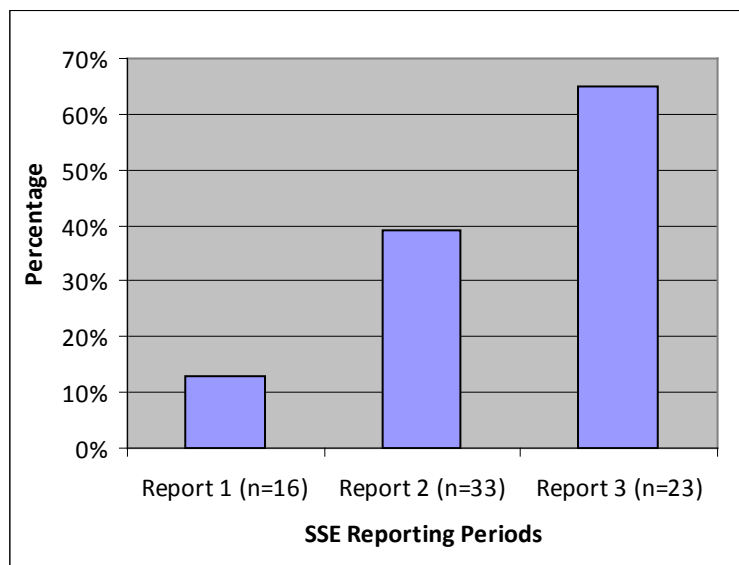
Figure 14: Percentage of clinicians who strongly or partly agreed with the statement 'There has been an increased interest from patients to seek support to implement healthy lifestyles.'

Fifty-eight per cent (14/24) of clinicians reported there had been a positive change in behaviour towards healthier lifestyles among local Aboriginal and Torres Strait Islanders over the past six months.

The need for programs designed to impact on young people

The strong theme that emerged from stakeholder interviews in the previous reporting period, about the need to develop programs designed to impact on young people, was less evident in interviews conducted in this reporting period. It is notable that the school program that operates from the IUIH targets healthy lifestyle and smoking cessation / prevention messages at young people.

Community members' perceptions of community campaigns

As previously reported, community focus groups recognised existing social marketing techniques such as posters, stop smoking signs and TV advertisements. This level of recognition was very similar to that reported in the previous SSE reports. There was no indication from the community focus groups that there had been any change in the scale or quality of social marketing activities since the previous reporting period.

The data reported in the sections above indicate that existing social marketing and health promotion programs are impacting on the awareness of community members. As reported previously, there is evidence that the support available through the existing primary health care system is not always adequate for providing ongoing support, and there is evidence of an awareness of the importance of personal motivation. These data suggest there is good potential for the new tobacco control initiatives to add substantially to existing programs and services in a way that can make a real difference.

Smoke free workplaces

In the previous reporting period a number of stakeholder interviewees and community focus groups expressed concern that Health Service staff were smoking on Health Service grounds, and this was not setting a good example. In this reporting period the issue was not raised by community focus groups, or as strongly by stakeholder interviewees. However, one

community focus group did discuss the need for enforcement of smoke free places, which included public spaces such as shopping centres.

Half (16/32) of all stakeholder interviewees either partly or strongly agreed with the statement, '*workplaces have implemented smoke free workplace policies as a result of the new tobacco workforce.*' A number of stakeholder interviewees stated that there were pre-existing smoke free workplace policies, but they required enforcement. They also noted the need for programs to support the Health Service staff.

> *'All AHSs had a tobacco policy in place and they had this sometimes in Queensland. What we are looking at in SE Queensland is the enforcement of the policy. Connecting with the policy is putting in place proper programs to support staff members of AHSs who are willing to quit smoking, for example, putting in place a tobacco cessation group, some innovative programs of using incentives to motivate staff to quit smoking.'* (Interview, AHS)

The Regional Tackling Smoking and Healthy Lifestyle team in Cairns has had a strong focus on supporting implementation of smoke free workplaces in the AHS for staff and community. In remote settings, having the additional capacity to enforce smoke free workplace messages was viewed positively, but there were concerns about the large areas that teams were expected to cover and the likely impact of the new teams across such large areas.

> *'KWHB are already supporting and implementing the 'smoke free' policy in their buildings as well as integrating into orientation programs, the Chronic Disease Coordinator says; all three of us are talking the same 'no smoking' language, but at the moment it is too* early to comment about how this will be rolled out in the region.' (Interview, AHS, remote site)

> *'Smoke free workplaces are becoming more common - that is the way it is and get used to it. Effort has been made by some clinics to give people alternatives like fruit platters and bowls around the place. Supported from the top down staff have accepted that it is. Remote communities may be harder to police, RTC based in [town] 700 km away … RTC put up rules and educates community and if clinic manager and health staff [are] smokers it will have to be them that will have to monitor and enforce it. The boss or the RTC isn't there on day to day basis - it will come, health community manager will enforce it.'* (Interview, NACCHO state affiliate)

The perceptions of the importance of smoke free work places, and early indications of changes in health workers attitudes to (and possibly practice in) smoking, are positive signs for the potential impact of the ICDP smoking cessation measures.

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/clients. As a result, the approach was taken that staff should lead by example before such a policy could apply to clients. 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 AMSs 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 AMS 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'

Nicotine replacement therapy and ongoing support programs

A consistent theme across community focus groups was the perceived lack of support for patients throughout their quit smoking journey. There was a strong perception that patients were often prescribed Nicotine Replacement Therapy (NRT) but then there is no ongoing support.

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

In future reports we will review the uptake of NRT by examining the PBS Co-payment data. The data were not available this reporting period.

There appears to be widespread awareness and use of NRT and the data continue to point to the need to ensure good quality information and education for health workers and community members regarding appropriate use of NRT. To help meet this need, 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.

Summary

It is evident that the RTC, TAW and HLW positions are becoming increasingly well established in the majority of sites. However, some sites continue to have difficulty with recruitment and retention of staff for these positions. Recruitment and retention is a particular challenge in remote sites. Recruitment to the A1 and A2 related positions does not appear to be having a significant negative impact on staffing of other positions.

The approach to deployment of these new workers varies between locations. With deployment still being relatively recent in most sites, and with large geographic areas and/or numbers of services within the areas to be covered by each team, there appears to be limited awareness of these positions (particularly in regional sites, and particularly amongst General Practice staff, amongst clinical staff and amongst community members). The patterns of awareness appear consistent with the focus of work of these teams.

The deployment of the RTC, TAW and HLWs in teams was perceived to provide a positive support structure for these workers. There was also evidence that having the teams located within a strong broader management structure within the employing organisation, and having more senior positions established before recruitment to lower level positions, and linking the teams with established programs (where they exist) has contributed to the effective functioning of these teams. There continues to be a widespread perception among many stakeholders that the positions have not been in place long enough to make an assessment of their impact. Some stakeholders felt the new teams had contributed to availability of smoking cessation resources, implementation of smoke free workplace policies, developments of partnerships related to smoking cessation activities, knowledge and resourcing of the health workforce in relation to smoking cessation activities, but that it was too early and that teams were too thinly spread to expect an impact on smoking rates in the community.

The design and delivery of services and programs being developed by the Regional Tackling Smoking and Healthy Lifestyle teams appears to generally be at a relatively early stage.

Significant attention continues to be focused on recruitment and training. There appears to have been greater difficulty with accessing relevant training for the TAWs than for the HLWs.

A range of approaches and programs relevant to the A1 and A2 measures are emerging, with the focus for activities being on schools, workplaces, communities or service systems in different locations, depending on perceptions of local needs and priorities.

Consistent with the previous report, there was a high level of awareness among community members of health related behaviours. There is also evidence that an increasing proportion of clinicians believe there is increasing interest amongst Aboriginal and Torres Strait Islander clients to seek support to implement healthy lifestyle changes. A key requirement appears to be in enhancing the quality and availability of appropriate support for people to adopt healthy behaviours.

The diversity in the programs that are emerging under this measure, the diversity in the focus of the target groups and the goals of these programs, the large areas and/or the large number of people and services within the areas that these teams are responsible for, the wide range of concurrent influences on health related behaviour and associated difficulties with attributing causality, and the timeframes in which real and measurable change might occur, will present significant challenges to providing a widely applicable and meaningful assessment of impact of these programs.

10. Local Aboriginal and Torres Strait Islander Campaigns to Promote Better Health (*Measure A3*)

It was agreed with DoHA that due to early stages of implementation and limited impact at this stage within Sentinel Sites this measure would not be covered for this reporting period. The measure area did, however, provide an update on the state of implementation and this is presented below, along with an overview of activities that may impact at the Sentinel Site level.

10.1. Description of measure

Local Community Campaigns to Promote Better Health are being developed under measure A3 to ensure that Aboriginal and Torres Strait Islander people have a better understanding of the risk factors involved in chronic disease and know how lifestyle choices and quality primary Health Services can help prevent or better manage chronic disease. The local community campaigns program includes a grants program with two rounds of funding. These campaigns are intended to be community derived and delivered. The grants are supported by national activities under the 'Get Active, Eat Good Tucker, Live Longer!' banner, including a series of Healthy Community Day events which have been held across Australia, a national website (Live Longer)[47] and the Community Health Action Pack, a health promotion tool kit to assist local communities and Regional Tackling Smoking and Healthy Lifestyle Teams to deliver chronic disease prevention activities.[48]

10.2. State of implementation

The following information was provided by DoHA in September 2011 about the state of implementation of measure A3 at a national level (relevant to SSE): [49]

- A targeted round of funding for local community campaigns was held between 21 March and 29 April 2011, with 38 projects funded in June 2011 across Australia to a total value of $10 million. A wide range of health promotion and social marketing projects was included, addressing nutrition, exercise, smoking cessation and access to primary health care. These projects mostly span the years 2011-2013, although a small number of projects finish in 2012.

- A further open competitive round of grants funding opened on 13 June and closed on 30 September 2011. Nationwide advertising occurred in May and June 2011. It is expected that funding agreements with organisations successful in the open round will be put in place in the second quarter of 2012.

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[47] Live Longer! [website], (accessed 2 November 2011).
[48] DoHA, Report on ICDP measure A3, 8 February 2011,
Cox Inall Ridgeway, Local Community Campaigns to Promote Better Aboriginal and Torres Strait Islander Health Background paper, 8 February 2011.
[49] DoHA, A3 report, 7 September 2011.

- The development of the campaign brand 'Get Active, Eat Good Tucker, Live Longer!', by consultancies Cox Inall Ridgeway and Carbon Media, supports and extends the local community campaigns project. The branding is to provide a consistent look and feel for national-level activity; however communities are encouraged to develop their own branding for local activities.

The Live Longer! campaign was launched by Minister Snowdon on 11 April 2011.[50] It encompasses website access to a new resource titled 'Community Health Action Pack' (CHAP), information on grants and Healthy Community Days: [51,52,53]

- Between 11 April 2011 and 8 December 2011, forty eight Healthy Community Days were held in urban, rural and remote communities across Australia. Future Healthy Community Days will be managed under measure A1/A2.

- The Community Health Action Pack (CHAP) was launched on 6 September 2011 and is freely available on the Live Longer! website:

    - The full resource including the manual, flip camera and small anatomical model was distributed to twenty-nine organisations for Regional Tackling Smoking and Healthy Lifestyle teams and grant recipients. The next round of grant recipients, due to be notified in April 2012, will also receive the pack.

    - The CHAP is 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. An online 'Survey Monkey' evaluation of the resource is being undertaken.

    - Feedback from a workshop held with Tackling Smoking and Healthy Lifestyle Teams in May 2011 was used to refine the CHAP, and further feedback will be used to shape the provision of future training and assistance, including a possible future workshop.

- The Live Longer! website provides information about Healthy Community Days and the grants program, hosts an online version of the CHAP and will showcase success stories from grants recipients as their projects develop. It is planned that the website eventually be withdrawn from public access.

- The DoHA has engaged consultants Cox Inall Ridgeway to undertake various aspects of the Live Longer! Campaign. As part of their role, Community Coordinators can provide assistance to communities developing applications for Local Community Campaign grants, and in hosting a Live Longer! Healthy Community Day. Community Coordinators can also provide guidance and support in the delivery of projects that receive funding through the Local Community Campaigns program and can be contacted via the website.

The 'Closing the Gap' Project – Promotion of the Medicare Benefits Schedule (MBS) Aboriginal and Torres Strait Islander people's Health Assessment Item, Chronic Disease Management Items and Follow-up Items for 2010-11 was funded by DoHA for roll out by NACCHO affiliates and Division of General Practice State Based Organisations (SBOs). By September 2011 all

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[50] Live Longer! [website], (accessed 2 November 2011).
[51] DoHA, A3 report, 7 September 2011.
[52] DoHA, A3 personal communication, 21 November 2011.
[53] Live Longer! New Health Promotion Resource to Help Close the Gap, News Release [website], (accessed 12 February 2013).

states and territories except WA had undertaken activities and promotions. Activities included resources and posters alerting and identifying pathways of care, up skilling through academic detailing and community and health provider events, broader advertising and quality improvement and IT initiatives. [54,55]

10.3. Findings from the Sentinel Sites

Table 10 outlines some activities funded under measure A3 and coverage within the Sentinel Sites.

Healthy Community Days were held in eight Sentinel Sites regions:

- Case study sites - Tamworth, Campbelltown and Katherine West (not held in Lajamanu)

- Enhanced tracking sites - Dubbo, Newcastle and Swan Hill/Mildura

- Tracking sites - Geraldton and North Lakes/Caboolture.[56]

Phase 1 Targeted Local Community Grants activities had potential exposure to nine Sentinel Sites regions. They are Campbelltown, Katherine West, Brisbane South, Logan/Woodridge, North Lakes/Caboolture, Newcastle, Derby, Darwin and Kalgoorlie.[57]

[54]DoHA, A3 MBS promotional activities – SBO, 5 September 2011.
[55] DoHA, A3 MBS promotional activities – NACCHO, 5 September 2011.
[56] DoHA, A3 report healthy community day events in Sentinel Sites, 1 September 2011.
[57] Live Longer! [website], (accessed 11 February 2013).

Table 10: Local community campaign reach in Sentinel Sites

Site type	Sentinel Site	Healthy Community Days[a]	Local community Grant[b]	NACCHO affiliate or SBO activity[c,d]
Case study sites	Tamworth	X	-	-
	Campbelltown	X	X	-
	Katherine West	X	X	X
	Brisbane South	-	X	X
	Logan/Woodridge	-	X	-
	Bairnsdale	-	-	X (activity not held by the end of promotional activity funding timeframe)
Enhanced tacking sites	Dubbo	X	-	X (Wellington)
	Newcastle	X	X	-
	Swan Hill/Mildura	X	-	-
	Derby	-	X	-
	Darwin	-	X	X
	Cairns	-	-	X
	Barkly (Tennant Creek)	-	-	X
Tracking sites	Geraldton	X	-	-
	North Lakes/Caboolture	X	X	-
	Kalgoorlie	-	X	-
	Canberra	-	-	X
	Gladstone	-	-	X
	Hobart	-	-	X
	Dandenong	-	-	X

[a] DoHA, A3 report Healthy Community Day events in Sentinel Sites, 1 September 2011.
[b] Live Longer! website (accessed 2 November 2011).
[c] DoHA, A3 MBS promotional activities – SBO, 5 September 2011.
[d] DoHA, A3 MBS promotional activities – NACCHO, 5 September 2011.
Note: This table excludes the Sentinel Sites of Port Augusta, East Pilbara, Elizabeth and Grafton.

11. Subsidising PBS Medicine Co-payment (*Measure B1*)

11.1. Description of measure

From 1 July 2010 Aboriginal and Torres Strait Islander peoples with or at risk of developing chronic disease have had improved access to Pharmaceutical Benefit Scheme (PBS) medicines. This assistance is provided by lowering or removing the patient co-payment for PBS medicines (the co-payment is the amount paid by patients their PBS medicine).

Lower costs for PBS medicines is available to eligible patients receiving care at a General Practice participating in the Practice Incentives Program (PIP) or non-remote (regional and urban) Aboriginal Health Services. The measure is intended to benefit Aboriginal and Torres Strait Islander peoples of any age who present with an existing chronic disease or who 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.

When obtaining PBS medicines at their local pharmacy, eligible patients who would normally pay the full PBS Co-payment ($33.30 per item in 2010) will pay the concessional rate ($5.40 per item in 2010).[58] Those who would normally pay the concessional rate will receive their PBS medicines at no charge. However, manufacturer brand premiums for a small number of medicines are required to be paid by the patient.

Community pharmacists are reimbursed for the proportion of the normal PBS Co-payment that has not been paid by the patient.[59]

The prescriptions written and dispensed under the PBS Co-payment measure are commonly referred to as Closing the Gap (CtG) prescriptions.

The PBS Co-payment measure superseded the pharmaceutical subsidy formerly provided under the Quality Use of Medicines Maximised for Indigenous People (QUMAX) Program. The focus of the QUMAX Program is 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 planned to end in June 2010, the QUMAX program was extended to June 2011 to allow AHSs to transition to the new PBS Co-payment measure. Further, since the national evaluation of the program, it has been announced that the QUMAX Program continues under the Fifth Community Pharmacy Agreement from 1 July 2011[60] but with the Co-payment component removed. 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. [61]

On 5 July 2010, the Minister approved the ability of medical specialists to annotate 'CtG' (Closing the Gap) prescriptions for registered patients when they are (a) providing services at a registered urban or regional Aboriginal Health Service; or (b) treating a registered patient who

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[58] PBS patient contributions are adjusted annually in line with changes in the Consumer Price Index. From 1 January 2011, the amounts are: General patient co-payment $34.20; concessional co-payment $5.60. DoHA, 2011. PBS Copayment and Safety Net Amounts [website], (accessed 12 February 2013).

[59] DoHA, Subsidising PBS Medicines Co-Payment Scheme Fact Sheet, Indigenous Chronic Disease Package [website], (accessed 25 November 2011).

[60] NACCHO Medical Release 30 June 2011 [website], (accessed 12 February 2013).

[61] DoHA, QUMAX Program Specific Guidelines [website], (accessed 25 November 2011).

has been referred to them by a service in an urban or regional location and that is registered for the PIP Indigenous Health Incentive.[62]

While not a part of the Closing the Gap measure, patients of around 170[63] remote area Aboriginal Health Services already had, and continue to have, access to free medicines through Section 100 (S100) of the *National Health Act 1953*. This provision, introduced in 1999, provides medicines to patients of eligible Remote Area Aboriginal Health Services without a requirement for the normal PBS prescription form, and without charge.[64]

11.2. Program logic

As specified in the National Framework, the following outputs and early results in relation to measure B1 and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond:

- Health Services participate in the program.

- Eligible Indigenous Australians participate in the program.

Expected early results (year 2-4):

- The financial barrier to using PBS medicines is removed/reduced.

Expected medium term results (year 4+):

- The utilisation of PBS medicines by Indigenous Australians with or at risk of chronic disease is increased.

11.3. State of implementation

The following information was provided by DoHA about the state of implementation of measure B1 at a national level (relevant to the SSE) as at 30 June 2011.[65]

Nationally, since the commencement of the measure in July 2010:

- More than 1900 General Practices and Indigenous Health Services had registered for the PBS Co-payment Measure.

- The number of individual patients receiving a benefit was 79 076.

- There has been a consistent increase in the number of people receiving a benefit each month.

- The total number of pharmacies making a claim at the end of June 2011 was 3694.

- The ten medicines most frequently dispensed were for cardiovascular disease, diabetes, respiratory disease, pain and infection management: atorvastatin, metformin hydrochloride, perindopril, salbutamol sulphate, codeine phosphate with paracetamol, amoxicillin, paracetamol, cephalexin, ramipril and amoxicillin with clavulanic acid.

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[62] DoHA, Report on ICDP measure B1, 30 March 2011.
[63] DoHA, Alternative Arrangements for Medicines [website], (accessed 25 November 2011).
[64] DoHA, Supply of pharmaceutical benefits to remote area Indigenous Health Services under Section 100 of the National Health Act 1953 - Responses to Frequently Asked Questions [website], (accessed 25 November 2011).
[65] DoHA, B1 report, 30 June 2011.

- The hotline statistics show a total of 4847 calls over 270 working days averaging almost 18 per day (initially commencing with higher call numbers, it has settled to an average of 13-21 per day since September 2010). The hotline is staffed by measure area personnel.

- There have been a total of 1627 email enquiries over 270 days which is an average of 6 per day (ranging between 3 to 8 per day since inception).

- 827 493 scripts have been claimed by patients with different needs: by ordinary, concessional and repatriation patient categories and related safety nets.

- 827 493 PBS Co-payment prescriptions were dispensed, with uptake being highest in NSW (41.79%), followed by Qld (26.62%), Vic (10.08%), WA (9.91%), SA (8.17%), Tas (1.85%), ACT (0.93%), and NT (0.66%).

The measure has been communicated and promoted at three conferences since July 2011: Meet the Mob Who Do the Job Expo in South Australia in June, General Practice Victoria in August and the GP11 Summit organised by the Royal Australian College of General Practitioners in October.

11.4. Findings from Sentinel Sites

Notes on collection, analysis and interpretation of data

Interviews with key informants in all eight case study and five enhanced tracking sites included enquiry about their awareness and perceptions of the PBS Co-payment measure. A number of the interviewees from remote case study sites were not asked to respond to statements in relation to this measure because residents have access to free medication under the S100 supply arrangements (S100).

Community focus group discussions covered perceptions of the influence of financial barriers on access to medications and medication adherence and perceptions of change since the previous reporting period. The findings reported here are based on information gathered from seventeen community focus groups held in seven case study sites.

PBS Co-payment administrative data are not presented in this report following a new process of data extraction being agreed upon with DoHA, and a reschedule of the data extraction. This will allow analysis by both Sentinel Sites and the rest of Australia to be broken down by urban, regional and remote in a comparable way. PBS Co-payment data will be presented for this time period in the next SSE report.

The National Evaluation Framework program logic deals separately with the participation of Aboriginal Health Services and General Practices in the PBS Co-payment measure (see Appendix A for relevant program logic). We report here on both sectors together as the issues raised were similar in this reporting period.

Awareness of the PBS Co-payment measure

As in the previous two reporting periods, there is a high level of awareness among stakeholders of the PBS Co-payment measure. Ninety-five percent (82/86) of interviewees indicated that they were aware of the PBS Co-payment measure. Awareness was highest among interviewees in urban and regional sites (100%). In remote sites there was some evidence of increasing awareness, with 17 out of 21 (81%) interviewees in this reporting period saying they were aware of the measure compared to 11 out of 16 (69%) interviewees for the previous reporting period. The lower level of awareness in remote sites is likely to be related to a perception that the measure has less relevance to remote areas because the S100

arrangement has been in operation in remote locations for over 10 years. However, the PBS Co-payment measure has the potential to provide additional benefits for people living in remote locations if that location has both General Practice and community pharmacy infrastructures. There is some evidence that some patients in remote locations may be using the PBS Co-payment measure to obtain medications that may not be stocked by Health Services in some locations covered by the S100, or to obtain medications through pharmacies when they are visiting towns and need to access care through Health Services that are not eligible to use the S100 arrangements.

There is a high level of awareness of the PBS Co-payment measure amongst key informants in urban and regional locations. There is some uncertainty about the use of the PBS Co-payment measure for people in remote areas, particularly where people from remote areas are visiting locations and services that are not covered by the S100. Such people are generally not registered for the PBS Co-payment measure. The cost of their medications therefore needs to be covered by the Health Service or by the patient. While the PBS Co-payment measure has generally been highly successful, there continues to be room for improvement in some specific areas.

Provision of information on the PBS Co-payment measure

As in the previous reporting period, there was a high level of agreement among interviewees [75% (60/80)] that Health Services were provided with adequate and timely information about the PBS Co-payment measure. Interviewees in urban and regional sites showed particularly high levels of agreement (72% and 91% respectively), with 47% of interviewees in remote locations agreeing with this statement.

In the previous reporting period the pattern of responses to a similar statement 'stakeholder organisations were clearly informed of the new PBS Co-payment measure' to which interviewees in management positions were asked to respond supported the finding that stakeholders in remote sites felt less well informed about the PBS Co-payment measure. While the data by rurality on this statement are limited by small numbers, there is some indication that managers in remote sites are now feeling better informed with five out of eight managers in remote sites agreeing with the above statement compared to 24/36 (67%) and 20/32 (63%) respectively in urban and regional sites. An increase in awareness among managers should contribute to increasing awareness more broadly over time.

Stakeholder interviewees from General Practices and DGPs again highlighted the role of the Indigenous Health Project Officer (IHPO) and the Outreach Workers based in the DGPs in informing General Practice of the PBS Co-payment measure.

There were a number of stakeholders in the previous reporting period who indicated that there had been some instances of inconsistent information being provided by Medicare officers and the dedicated hotlines for PBS and PIP Indigenous Health Incentive. Despite some perceptions of inconsistent information from hotlines and Medicare Liaison officers, the resources were often highlighted by stakeholders, particularly in AHSs, as good resources for support on the PIP and PBS Co-payment measures.

In addition to the Medicare Liaison officers, stakeholder interviewees at DGPs and State Based Organisations consistently highlighted that the measure manager for this area was very responsive to requests for clarifications by email and phone. The SBOs have been managing state based email lists of ICDP workers based in the DGPs, and these were noted as good dissemination points of information obtained from the measure area. The program data from DoHA indicate that there have been numerous systems established by the measure area to increase awareness of the measure and also provide ongoing information and support (note

that front line health service staff do not necessarily distinguish between systems implemented by the measure area and Medicare, as evident in the quotes below).

> *'We all get fantastic support from the Medicare PBS Co-payment office. They respond quickly to queries and have established a dedicated hotline. They also do lots of presentations at events which assists in raising awareness of DGP staff to support General Practice and also Aboriginal health staff.'* (Interview, SBO)

> *'One of the good things that happened they set up a helpline and Medicare hotline and email for PBS which was a good thing. We had a direct line to [name] and he would follow this up. We found we had a lot of specific very individual queries that needed following up and this process was very responsive and timely. That really changed the way things operated. We couldn't answer specific questions on fine details people wanted. If we found a pharmacist who would refuse, that would not prescribe they would get onto them and ring them. We just had to highlight the pharmacist and they would make contact with them and explain the program. A lot of trouble at first but enquiries really dropped now and this hotline and sharing of responses around the network on email lists really helped with the information sharing between Divisions [of General Practice].'* (Interview, SBO)

There continued to be comments from interviewees about the need to inform the Aboriginal and Torres Islander communities of the PBS Co-payment measure. A number of interviewees highlighted gaps in understanding of the measure among community members in regards to access to specialists prescribing scripts, confusion about hospital doctors' eligibility to prescribe and access to PBS Co-payment scripts when visiting another location. IHPOs and OWs based in the AHS and General Practice were raising awareness at community education events. Education about the PBS Co-payment measure appears to require continuing refinement.

> *'To build on the momentum I have a suggestion to do some social marketing from the commonwealth on this measure to the community. There have been many adverts on television about smoking and [in the] newspaper which have been very visible but I think there is a place for this to happen about the PBS also. The DGPs have been doing this to some extent but a coordinated national effort would be better.'* (Interview, SBO)

Participation by Health Services in the PBS Co-payment measure

Of those interviewees who indicated they were aware of the PBS Co-payment measure, 89% (42/47) of the clinician and practice manager interviewees indicated that their Health Service participates in the PBS Co-payment measure. This figure is similar to the previous two reporting periods. Interviewees in urban and regional sites indicated very high levels of participation (100% each), while interviewees in remote sites showed relatively low participation (although number of respondents to this statement in remote sites was small), again suggesting the need for improved understanding of how this measure interacts with the S100supply arrangements (S100), to enable clients to distinguish between the two complementary but separate programs.

Eighty-four per cent (37/44) of clinician and practice manager interviewees indicated that all doctors in their Health Service prescribe under the PBS Co-payment measure, again with particularly high levels in urban [84% (37/44)] and regional [89% (17/19)] locations. This figure for regional locations is higher than for the previous reporting period [63% (15/24)].The data are a positive indication of increasing uptake, but the high participation rates of doctors in the urban and regional Sentinel Sites is likely to be related to the selective nature of practices that

agreed to participate in the SSE , where practices with a particular interest in Aboriginal health were targeted for participation and should not be considered representative of practices more generally.

Similar to the responses from the previous reporting period, the data from a similar statement included in the interviews with pharmacists provides a different perspective: In response to the statement '*all doctors in this area prescribe under the PBS Co-payment measure for Aboriginal and Torres Strait Islander people*', four out of thirteen agreed with the statement. Of those in urban sites, two out of seven agreed with the statement and for regional sites two out of four agreed. While the number of pharmacists interviewed is small and the data should not be seen to be representative, these data do help to put the data on participation by doctors in the PBS Co-payment measure derived from interviews with staff of selected Health Services into the broader community context.

There were a number of stakeholder interviewees and community focus groups who indicated that although GPs may be aware of the PBS Co-payment measure, they were at times forgetting to annotate scripts. Nearly all pharmacists interviewed highlighted this as an issue. This appears to be a particular issue in General Practice, and is possibly related to Aboriginal clients being a minority of the service population in this context. The clinical indicator data presented from General Practices indicated that either practices have only a small proportion of Aboriginal clients, or they were not identifying them on the patient information system. There continues to be scope for improved identification of Aboriginal and Torres Strait Islander people attending General Practices. Without good systems for identification of Aboriginal and Torres Strait Islander people, practices are not easily able to identify who is eligible for the PBS Co-payment measure and practice computer software will not automatically annotate scripts.

> ' … most of the problems come from patients who come from mainstream GPs saying they should be CtG but the doctor hasn't annotated the script so we have to ring them up.' (Interview, Pharmacist)

> 'In the last six months I have had eight Aboriginal patients, two requested CtG. If I am busy with time pressures I don't have time to think about it.' (Interview, GP, General Practice)

> 'Across the region, most doctors wouldn't have a clue and thus are not prescribing under the PBS Co-payment measure. Many patients are sharing the medications as they may not have access to practices who have signed up for the measures. In the region most of the Divisions [of General Practice] and GPs are struggling with the issue of Aboriginal 'identification'. Some see it as an insult to ask if Aboriginal or not.' (Interview, NACCHO state affiliate)

As in the previous reporting period, interviewees in this reporting period spoke about barriers related to the ongoing implementation of the measure, rather than barriers to initial uptake of the measure.

As highlighted in the previous reporting periods, barriers to participating in the PBS Co-payment measure included Health Service registration for the PIP Indigenous Health Incentive, issues regarding patients' eligibility for the PBS Co-payment and systems for identifying Aboriginal and Torres Strait Islander patients. These issues are discussed further below, and Chapters 7 and 13 provide further information about the barriers to Health Services implementing the PIP Indigenous Health Incentive, including systems for identifying Aboriginal and Torres Strait Islander patients. The issues raised by stakeholders regarding the implementation of the PBS Co-payment eligibility criteria are addressed in a separate section below.

Community members' awareness and perceptions of the PBS Co-payment measure

As reflected in the previous reporting periods, there is a high level of awareness of the PBS Co-payment measure amongst community focus group participants. Focus group participants commonly made positive comment on the reduced costs of medications.

Focus group participants in remote sites reported that the introduction of the PBS Co-payment measure had little impact, as patients had access to free medication under S100 and through existing aged care packages. This would be consistent with the understanding that the measure has relatively limited application in remote sites because of the availability of medicines through the S100 in remote and very remote Australia.

PBS Co-payment measure increasing access to medications

There was an increase from the previous reporting period in the proportion of interviewees agreeing with the statement '*medications for Aboriginal and Torres Strait Islander people are more accessible than they have been previously*', from 72% (46/64) to 84% (52/62). Only 3% disagreed and 13% said they didn't know or couldn't say.

As in the previous reporting period, levels of agreement with this statement were particularly high in urban and regional sites (92% and 88% respectively). The relatively lower level of agreement to this statement in remote sites (62%) is almost certainly because of the existing S100 arrangements in remote locations. However, there has been an increase in remote sites from 1/11 agreeing to this statement in the previous reporting period to 8/13 in the current reporting period.

Clinician's [78% (21/27)] strongly agreed that medications are more accessible, and this agreement was evident in both the GP and AHS sectors (see Figure 15).

> '*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.*' (Interview, GP, AHS)
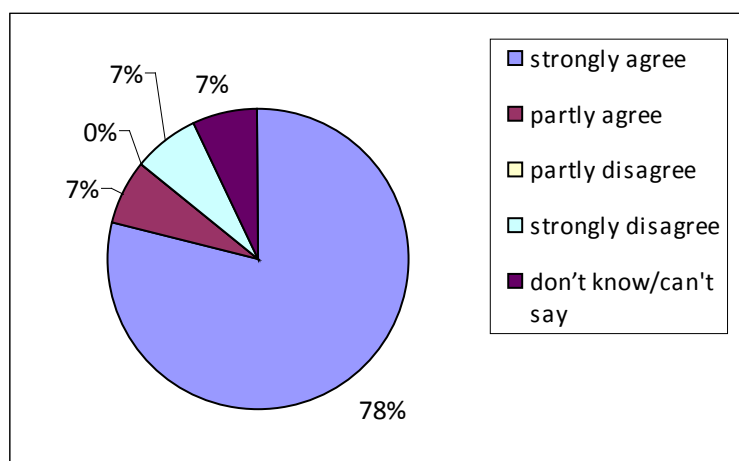
Figure 15: Clinicians' responses to the statement: 'medications are more accessible than previously.' (n= 27)

PBS Co-payment and medication adherence

There continued to be a strong perception amongst stakeholder interviewees and community focus group participants that having medications subsidised or free is translating into improved access to medications and subsequent medication compliance.

Two thirds of clinicians [63% (17/27)] agreed with the statement '*medication adherence has improved because of the PBS Co-payment measure.*' Within AHSs clinicians tending to be more positive (with 9/11 agreeing) than clinicians based in General Practice (8/16).
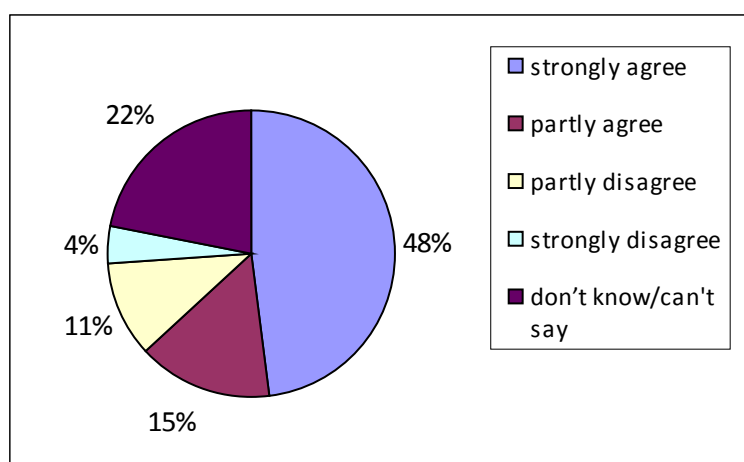
Figure 16: Clinicians' responses to the statement: 'medication adherence has improved because of the PBS Co-payment measure.' (n=27)

To the extent that the data allows assessment of trends at this stage of the SSE, and with small numbers in remote sites in particular, there was indication of a positive trend across all ruralities of perceptions that medications were becoming more accessible (Table 11).

Table 11: Perceptions of medication accessibility (% who strongly or partly agreed), overall and by rurality

Interview statement	Rurality	December 2010	June 2011	December 2011
Medications are more accessible for Aboriginal and Torres Strait Islanders than they have been previously. MS, CS[a]	Overall	77% (n=26)	72% (n=64)	84% (n=62)
	Remote	33% (n=3)	9% (n=11)	62% (n=13)
	Regional	75% (n=12)	83% (n=30)	88% (n=24)
	Urban	91% (n=11)	87% (n=23)	92% (n=25)

[a] Type of interview respondent, see Appendix D 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'.

There is a perception that previously patients were prioritising other things above medications due to cost of medications. This perception was evident in the previous two reporting periods and again in the period covered by this report, as indicated by the following quotes:

> '*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 … I also do a lot of follow-up so I put them on a care plan so we catch them that way as well to make sure they have regular visits with a GP and a lot of my patients are regulars.*' (Interview, GP, General Practice)

> '*… 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, regional site)

> *'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, regional site)

A number of stakeholder interviewees indicated that there needs to now be a greater emphasis on home medication reviews (HMRs)[66] as patients were now more likely to be accessing all their medications but not necessarily understanding how to use them. One AHS in a regional site recognised the need for this service of HMRs, but was having difficulties organising reviews as there was no accredited pharmacist in town to undertake these reviews. They came up with a solution by having someone else within the Health Service undertake the HMR and then send this onto an accredited pharmacist. They also organised for a pharmacist to fly from Sydney twice a year.

> *'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.'* (Interview, Nurse, AHS)

However, a small number of interviewees continued to indicate that medication adherence was not necessarily improving.

There has to date been a focus by DGPs, AHSs and ICDP funded workers on increasing awareness of the PBS Co-payment measure. Given the high level of awareness of the measure, emphasis may now need to be shifted to promoting safe use of medications and providing medication reviews and advice and support in safe use of medications. The Quality Use of Medicines Program (QUMAX), through the National Prescribing Service[67] offers community education material and also training and support for clinicians on prescribing. QUMAX is designed to offer a similar range of services. In addition, they have been running training sessions for Aboriginal Health Workers on medications.

Role of the Outreach Worker

The OW role to date, in relation to access to medications, appears to have been focused on providing patient transport. This has been viewed as a key component of their role and number of trips made to support patients with access to medications is one of the performance indicators for OWs. There is an opportunity for OWs to provide broader support in promoting patient awareness about safe use of medicines and where patients can access support. The potential for role expansion in a supported environment may assist with medication adherence, and would require additional training for OWs in safe use of medicines. There was some evidence of role expansion occurring; some OWs have assisted patients by translating or explaining information during consultations:

> *'This measure (PBS Co-payment) may not have been as effective without the OWs. They have provided a cultural liaison point, understanding of why to take meds to some degree … maybe consider it as encouragement, assisting the number of people supported to fill a script. The OWs are physically taking people to the pharmacist to fill scripts, having OW there was helpful if script was not annotated – that level of patient advocacy would not have happened if not there.'* (Interview, DGP)

Increased access to Health Services

In this reporting period, a number of stakeholder interviewees indicated that patients were now coming back more readily for repeat scripts. This has the two fold benefit of patients accessing medications more readily and also attending more regularly for care.

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[66] DoHA, Home Medications Review [website], (accessed 30 November 2011).
[67] National Prescribing Service [website], (accessed 30 November 2011).

> *'The PBS Co-payment has really driven the PIP [Indigenous Health Incentive] and also uptake of health assessments. This has been the carrot to sign up and also to come back to the Health Service. Community want access to free or subsidised medications and this is bringing them back to Health Services.'* (Interview, DGP)

> *'Previously it put a lot of people off accessing health care, the cost of the scripts and people just felt why bother. It was a barrier, the cost just to check up on how you are going, as you would be worried that you will get a whole heap of scripts you can't afford.'* (Interview, DGP)

Patients' difficulty in identifying practices registered for the PIP Indigenous Health Incentive

Generally, barriers to patient participation in the PBS Co-payment measure were similar to those identified in the previous two reporting periods, and included the level of patient awareness of PIP Indigenous Health Incentive registered practices. Stakeholder interviewees and focus group participants noted that a lack of awareness of PIP Indigenous Health Incentive registered practices presented challenges for accessing PBS Co-payment scripts, particularly for patients in remote sites when they travel from an area covered by S100 supply arrangements (S100). However, this lack or awareness is not unsurprising given that the PBS Co-payment measure has relatively limited application in remote and very remote Australia.

There continued to be opportunities for work on raising community awareness, not so much on availability of the PBS Co-payment and PIP Indigenous Health Incentive (as prior), but rather on where consumers can access these programs, and to work towards a consistent approach to making information widely available in a recognisable form. With the advent of Medicare locals and the greater role they are to play in connecting communities with Health Services, there is an opportunity to develop standard ways for consumers to easily identify where a PBS Co-payment script can be obtained.

Similarly, there were challenges for Health Services when a patient who was not a regular client presented and asked for a CtG annotated script. GP interviewees in some services indicated some reluctance to annotate a script if they were uncertain whether the patient was registered for the PBS Co-payment measure, thus contributing to rejection of patient requests. In addition, some interviewees indicated that they tackled this uncertainty by signing the patient up for PBS Co-payment (and at times also the PIP Indigenous Health Incentive), simply to ensure they could legitimately annotate a script. This strategy contributed to unnecessary paperwork. These problems could be overcome by developing a system whereby Health Service staff can verify whether patients are registered for the PBS Co-payment.

In December 2011, in response to feedback regarding access by patients, Medicare Australia announced they were writing to Health Services signed on for the PIP Indigenous Health Incentive, to seek permission to include contact details on a register. The aim of the register is to help patients locate a Health Service at which they can receive treatment and PBS Co-payment scripts.[68]

Perceptions of PBS Co-payment eligibility criteria

Similar to the previous two reporting periods, 72% (66/92) of interviewees either strongly or partly agreed with the statement '*patient eligibility criteria for the PBS Co-payment are workable in practice'.* Levels of agreement with the statement were higher amongst interviewees in urban and regional sites (74% and 78% respectively), compared to 50% in remote sites.

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[68] General Practice NSW, PIP Indigenous Health Incentive e-communication, 6 December 2011.

Practice managers [83% (14/17)] tended to be slightly more positive about the eligibility criteria being workable than clinicians [74% (19/27)]. Similarly, clinicians and practice managers in Aboriginal Health Services tended to be slightly more positive than those in General Practice [83% (15/18) and 73% (19/26) respectively].

Despite this high level of agreement from interviewees in different roles and different sectors that the eligibility criteria were workable, a number of interviewees expressed concern that some aspects of the eligibility criteria have the potential to impact on patient participation in the PBS Co-payment measure. These concerns were predominately raised by clinicians and may give some explanation as to why clinicians felt slightly less positive than practice managers. Consistent with previous reports, issues included:

- confusion between age and health requirements for the PBS Co-payment measure and that of the PIP Indigenous Health Incentive registration

  'My understanding is that to be eligible for PBS you have to have a chronic disease.' (Interview, Nurse, General Practice)

- how to apply the 'at risk' and needs based eligibility criteria

  'We had a practice meeting about how to apply this at a practice level and we all decided to approach it differently as we all interpreted the criteria differently. Are all Aboriginal people at risk of a chronic disease, even the 18 month baby? Difficult part is up to doctor's interpretation.' (Interview, GP, General Practice)

- not providing access to non-Indigenous partners / family members

- uncertainty if patients were registered for PBS Co-payment measure

  'I have lots of non-Indigenous people asking for the scripts. They come in and say just write CTG on it for me. Not sure how to know if someone is registered for CTG. They come in and say I'm registered and just write it on script. [I am] concerned that once CTG written on it there are no checks and balances when presenting at pharmacy [to find out] if they are registered.' (Interview, GP, General Practice)

These comments provide an indication of where clarification of the eligibility criteria, or their application, may be beneficial. A number of interviewees questioned why the criteria were not broadened to include all Aboriginal people, as there was a perception that way the criteria are generally being applied in this manner.

Vignette – establishing eligibility

While the PBS Co-Payment is widely acknowledged as having removed an important barrier to improved medical management for many patients (cost of medications), one long established Aboriginal Health Service described how eligibility criteria for PBS Co-payments have presented the service with conflicting concerns and strategies. The service described how QUMAX had covered Aboriginal people, as well as non-Aboriginal family members. They felt this was appropriate because the cost of medicines is to some extent borne by the whole family. However, non-Aboriginal family members are not eligible under the PBS Co-payment measure, and the costs of medicines for non-Aboriginal family members now impacts on the disposable income of the whole family. The Service has a number of patients on whom this change has impacted.

Practitioners in this service reported that in some instances the PBS Co-payment eligibility criteria create hardship, encourage non-compliance and impact on the whole family, including Aboriginal members. Non-Aboriginal family members live in the same circumstances and rely on the same household income as their Aboriginal partners and children, and when family finances are under stress, decisions may be made not to spend available money on medication. Some practitioners report that they feel obliged not to strictly apply the eligibility criteria when they feel patients and their families may be worse off under the new PBS Co-payment arrangement.

At the same time there is a perception that some patients are falsely self-identifying as Aboriginal. Therefore, some community controlled services, in some instances, are asking patients for proof of Indigenous status, a formal procedure that takes two months to complete. This may result in more rigorous application of the PBS Co-payment eligibility criteria, but may also result in delaying client registration and benefits for clients who are eligible.

This vignette illustrates how, even for a measure as successful as the PBS Co-payment, issues of identification and eligibility present significant challenges in the day-to-day operation of health services.

Perceptions of administrative workload

In contrast to perceptions of administrative workload (see below), about two thirds [68% (68/100)] of interviewees agreed with the statement *'organising access for Aboriginal and Torres Strait Islander people to the PBS Co-payment measure has been easy'*, while 13% partly disagreed and only 6% strongly disagreed (13% said they didn't know or couldn't say) (see Table 12). To the extent that the data allows assessment of trends at this stage of the SSE, there was indication of a positive trend in responses to this statement with agreement overall and across urban, regional and remote sites. The increase in agreement with this statement in remote sites is consistent with interview data with regard to increasing awareness of how PBS Co-payment and S100 overlap.

Table 12: Trends in perceptions of ease of access to PBS Co-payment measure (% who strongly or partly agreed), overall and by rurality

Interview statement	Rurality	December 2010	June 2011	December 2011
Organising access for Aboriginal and Torres Strait Islanders to the PBS Co-payment measure has been easy. PS, MS, CS, OW, PM[a]	Overall	44% (n=32)	64% (n=90)	68%(n=100)
	Remote	0% (n=3)	25% (n=12)	33% (n=18)
	Regional	53% (n=15)	70% (n=46)	80% (n=40)

Interview statement	Rurality	December 2010	June 2011	December 2011
	Urban	43% (n=14)	72% (n=32)	71% (n=42)

[a] Type of interview respondent, see Appendix D 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'.

Levels of agreement with the statement were relatively high in urban and regional sites (71% and 80% respectively), but lower in remote sites (33%). Interviewees in remote sites have indicated that they struggle with administrative aspects of sign on for patients to the measure, and this may explain the lower agreement with the statement.

Similar to the previous two reporting periods, there were mixed responses about the perceived administrative workload associated with the PBS Co-payment measure. Forty-four per cent (16/36) of interviewees strongly or partly agreed that the PBS Co-payment measure has added a large administrative workload to the Health Service.

Practice managers tended to be more likely to regard the measure as being an administrative burden than clinicians. This may be due to practice managers generally managing the paperwork processes within the practice and being responsible for establishing systems to support this new measure.

Almost 40% (10/26) of practice managers and clinicians in General Practices agreed that the measure had caused a large administrative burden compared to 50% (9/18) in AHS (see Figure 17).
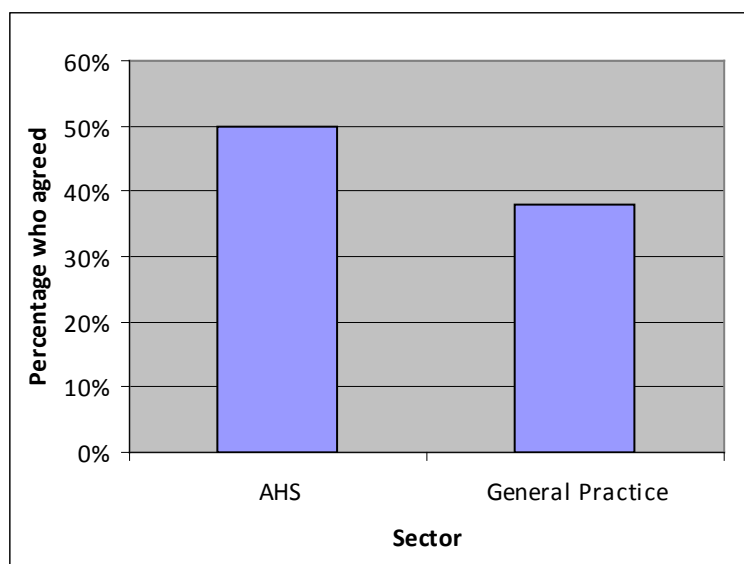
Figure 17: Clinicians' and practice managers' responses to the statement 'The PBS Co-payment measure has caused a large administration burden' (% who strongly or partly agreed) (n=44)

Due to the volume of registrations in AHSs compared to General Practices, where Aboriginal and Torres Strait Islander clients generally make up a small proportion of the client population, it would be expected that AHSs would find this measure (and the PIP Indigenous Health Incentive) administratively burdensome during the early registration period.

It was noted by a number of interviewees that the one off registration (in contrast to PIP Indigenous Health Incentive that is yearly registration) should mean that the administration burden for PBS will decrease over time as systems are established to annotate scripts and register patients (as opposed to the ongoing registration process for the PIP Indigenous Health

Incentive). There were a number of aspects of administrative burden highlighted in the PIP section of this report that relate to the PBS Co-payment measure as well. Some perceptions of administrative burden that relate directly to PBS Co-payment measure included:

- Unnecessary paperwork for the PBS Co-payment due to lack of systems for Health Service staff to identify whether a client is registered for the PBS Co-payment.

- Community members lacking understanding of their registration status, which created unnecessary paperwork. Some Health Services are registering patients 'just in case'.

  'When a patient is travelling often the practices don't realise that they can annotate scripts without the patient being registered for PIP at their practice. What happens is patient is signed up again.' (Interview, DGP)

- Patients presenting at Health Services to get scripts annotated after not having them annotated by specialists or hospital doctors.

  'A lot of patients get scripts from [hospital name] and they are not CTG. Patients then have to take scripts to another service to have them annotated.' (Interview, DGP)

- Some challenges with patient information system software not annotating scripts, or practitioners forgetting to annotate scripts, and then having to reissue:

  'If a script is missed and not annotated the patient comes back. Time consuming when not done.' (Interview, Nurse, General Practice)

Software systems to support use of the PBS Co-payment measure

Under the PBS Co-payment measure, GP providers and pharmacists have access to new software that enables them to write and dispense prescriptions using an annotated PBS Co-payment script. A range of stakeholders continued to raise a number of issues about the new software and process that enables Health Service providers to prescribe and pharmacies to dispense medicines under the PBS Co-payment measure. Comments from interviewees continue to suggest that there were more challenges in implementing the system for prescribing medicines, than the system for dispensing PBS Co-payment prescriptions by the pharmacist.

Comments from interviewees in Health Services indicated challenges with linking records of Aboriginal status in existing information systems with the CtG annotation system.

As in the previous two reporting periods, stakeholder interviewee comments were generally positive about the pharmacist dispensing system developed under the PBS Co-payment measure. The majority (11/13) of pharmacists agreed with the statement '*the pharmacy software developed to support the PBS Co-payment measure is easy to use.'* It was not viewed by the interviewed pharmacists to be administratively burdensome. There was some uncertainty from a small number of pharmacists about whether they continue to use PBS Co-payment once a patient reaches the safety net.

Awareness among specialists of the PBS Co-payment measure

In addition to the barriers to participating in the PBS Co-payment measure described above, interviewees and community focus group participants identified a range of factors that may impede patient access to the program. These barriers were highlighted in the previous reporting period and continue in this period, and are related to the awareness of, and engagement in, the PBS Co-payment measure, particularly amongst medical specialists and

pharmacists, and the level of understanding of the PBS Co-payment patient eligibility criteria amongst Health Service providers and patients.

A perceived lack of awareness of the PBS Co-payment measure was thought to contribute to medical specialists not writing PBS Co-payment prescriptions for registered patients. In addition to lack of awareness of specialists, there is a lack of awareness among GPs that in writing referral letters to specialists they should indicate if a patient is registered for the PBS Co-payment.

Furthermore, there appear to also be some instances of contradictory advice being given by Medicare Liaison officers on the ability of specialists to annotate scripts.

> *'so we had Medicare on site recently and they said no they can't annotate scripts … there really has been a lot of confusion.'* (Interview, AHS)

It appears that further work is required on increasing awareness among Health Service staff of how to indicate in referral letter that a patient is eligible for the PBS Co-payment, but also in awareness raising for specialists. Some State Based Organisations indicated that there were examples of electronic templates being developed for doctors to refer patients, which have automated text that the patient is eligible for the measure. However, this initiative relies on Health Service using automated systems and having good identification procedures.

> *'Templates have been developed for Medical Director [software] by another DGP which have been shared around the network. These templates allow for when an Aboriginal patient has been correctly identified in the medical software as Aboriginal and eligible for CTG, when the GP writes a referral letter to a specialist, the referral letter will automatically have written down the bottom that the patient is eligible for Close the Gap scripts. This will hopefully assist with difficulties experienced with specialists not knowing when a patient is CTG registered and also to raise awareness of the specialists of the scheme.'* (Interview, SBO)

Hospital doctors, aged care facilities and after hours clinics

There continues to be concern expressed by stakeholders and community focus groups that patients who are discharged or referred to specialists from hospital, or who are presenting at outpatients at the hospital, would not be able to access the PBS Co-payment measure. Under the PBS Co-payment program, hospital doctors are not eligible to provide patients with an annotated PBS Co-payment script. There were instances of some doctors who work in primary care services and also do sessions in hospital taking script pads from their surgery to the hospital to overcome this issue.

State Based Organisations have begun to receive queries from DGPs about whether GPs who visit aged care facilities are able to write CtG scripts for patients in these facilities. There appears to be uncertainty about this because aged care facilities are not eligible to be registered for the PIP Indigenous Health Incentive as they are not "General Practices" as such.

> *'The aged care facilities often have a contract with the GP and therefore the patients can't access PIP and therefore cannot access the benefits of medications under the PBS measure.'* (Interview, SBO)

An emerging issue raised by interviewees in two State Based Organisations (SBOs) is confusion over whether GPs working at an after-hours clinic can annotate scripts. Some after-hours clinics are not accredited and therefore are not able to access incentives such as PIP, which excludes them from annotating scripts. The quote below illustrates the confusion around who can and can't annotate scripts:

> *'The guidelines state that if the GP is providing services at an after-hours service from a practice that is accredited they can have a special arrangement where they can write annotated scripts– I'm yet to see this special arrangement. It does raise issue about how does a GP know if they are CTG registered if not a regular client and they are not marked in their system as CTG registered – I guess that is where the hand held patient cards are useful that say I am CTG registered? Often patients are going to after-hours services and getting scripts then going to another doctor a few days later to get them annotated or worse not getting them filled or presenting them at pharmacy and not knowing they haven't been annotated. To overcome this is to reconsider having hospital doctors and after hours service able to annotate scripts and CTG status is linked to Medicare card.'* (Interview, SBO)

Enablers and barriers in the pharmacy

There were mixed views amongst interviewees on the extent to which pharmacies were actively engaging in the PBS Co-payment measure. In response to the question on whether they agreed with the statement 'pharmacists have effectively introduced new systems to support implementation of the PBS Co-payment measure', 55% (44/80) strongly or partly agreed, 36% (29/80) of interviewees said they didn't know or couldn't say, and 9% (7/80) disagreed.

Levels of agreement with the statement were similar in urban [63% (20/32)] and regional sites [58% (19/33)], but lower in remote sites [33% (5/15)]. The number of respondents in remote sites is small and interpretation of the data should be made with caution. However, these data do add further weight to other data related to relatively limited development in relation to the PBS Co-payment measure benefitting people in remote locations.

It appears that pharmacists are effectively introducing new systems to support the PBS Co-payment measure.

> *'These teething issues were at the start. They are definitely decreasing. We get the odd refusal to fill a script from pharmacists but certainly nowhere near as many.'* (Interview, Pharmacist)

Despite increasing participation from pharmacists there continued to be concern expressed by stakeholder interviewees and community focus groups about the cultural safety of the pharmacy environment. There was an ongoing perception among some interviewees that Aboriginal and Torres Strait Islander patients may feel, or are made to feel, uncomfortable accessing their PBS Co-payment medications from some pharmacies. This finding continued to be particularly evident in urban sites.

> *'I mean how Aboriginal do they have to be! One eighth? Some of them don't look Aboriginal.'* (Interview, Pharmacist)

> *'The awareness amongst pharmacists and pharmacy staff still needs to be raised. It is not just about the pharmacist but also the staff. 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 where they can [on topics that are relevant to closing the gap]. Patients are still reporting that some pharmacy staff are still questioning Aboriginal status. This has prompted us to encourage DGPs to continue to provide an education service to pharmacists. It appears to be an issue in urban areas more possibly due to the large volume of pharmacies and staff in each of these.'* (Interview, SBO)

A number of interviewees identified the need for cultural awareness training for pharmacists and pharmacy staff. Interviewees also indicated that cultural awareness training for pharmacists is available through the QUMAX program there, but there were often challenges finding someone to deliver the training and challenges in engaging pharmacists to undertake the training despite the training being part of their agreement.

> *'Funding has been provided for cultural awareness training for pharmacists through QUMAX but just can't find anyone to do it despite many attempts. With often entire staff turnover it is important to keep doing. Also need to do the whole service not just the pharmacists.'* (Interview, Nurse, AHS)

The majority of pharmacists interviewed (11/13) agreed that the pharmacy had been well informed about the PBS Co-payment measure. A number of pharmacists made positive comments about the literature disseminated by DoHA on the PBS Co-payment. This was generally seen to be informative and easy to read. A number of pharmacists also noted that the Pharmacy Guild were undertaking visits to inform pharmacists about the measure, and this was viewed positively.

There has been some confusion around the support that IHPOs can offer pharmacists. 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 its so important, we go through the backdoor. I ask when I pick up my scripts how things are going.'

The support to pharmacists has nevertheless been generally been viewed as an important component of work of IHPO.

> *'The department [DoHA] 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.'* (Interview, DGP)

Examples of work being undertaken with pharmacists by the IHPO included:

- information visits to pharmacists

- organising information evenings for pharmacists and pharmacy staff

- provision of cultural awareness training and having a section specifically on appropriate practice in dispensing various types of gender specific medications to both females and males

- provision of information on the measure through other methods.

There was concern that information may be targeted at the pharmacists specifically, and that the information may not be disseminated throughout the pharmacy team:

> *'The information still at times does not filter to people at the front line serving. There are just so many people at front desks and part-time workers. Often the pharmacist may know about the measure but not the other staff. Pharmacists know about measure but staff don't, it hasn't filtered through to all levels. part-time'* (Interview, DGP)

> *'The pharmacy guild has sent letters but again these go to the pharmacy owner and not necessarily filter down.'* (Interview, DGP)

Based on the small number of interviews, pharmacists appeared to be well informed about the measure and generally comfortable with the eligibility criteria and the workload. However, comments from other interviewees working in the health system and from the focus group participants indicated that more work needs to be done with some pharmacist to ensure the measure is implemented in a way that will provide maximal benefit to the Aboriginal and Torres Strait Islander community.

There is potential for suspicion and inappropriate questioning regarding Aboriginal or Torres Strait Islander status to present barriers to accessing medications through the PBS-Co-payment scheme, and to limit the potential for the program to benefit Aboriginal and Torres Strait Islander people. This continued to be greater than problems related to 'leakage' to people who were not eligible for the scheme and highlights the importance of programs to promote cultural competence and cultural safety in relation to access for Aboriginal and Torres Strait Islander people to health care services.

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 don't 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'* (Manager and IHPO, DGP).

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 doesn't reach staff at all levels. '*The student who works part-time on Saturday, how do we reach them?'*

PBS listed medicines, generics and the availability of other medications

Under the PBS Co-payment measure, pharmacists will only be reimbursed the PBS agreed price. In some instances there are a number of bio-equivalent brands of a PBS medicine and some of these bio-equivalent brands are subject to a manufacturer brand premium, known as a special patient contribution. While pharmacists are required to stock premium and generic brands they are able to offer and provide a non-premium brand for any PBS Co-payment prescription, some patients appeared to be unaware that there are different brands of the same medicine listed on the PBS and that some brands cost more because they have a brand premium added.

Pharmacists continued to raise this as an issue and indicate that they consistently need to explain to patients why a different brand of medication had been dispensed. The following quotes are illustrative of the discussion on these points:

> *'Sometimes there are difficulties explaining to the customers because CtG is only for generic brands. Sometimes the customers are reluctant to pay additional if they want the original brands. They are not happy if have to pay extra because they know that under the co-payment the medications are free.'* (Interview, Pharmacist)

Availability of dose administration aids (DAAs)

In this reporting period, stakeholder interviewees and community focus group participants did not express concern about access to Dose Administration Aids (such as Webster packs[69]) under the PBS Co-payment measure, which suggests that the decision to extend the QUMAX agreement with the associated support for DAAs has allayed the concern expressed in the previous reporting period. (Patients who are registered under the PBS Co-payment measure and who are clients of Aboriginal Health Services participating in the QUMAX Program are still able to access Dose Administration Aids (DAAs) for free, or at a reduced rate.) There were however ongoing concerns that such aids were not being funded under the PBS Co-payment measure, and that they should be available to other patients as well as those covered by QUMAX. Patients who are registered for the PBS Co-payment Measure and attend a General Practice or Aboriginal Health Service not participating in the QUMAX Program need to pay for their DAAs. While Dose Administration Aids (DAAs), such as Webster packs continue to be funded under the QUMAX Program, there is a perception amongst interviewees and focus group participants that medication compliance could be affected by the variable availability of these dose administration aids in the future.

Summary

There is a continuing high level of awareness of this measure among stakeholders in the case study sites, and positive perceptions of the information provided about the measure. The areas identified in the previous report where awareness needs to be increased and information more tailored to meeting the needs of particular groups (notably Aboriginal community groups, specialists, hospital staff and stakeholders in remote sites) continue to be identified as problematic. After hours services have also been identified as an area where the process for the PBS Co-payment needs to be clarified.

There is ongoing evidence of a high level of participation by Health Services identified as having an interest in Aboriginal health, but lower levels of participation across the primary health care service sector more generally, and by Health Services in remote sites. The role of the IHPOs and OWs in promoting the use of the measure has been positively regarded.

There is an increasingly widely held perception that the PBS Co-payment has made medications more accessible, and that the improved access through removal (or reduction) in cost is encouraging more regular attendance for health care and is translating into improved adherence to prescribed medications. However, concerns continue to be expressed regarding the change from QUMAX, with non-Indigenous members of Aboriginal and Torres Strait Islander families not being eligible for the PBS Co-payment measure. Clinicians and others have argued that the cost of medications comes out of the family income, and the family is therefore affected by the need for any member to pay for medications. There are also ongoing concerns regarding the application of the 'at-risk' aspect of the eligibility criteria. While the issue of in-eligibility of non-Indigenous members of Aboriginal and Torres Strait Islander families may be seen to be beyond the objectives of the measure, and the application of the 'at-risk' criteria is at the doctor's discretion, the concerns expressed by key stakeholders as described above is an important issue to emerge from the evaluation and requires documentation.

Identification of Aboriginal and Torres Strait Islander people continues to be identified as an important barrier to utilisation of the PBS Co-payment scheme, and systems to increase identification continue to be the focus of strategies to increase utilisation of the measure. There is also an ongoing need to improve consistency of GPs in annotating CtG scripts.

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[69] For more information on: Webster Packs [website], (accessed 28 November 2011).

Patients continue to report difficulty with identifying PIP registered practices, particularly when they are visiting locations away from their regular care provider. Similarly, Health Service staff reported difficulties with determining if non-regular clients are registered. There is an ongoing need for a system to allow staff to ascertain if clients are already registered for the PBS Co-payment.

There continues to be evidence of a need to raise cultural awareness among some community pharmacists, and to promote development of cultural safety in the pharmacy environment.

As expected, the new measures to support ongoing availability of DAAs for QUMAX sites have been positively received.

12.   Higher Utilisation Costs for MBS and PBS (*Measure B2*)

12.1. Description of measure

The Australian Government is providing funds to meet the expected increased costs to the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) as a result of Aboriginal and Torres Strait Islander people making greater use of mainstream medical services.

There is expected to be an increase in MBS and PBS expenditure due to synergies between a number of measures within the ICDP, including specifically providing 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 mainstream healthcare; providing coordinated care and flexible funding for follow-up care through the new Care Coordination and Supplementary Services Program (CCSS); and changing the MBS schedule to allow ten, rather than five, follow-up services per patient per calendar year by a practice nurse or Aboriginal Health Worker to a patient who has received an adult health assessment.[70]

12.2. Findings from Sentinel Sites

Notes on analysis of adult health assessment data

It is important to note the following:

The focus of the analysis for this component of the measure is on 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 in Sentinel Sites compared to the rest of Australia. The analysis excludes 0-14 years from the MBS 715 claims.

- Data represent the uptake of MBS items for all Health Services within the boundaries of the Sentinel Site, and therefore reflect the overall activity of all services within the site. The data are not directly attributable to any specific health centre. These data will capture services delivered to patients visiting from elsewhere.

- Data presented in this report reflect billing for MBS items and do not necessarily accurately reflect the provision of clinical care by providers. Some providers may be carrying out adult health assessments and follow-up health services, or some components of these services, without submission of claims to Medicare Australia.

- In order to provide follow-up for allied health services (MBS items 81300-81360) under the MBS, allied health professionals must be registered with Medicare Australia and issued with a provider number. DoHA does not collect data regarding the number of allied health professionals who are providing non-MBS services. Therefore, the true extent of follow-up services by allied health professionals is not reflected in the Medicare claim data reported here.

- Aboriginal and Torres Strait Islander people are also likely to be accessing MBS items in the same way as the general population. Care provided to Aboriginal and Torres Strait Islander people under general MBS items is not reflected in the data presented in this report.

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[70] DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, [website], (accessed 28 November 2011).

- MBS data extraction is based on the date of service. However, MBS data are only captured when a claim has been processed by Medicare Australia, commonly known as the date of processing. Typically 99% of claims for the reference period are processed within six months of when the claim was made. For example, not all MBS claims for 2009 are processed in 2009, however we would expect that by 30 June 2010 we would know 99% of the activity in 2009 on a date of service basis.

The data available for analysis for the SSE for inclusion in this report are for a 27 month period between March 2009 and May 2011 inclusive. This includes a 12 month 'baseline' period (March 2009 to February 2010 inclusive) which preceded the implementation of the ICDP, and a fifteen month period (March 2010 to May 2011 inclusive) which covered a period coinciding with the early implementation of the ICDP. The inclusion of the baseline period is to allow an assessment of levels and trends in uptake prior to the implementation of the ICDP.

12.3. Adult health assessments

Overall trends in adult health assessments in relation to implementation of the ICDP

There was a marked increase in the number of adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people in the quarters from March 2010 - May 2011 following the introduction of the ICDP (Figure 18). The only exception was in the December 2010 - February 2011 quarter where there was a decrease in the number of health assessments items claimed. This probably reflects seasonal variation over the summer holiday period.

The trends in the number of adult health assessments claimed per 100 people were very similar in Sentinel Sites and the rest of Australia. The Sentinel Sites have gone from a lower level of adult health assessment coverage than the rest of Australia during the baseline period to a higher level of adult health assessment coverage during the implementation of the ICDP. For the baseline period (March 2009 - February 2010) in the Sentinel Sites, there were around 1.9 adult health assessments per 100 people, with an increase to around 5.0 per 100 people in the March - May 2011 quarter. In the baseline period the number of adult health assessments per 100 people for the rest of Australia averaged 2.3, increasing to about 4.3 per 100 people in the March - May 2011. The number of adult health assessments, and rate of adult health assessment per 100 people by rurality and absolute numbers are included in Appendix H, Tables H1 and H2 respectively.

The increase in claims for adult health assessments in the Sentinel Sites and in the rest of Australia coincided with the introduction of the ICDP (March - May 2010) when there was a change to allow claims for payment for a health assessment once a year instead of once every two years for people in the 15-54 year age group. Some of the increase in uptake of health assessments is therefore likely to be due to billing of health assessments for the same clients on an annual basis instead of a biannual basis. However, the uptake of health assessments in the final quarter of the period covered by this report is more than double the average number per quarter at baseline, confirming that at least some of the increase in uptake is due to health assessments being done for clients who have not previously received health assessments. As referred to below, there was an increase in health assessments for both the 55 years and over age group and the 15-54 age group. Health assessments could be claimed annually for the older age group prior to the introduction of the ICDP, so the increase for this group would not have been affected by the change to the timeframes as may have been the case for the younger group. Despite this, the increase in health assessments was more rapid in the 55 years and over age group than the 15-54 group. This adds to the evidence that at least some of the

increase in uptake is due to health assessments being done for clients who have not previously received health assessments particularly in high needs groups.

The increase also coincides with the introduction of the PIP Indigenous Health Incentive and PBS Co-payment measure. Health Services have often reported that on signing a patient up for the PIP Indigenous Health Incentive and PBS Co-payment they are also offering health assessment as '*part of the package.'*

In this reporting period there was a perception expressed by community focus groups and a range of interviewees that the PBS Co-payment has in many cases been the incentive for patients to sign up for the PIP Indigenous Health Incentive. Once they have access to PBS Co-payment (which is a once only sign on process) there is seen to be less incentive to re-register in subsequent years as this is not required to maintain access to the free or subsidised medications. There is a perception from community focus group participants and some interviewees that the standard of care is not necessarily improving as a result of registration for the PIP Indigenous Health Incentive, so patients may not see a clear incentive to re-register for PIP. The SSE will continue to monitor trends in registration for PIP and other related MBS items in order to discern the relative influence of the PBS Co-payment and other possible incentives for people in the community to engage with the health system.

Interviewees indicate that OWs in the DGP and AHS have been spending time in the community encouraging community members to have a health assessment and to be proactive and ask for one at their regular health service provider.
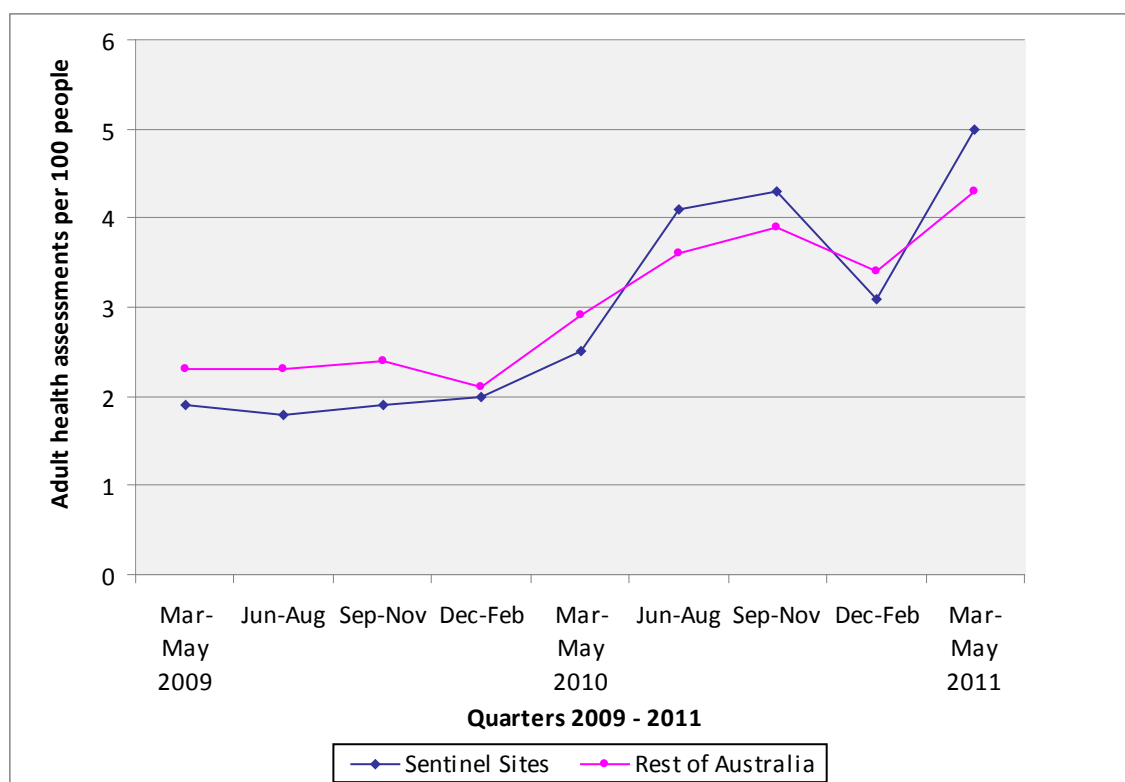
Figure 18: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by quarter

Trends in adult health assessments by age and sex

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 throughout the period

covered by this report. There was a similar relative increase in the number of adult health assessments per 100 people for people aged 55 and over and people aged from 15-54 years following the baseline period (Figure 19).

Figure 19: 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 2011

There has been a more marked increase in adult health assessments among people aged 55 years and over in Sentinel Sites in the final quarter of the period covered by this report. Interview results suggested that this may be due to people 55 years and over possibly accessing Health Services more frequently due to the higher prevalence of chronic disease in older age groups. There was also a perception that older people are less pressed for time and may regard attendance for health care as something of a social outing. The increase in adult health assessments per 100 people appears to have been slightly lower for men than for women (Figure 20), although there has been a similar increasing trend in both groups. Men commonly access Health Services less readily than women, so it is not surprising that adult health assessments are being carried out less frequently for males. To overcome this, a number of IHPOs and OWs based within DGPs in the Sentinel Sites indicated that they were specifically encouraging men to have health assessments by having stalls at events that are attended by males (such as football events). There have also been a number of DGPs that have been actively encouraging males to apply for the OW position or splitting funding for one full-time position to two part-time positions with one male and one female to encourage engagement with Aboriginal and Torres Strait Islander males.
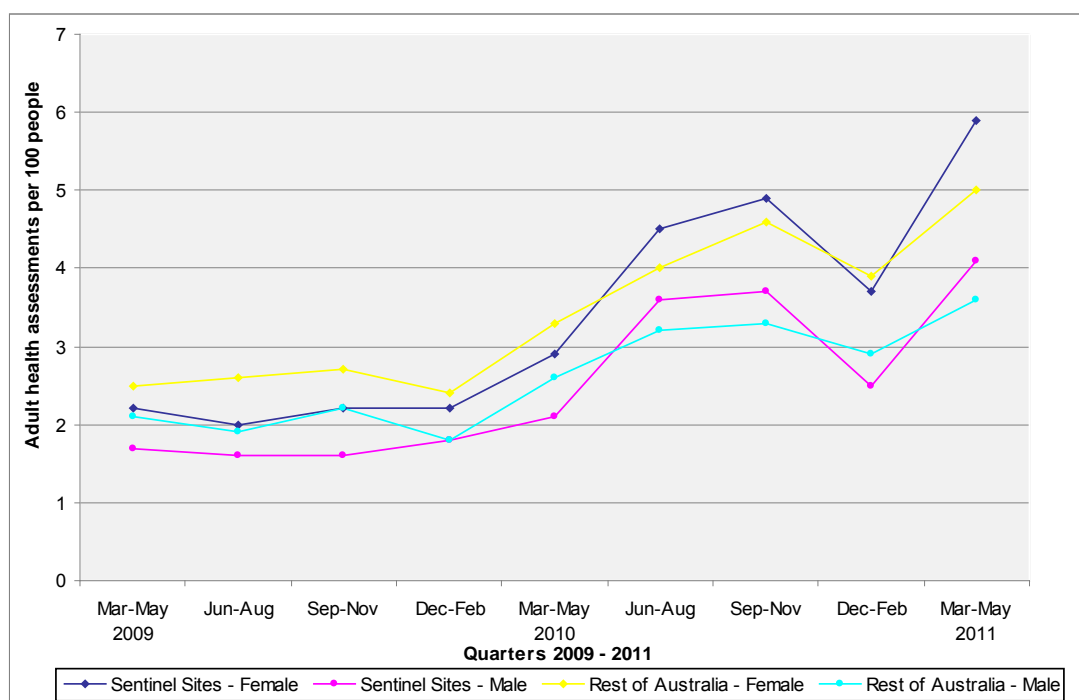
Figure 20: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by sex and quarter, March 2009 - May 2011

Trends in adult health assessments by rurality

Coverage of adult health assessments during the baseline period (March 2009 - February 2010) varied by rurality with coverage being greater in regional and remote areas than in urban areas (Figures 21-23).

All areas showed increases in the coverage of adult health assessments from the quarters of March - May 2010 to the March - May 2011.

Urban areas in the rest of Australia showed a steady increase through to the June 2010 - August 2010 quarter. The increase stabilised in the September 2010-November 2010 quarter, declined in the December 2010 - February 2011 quarter and then showed renewed growth in the March - May 2011 quarter (Figure 21).
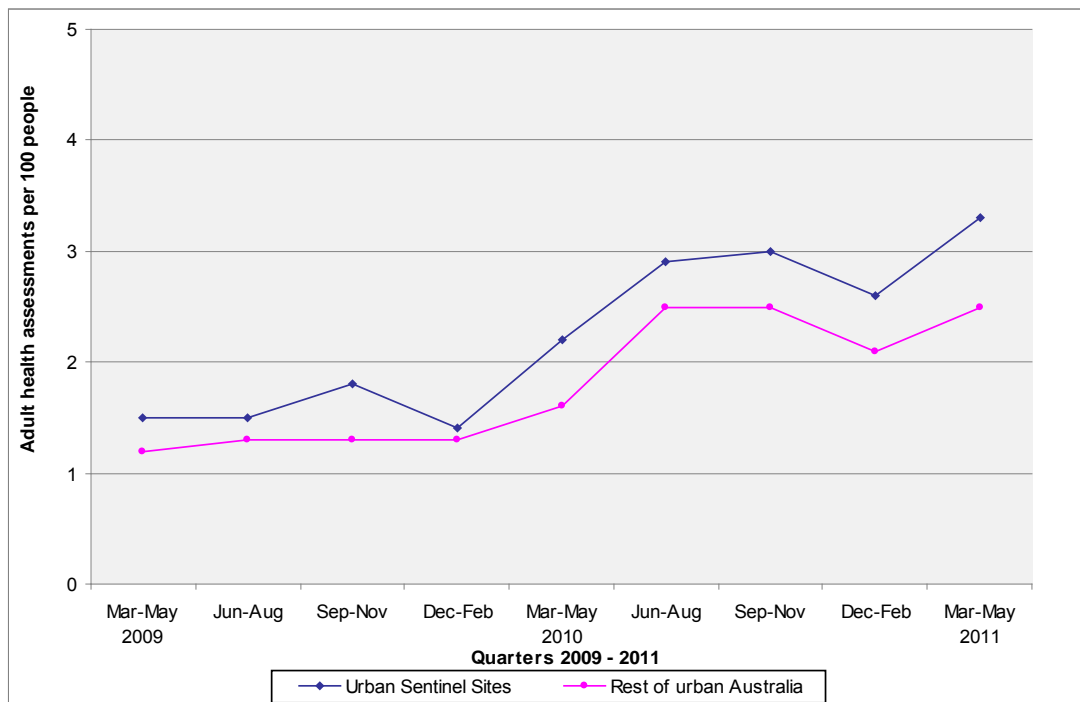
Figure 21: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - May 2011

Regional areas in the rest of Australia continue show strong increases which have gained momentum since the last report. However, there was a decline in the December 2010 - February 2011 quarter (Figure 22).
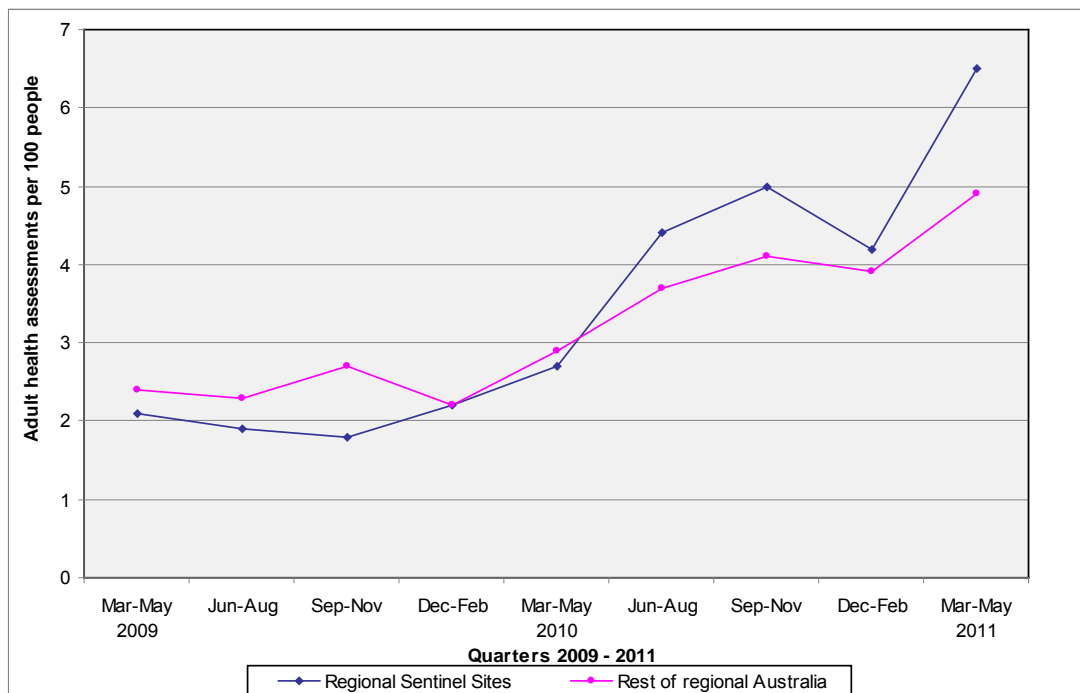
Figure 22: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - May 2011

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Remote areas in the rest of Australia showed a strong increase in adult health assessment claims overall. Remote Sentinel Sites showed considerable variability with much greater increases than the rest of Australia in the June 201 - August 2010 and September 2010 - November 2010 quarters, much greater declines in the December 2010 - February 2011 quarter and a relatively smaller increase in the March 2011 - May 2011. This variability is likely to reflect the small number of remote Sentinel Sites (Figure 23).
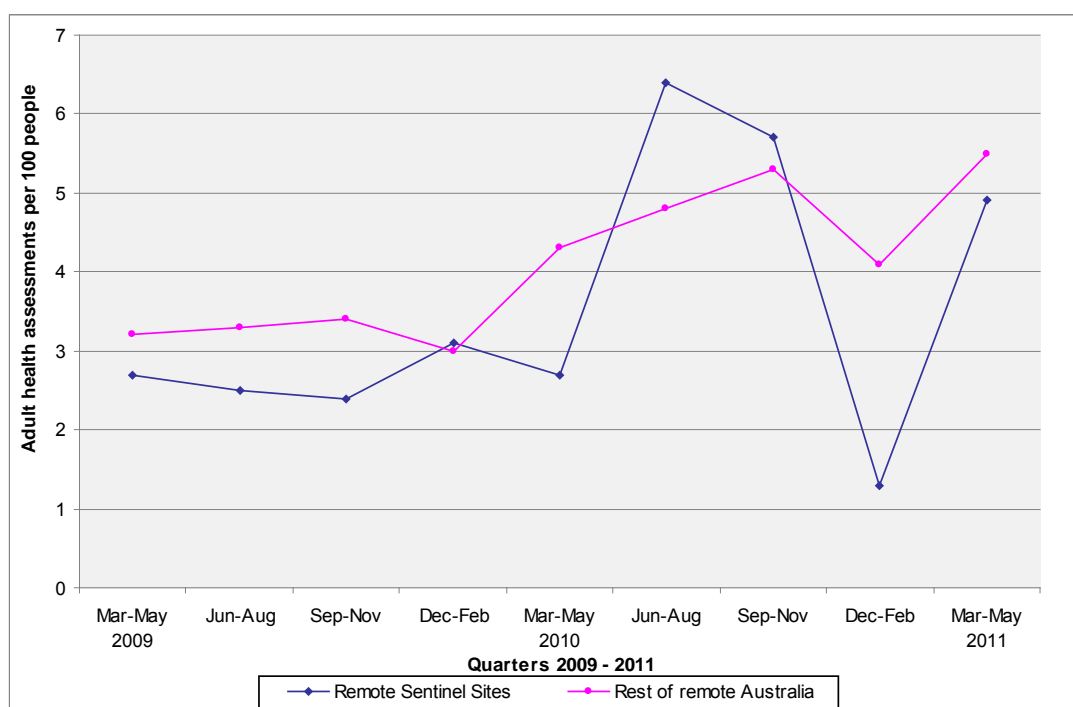
Figure 23: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - May 2011

The dip in health assessments in urban, regional and remote locations in the December-February period was probably associated with the Christmas holiday period. The reason for this dip being more marked in remote areas may be due to:

* less frequent visits by visiting doctors or resident doctors working in remote locations, due to taking longer periods of leave over the December-January period

* nursing staff taking leave and the focus of care shifting to acute care rather than preventive care (such as performing adult health assessments)

* period coinciding with the wet season for remote regions in northern tropical Australia, a season when local populations are likely to be concentrated in larger communities rather than dispersed across outstations and smaller communities which become isolated by flood waters during this time of year.

Key points from analysis of trends to date

The key points that emerge from this analysis for adult health assessments include:

* In the Sentinel Sites the number of adult health assessments per 100 Aboriginal and Torres Strait Islander people in the March - May 2011 quarter was more than double the

number in the baseline period (March 2009 - February 2010). The increase in the rest of Australia over the same period was slightly less marked.

- Claims for adult health assessments for people aged 55 years and over were approximately double that for people aged 15-54 years. There was a similar increase for both groups between the baseline period and the last quarter of the period covered by this report.

- Population coverage for adult health assessments was greater in remote and regional areas than in urban areas. The greatest increases in the number of health assessments per 100 people have been in regional areas.

- More emphasis may be required on increasing population coverage for adult health assessments in urban areas. IHPOs and OWs funded in the DGPs have as a core responsibility of their role, a focus on increasing the uptake of the universal ICDP measures, which includes adult health assessments. The number of Health Services in urban environments that might require their support presents a challenge for these workers.

Trends in uptake for specific Sentinel Sites

Graphs showing trends in coverage of adult health assessments for specific sites and for urban, regional and remote areas for the rest of Australia are included in Figures 24-28.

Urban Sentinel Sites

There was wide variation in the number of adult health assessments claimed per 100 people between the urban Sentinel Sites of Brisbane South, Campbelltown, Canberra, Elizabeth, Dandenong, Logan/Woodridge, North Lakes/Caboolture and Newcastle (Figure 24). These sites all showed a general increase in March - May 2011 compared to baseline. However the prevailing pattern from the June -August 2010 quarter has been one of stabilisation with increases in March - May 2011.

The key points from the data are summarised below:

- In Brisbane South and Campbelltown the number of adult health assessments per 100 people increased up to the June - August 2010 quarter, declined in September - November 2010 and the December 2010 - February 2011 quarters and then increased in the March - May 2011 quarter.

- Numbers of health assessment per 100 people in Canberra increased in March -May 2010, declined in the June -August 2010 quarter and then increased and stabilised in the following quarters.

- Numbers of health assessments in Dandenong, Elizabeth and Newcastle increased in the March - May 2010 quarter and then stabilised from the June - August 2010 quarter until the March - May 2011 quarter when they again increased. This increase was particularly marked in Elizabeth.

- Logan/Woodridge showed a marked increasing trend in the number of health assessments per 100 people. This increase began in the early stages of the introduction of the ICDP program and continued to the September - November 2010 quarter. This was followed by a decline in the December 2010 - February 2011 quarter and a subsequent levelling off at a period almost two fold higher than any other sites in the March - May 2011 quarter.
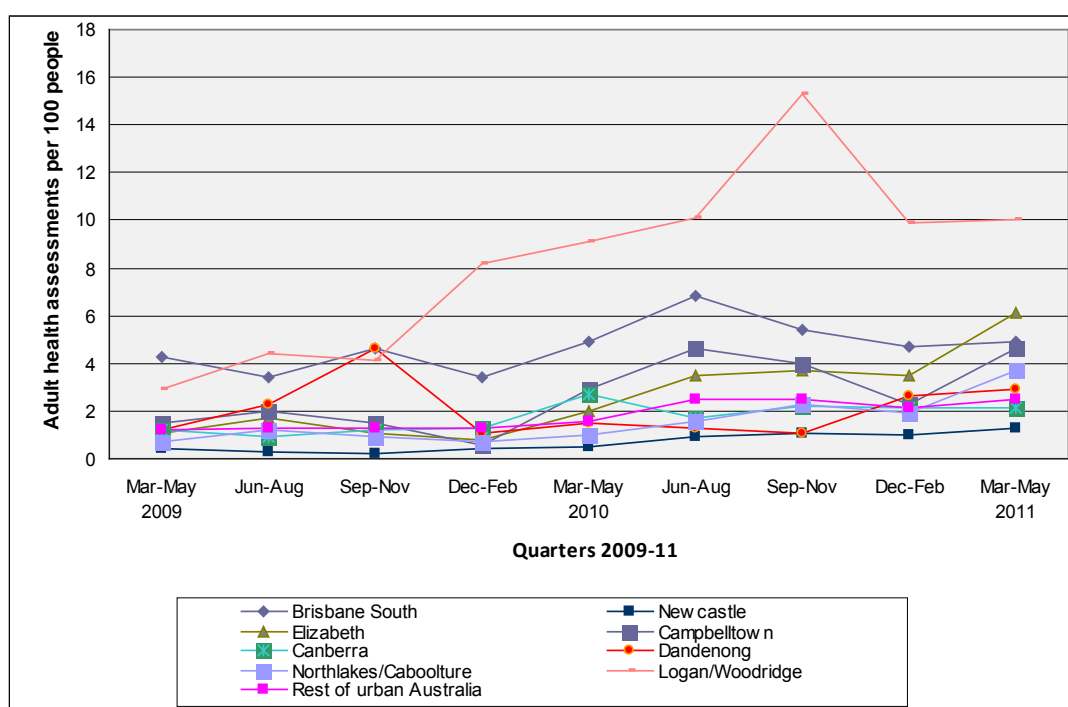
Figure 24: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in urban Sentinel Sites and the rest of urban Australia, by site and quarter, March 2009 - May 2011

Regional Sentinel Sites

Trends in the number of adult health assessment per 100 people showed even wider variability in regional sites (Figures 25-27).

The key points from the data are summarised below:

- The number of adult health assessments per 100 people showed no clear sign of increase over the period covered by this report in Port Augusta and Darwin.

- In Bairnsdale there was an increase above baseline levels for the first time in the March - May 2011 quarter.

- In Cairns and Geraldton the number of adult health assessments per 100 people increased in the March - May 2010 and June - August 2010 quarters compared to the baseline period, declined slightly in the subsequent two quarters and increased again in the March - May 2011 quarter (with a particularly marked increase in Cairns).

- The number of health assessments per 100 people increased most strongly in Dubbo and Swan Hill/Mildura between the baseline period (March 2009 - February 2010) and the September - November 2010 quarter. The number of health assessments per 100 people has subsequently stabilised in Dubbo and declined in Swan Hill/Mildura.

- Grafton and Tamworth showed relatively consistent increases in the number of health assessments per 100 people up to September - November 2010. Both of these sites showed a marked decline in the December 2010 - February 2011 quarter. This was followed by a marked increase in Tamworth, but a further decline in Grafton. Hobart showed an increasing trend from the September- November 2010 quarter through to March - May 2011 after a period of relatively little change.

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- The numbers of health assessments per 100 people showed a high level of fluctuation in Gladstone and did not constitute a discernible trend.

- Similarly, in Kalgoorlie there was a steep increase in the number of health assessment per 100 people in the latter half of the baseline period. Numbers of health assessments subsequently fell then increased in the December 2010 - February 2011 quarter and then again declined.
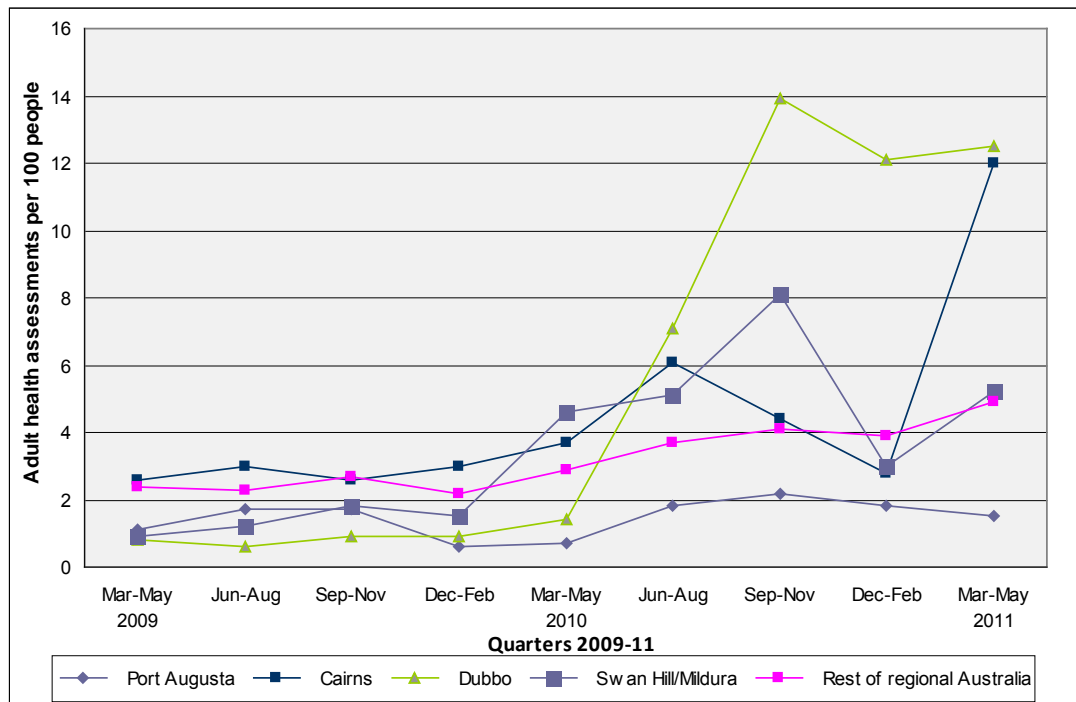
Figure 25: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 1 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2011
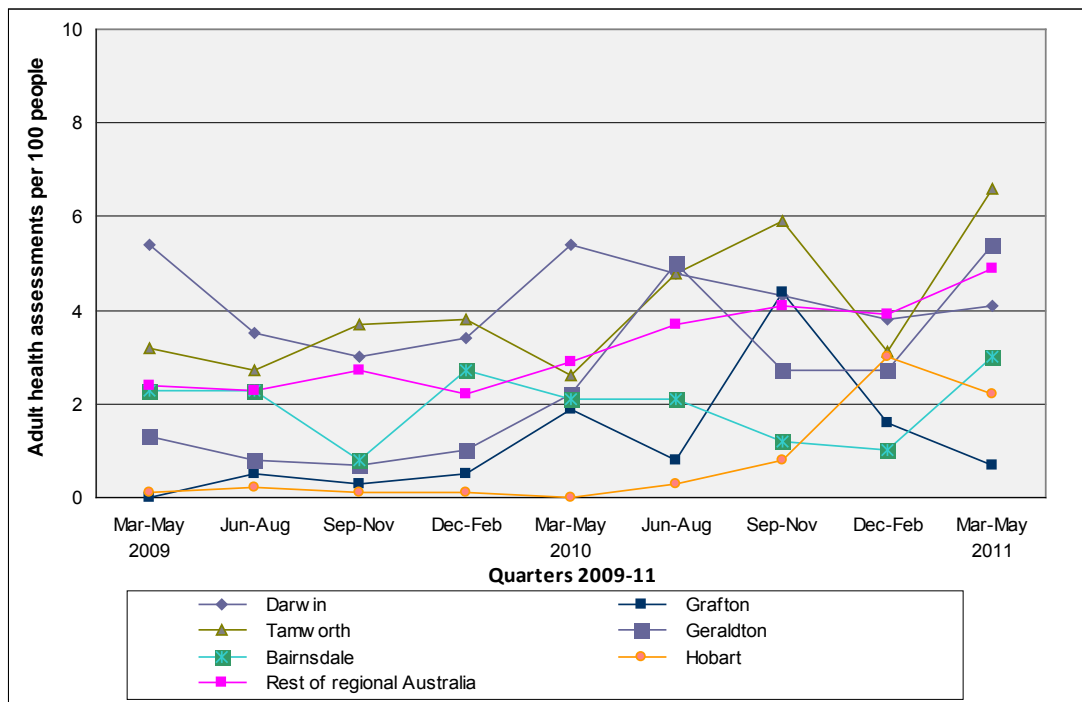
Figure 26: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 2 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2011
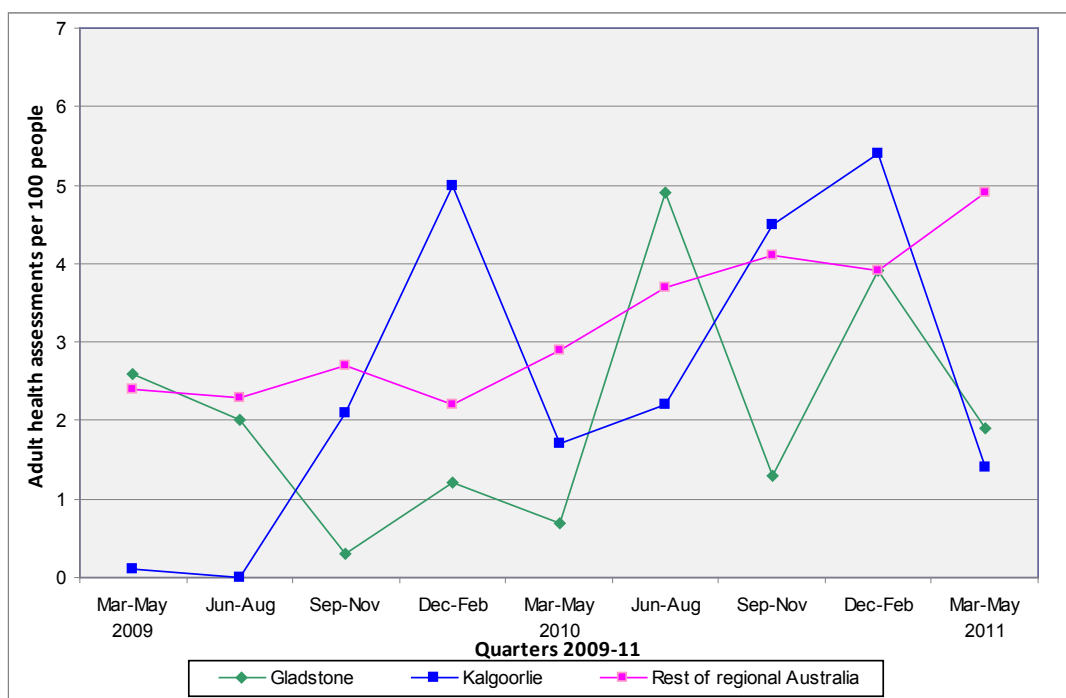
Figure 27: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 3 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - May 2011

Remote Sentinel Sites

There was wide variability in uptake of adult health assessments in remote Sentinel Sites (Figure 28).

The key points from the data are summarised below:

- Katherine West showed a steady increase in the number of adult health assessments per 100 people from the December 2009 - February 2010 quarter to the September - November 2010 quarter and subsequently declined.

- Derby showed a marked increase in the June - August 2010 quarter and then declined in the two subsequent quarters showing some recovery in March - May 2011.

- Barkly showed a similar trend, but at a generally higher level than Derby.

- Trends for East Pilbara fluctuated widely in the post ICDP implementation period, but showed a large increase in the March - May 2011 quarter.
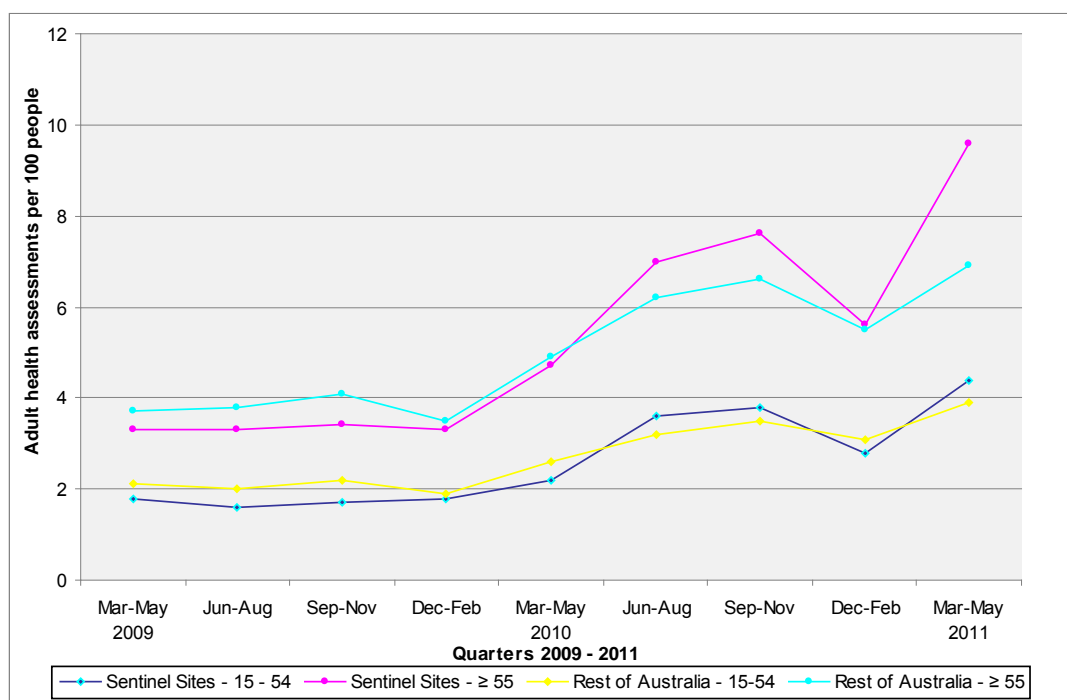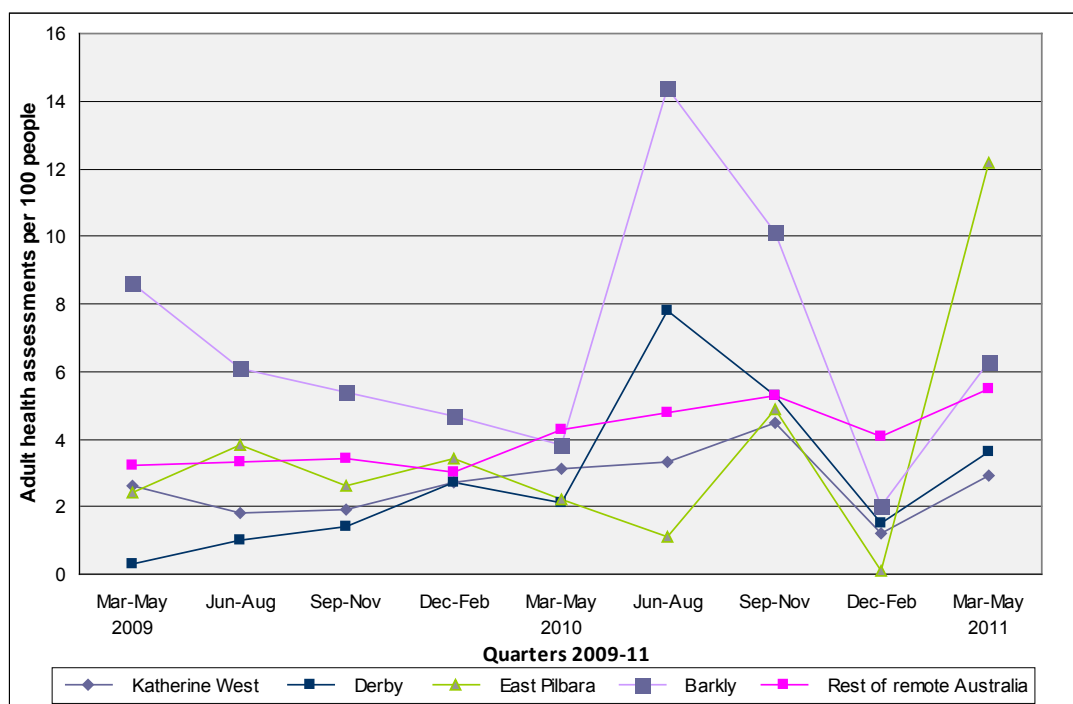

Figure 28: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in remote Sentinel Sites and the rest of remote Australia, by site and quarter, March 2009 - May 2011

12.4. Follow-up services by a practice nurse or registered Aboriginal Health Worker

Overall trends in relation to implementation of the ICDP

In Sentinel Sites the number of claims for follow-up services provided by a practice nurse or registered Aboriginal Health Worker (AHW) to Aboriginal and Torres Strait Islander people who had received an adult health assessment fluctuated between 7 and 57 claims over the baseline period, with an average of 43 items claimed per quarter in the baseline period. The number of follow-up services provided by a practice nurse or registered Aboriginal Health Worker (AHW) increased markedly in Sentinel Sites in the post-baseline period (from March - May 2010 quarter onwards) compared to before. The number of items claimed in the March - May 2011 quarter (515) was more than 10 times the average number claimed per quarter over the baseline period–an early indication of increasing use of this MBS item in the Sentinel Sites.

The small numbers of claims for follow-up services provided by a practice nurse or AHW in the Sentinel Sites means more detailed analysis of these data needs to be made with caution.

In contrast to the Sentinel Site specific data, the data for the rest of Australia on the number of claims for MBS items for follow-up services provided by a practice nurse or AHW showed a steady increase over the baseline period, from 244 for the first quarter of the baseline period (March - May 2009) to 749 for the final quarter of the baseline period (December 2009 - February 2010) (Table 13). The number of items claimed in March - May 2011 showed a more than a six-fold increase on the average number of claims made in the baseline period.

Table 13: 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

Sentinel Sites/ Rest of Australia	Mar-May 2009	Jun-Aug 2009	Sep-Nov 2009	Dec 2009-Feb 2010	Mar-May 2010	Jun-Aug 2010	Sep-Nov 2010	Dec 2010-Feb 2011	Mar-May 2011
Sentinel Sites	57	72	34	7	161	278	227	246	515
Rest of Australia	244	338	511	749	1102	1413	1921	2389	3050

Interviewees indicated a number of reasons why uptake of follow-up item numbers was low, including:

- Health Services may still be claiming general follow-up item numbers and not necessarily claiming the Aboriginal specific item numbers. The Aboriginal specific item numbers were introduced in 2010. Previously health professionals used the general item numbers. There is a general low awareness of the availability of these new item numbers, and even where providers are aware it is difficult to change the habit of using the general item numbers.

  'Were claiming under standard EPC [Enhanced Primary Care] items not the ones that are Aboriginal specific for some time. It is just that we were very comfortable with the others from a care plan.' (Interview, Nurse, AHS)

- Challenges with getting patients back for follow-up services after a health assessment.

- Challenges recalling patients for follow-up care due to clinical information systems recall and reminder system either not being used or too 'messy'.

- Getting provider numbers for the Aboriginal Health Workers has been a challenge, as not all have formal qualifications, and there is confusion over who can be registered as a provider. The additional paperwork was viewed as a barrier.

- There is a clear role for Health Services to link with the funded OWs in DGPs and AHS to assist with follow-up care. It appears that this function of the OW is not being fully utilised.

Analysis of trends by rurality

From March 2010 - May 2011 very few claims were made for urban areas for follow-up services provided by a practice nurse or AHW (urban Sentinel Sites=66; urban rest of Australia=708), compared to regional (regional Sentinel Sites=697; regional rest of Australia=3894) and remote areas (remote Sentinel Sites=664; remote rest of Australia=5273). This pattern was apparent throughout the baseline period and the period of the ICDP implementation (Appendix H, Tables H3 and H4).

Key points from analysis of trends to date

The key points that do emerge from this analysis for MBS item 10987 include:

- Overall the number of claims for follow-up services provided by a practice nurse or AHW increased in both absolute terms and as a proportion of adult health assessments in the post-baseline period (March - May 2010 and onwards) (Figure 29, Appendix H, Tables H3 and H4). The increase in follow-up services provided by a practice nurse or registered AHW was more marked in the rest of Australia than in Sentinel Sites.

- The overall increase in claims for follow-up services provided by a practice nurse or AHW was almost entirely driven by increases in services in regional and remote areas (Appendix H, Table H4). However there was an increase in claims for follow-up services in urban areas in the period from September 2010 - May 2011.

- The general trends in the number of MBS items claimed for follow-up by a practice nurse and AHWs per 100 adult health assessments was similar for the 15-54 and 55 years and over age groups, with consistently higher numbers of claims in the older age group and with the largest increase seen for the 55 years and over age group in the rest of Australia (Figure 30).

- The general trends were similar for men and women, with consistently higher numbers of claims for women (Figure 31).
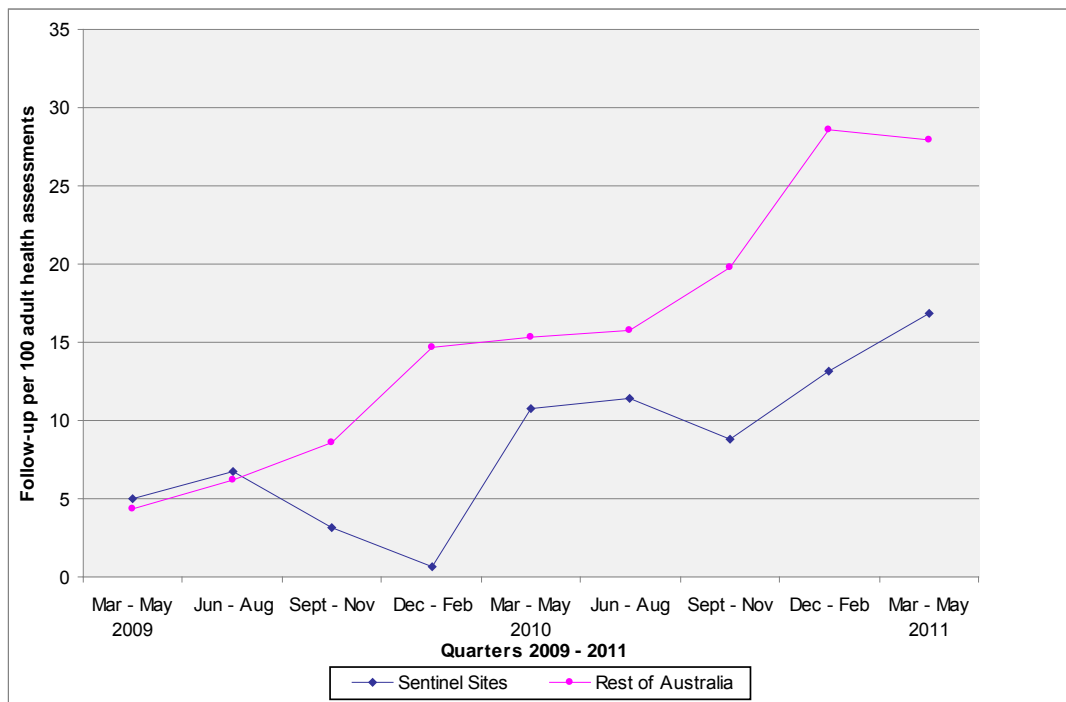
Figure 29: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2011
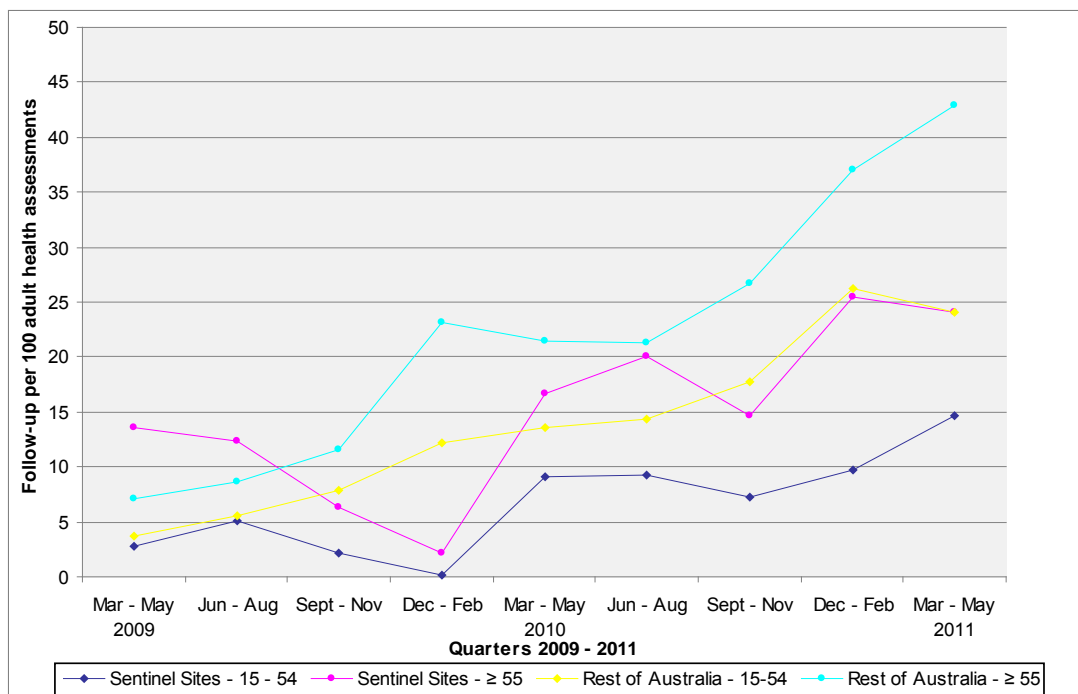
Figure 30: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - May 2011
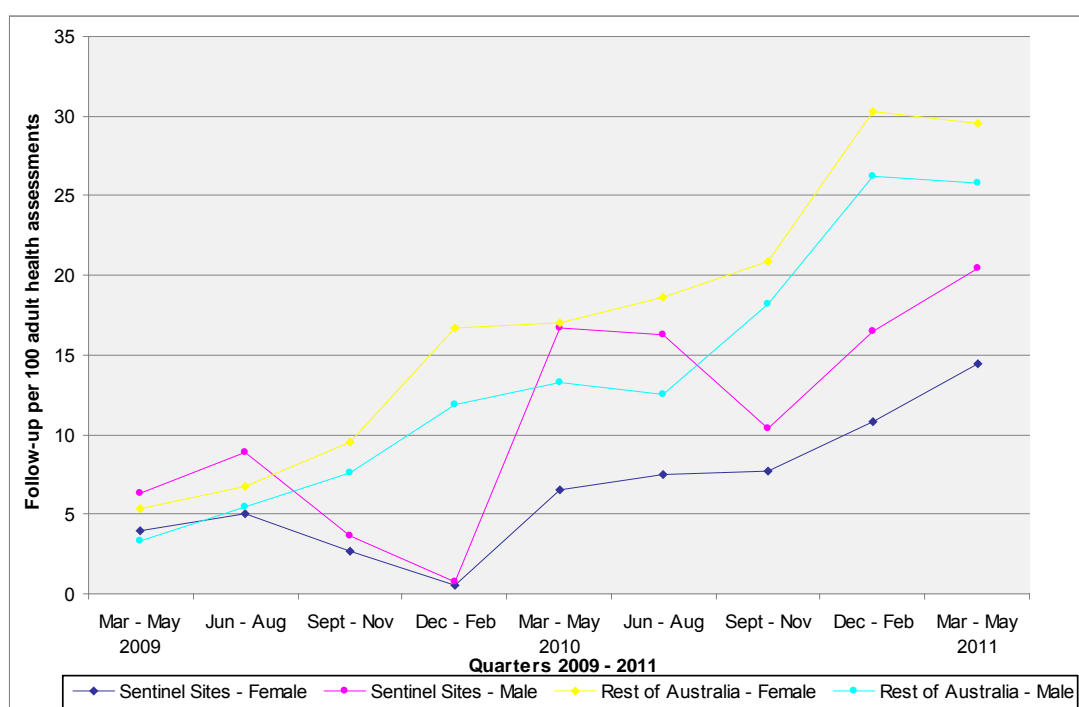
Figure 31: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by gender and quarter, March 2009 - May 2011

12.5. Follow-up by allied health professionals

Trends in the Sentinel Sites in relation to implementation of the ICDP

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 showed a steady increase since baseline, aside from a minor peak in the March - May 2010 quarter (Table 14). The number of items claimed in the March - May 2011 quarter was more than six times the number claimed on average in the baseline period for the Sentinel Sites.

The small numbers of claims for follow-up by allied health professionals in the Sentinel Sites (Appendix H, Table H5 and H6) means caution must be used in analysis of these data.

Interviewees indicated several reasons for lack of claims for follow-up by allied health professionals, including:

• A shortage of allied health professionals to refer to in some areas.

• Challenge in getting patients to attend follow-up allied health appointments due to general access issues such as transport, long wait times for appointments (which can be many months due to shortage of providers) and lack of reminder systems.

• A perception among some stakeholders that private allied health providers are not necessarily bulk-billing and patients may be faced with a gap payment for allied health services. General practice staff indicated it was difficult to know which providers would bulk-bill on request, and they generally did not have the capacity to ring ahead to ensure the patients would be bulk-billed.

'They can charge whatever they want, there is no regulation and because there are hardly any here the prices are high.' (Interview, DGP)

'We are promoting when you get your health check you are entitled to these allied health items but they have us over a barrel as they charge a huge gap. Practices identifying that they are doing health checks but nowhere to refer that will bulk-bill. The practice is saying well what the value was in this then?' (Interview, DGP)

- Allied health professionals employed by State health departments, DGPs or AHSs as salaried employees not necessarily eligible to bill Medicare. Services delivered by these providers are not showing up in the data.

- Confusion over whether salaried allied health providers can bill Medicare.

  'We haven't claimed the dietitian as we were under the impression we were double dipping and we have only just found some information last week to say that we are exempt from that as an AHS' (Interview, AHS)

Trends in the rest of Australia in relation to implementation of the ICDP

Similar to the Sentinel Sites, the data on 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 in the rest of Australia showed a steady increase over the baseline period, from 130 for the first quarter of the baseline period to 354 for the final quarter of the baseline period. This trend continued to the March - May 2011 quarter (Table 14) with the number of items claimed being more than four times the average claimed for the rest of Australia in the baseline period.

Table 14: 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

Sentinel Sites/Rest of Australia	Mar-May 2009	Jun-Aug 2009	Sep-Nov 2009	Dec 2009 – Feb 2010	Mar-May 2010	Jun-Aug 2012	Sep-Nov 2012	Dec 2010 – Feb 2011	Mar-May 2011
Sentinel Sites	33	31	40	47	123	99	104	136	262
Rest of Australia	130	169	267	354	370	426	786	647	906

The analysis of the number of claims for follow-up allied health services per 100 adult health assessments is complicated by the increase in the number of adult health assessments in the quarters reported between March 2010 - May 2011, as reported in the section on health assessments above.

The key points that do emerge from this analysis for MBS items 81300-81360 are summarized below.

- There was an increasing trend in the number of claims for follow-up allied health items per 100 adult health assessments in the Sentinel Sites and in the rest of Australia (Figure 32).
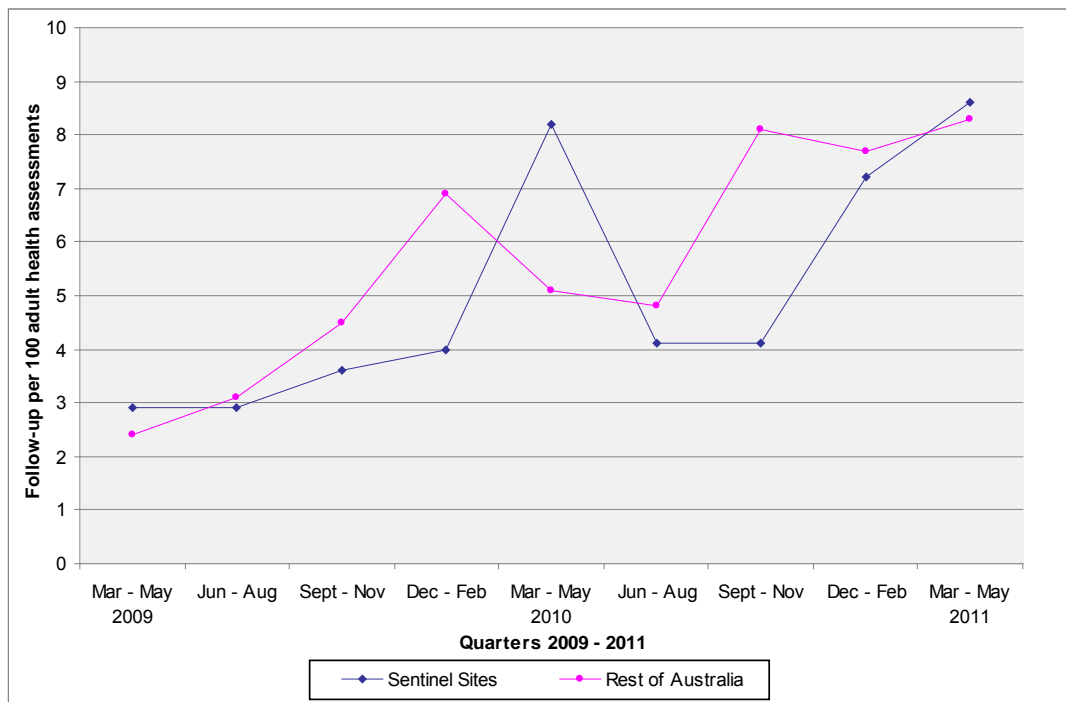
Figure 32: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS Items 81300-81360) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2011

- Very few follow-up allied health items were claimed in remote areas in both Sentinel Sites and the rest of Australia (Appendix H, Table H6).

- 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 was similar for the 15-54 and 55 years and over age groups, with the number of claims for services to the older group being about two to three times greater than for the younger group (Figure 33).
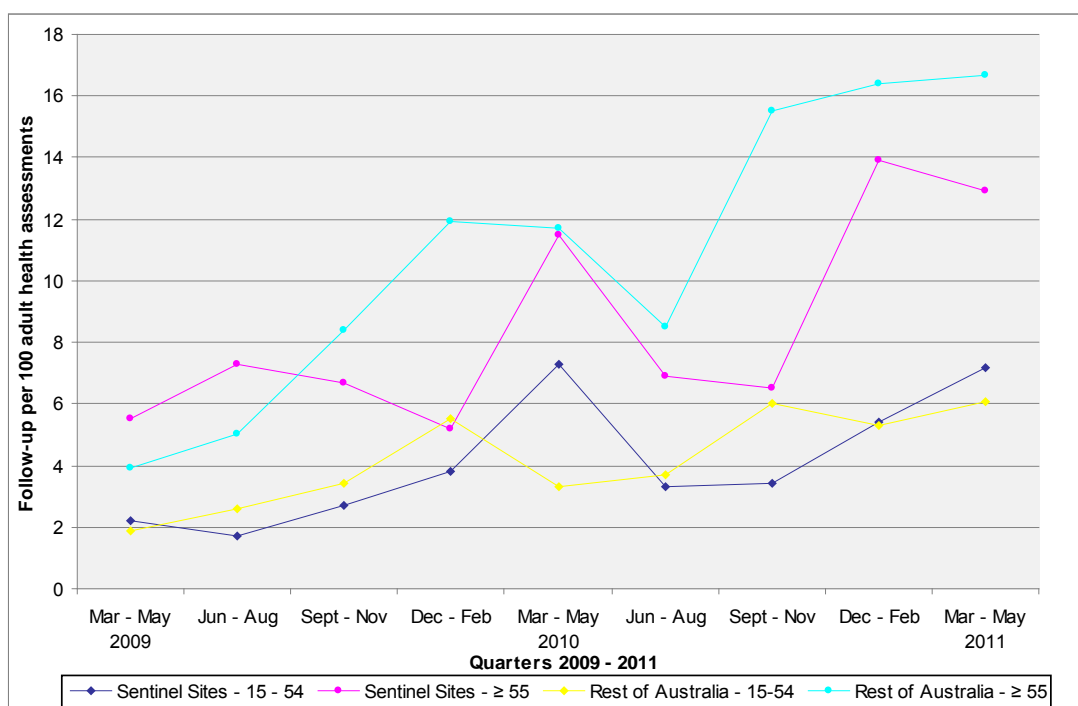
Figure 33: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS Items 81300-81360) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - May 2011

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 was similar for males and females, with the number of claims for services to females per 100 people tending to be slightly higher for females than for males (Figure 34).
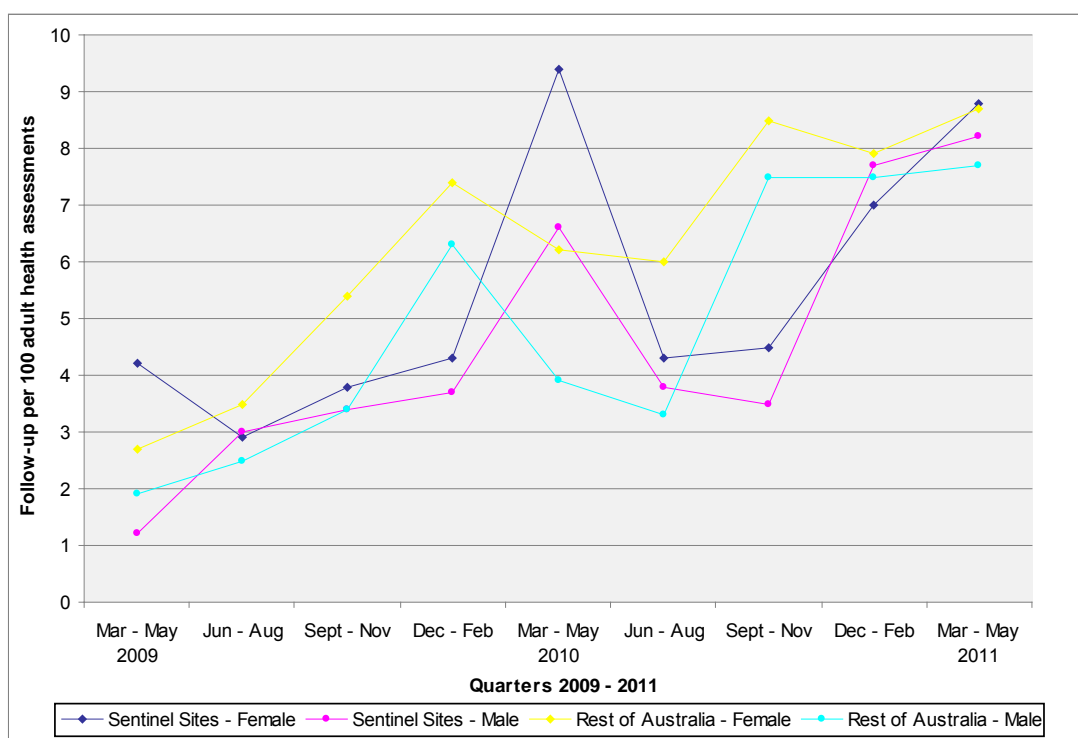
Figure 34: Follow-up by allied health professionals per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) for Sentinel Sites and the rest of Australia, by gender and quarter, March 2009 - May 2011

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12.6. GP Providers involved in claiming adult health assessments

This section of the report examines the trends in the number of adult health assessments claimed by GP providers and the trends in the numbers of providers who claimed adult health assessments.

In the Sentinel Sites, the number of GP providers 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 above 0.5 per 100 people in the September - November 2010 quarter and then to about 0.7 per 100 people by March - May 2011 (Figure 35, Appendix H Table H7).

For the rest of Australia, the number of GP providers 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 0.7 per 100 people in the March - May 2011 quarter (Figure 35).

The trends in the number of GP providers claiming for adult health assessment items were very similar in the Sentinel Sites and the rest of Australia (Figure 35).
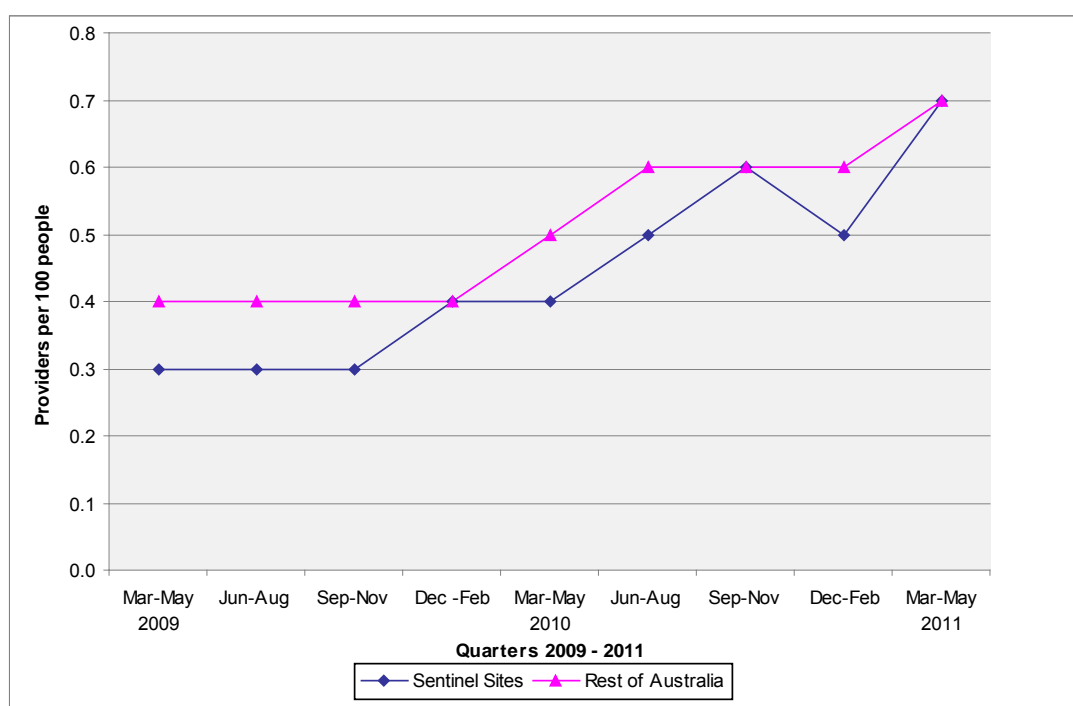
Figure 35: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2011

Although the differences in absolute terms were small (Figure 35) the timing of the increase in GP providers claiming adult health assessments coincides with the introduction of the ICDP (March - May 2010). However, the trends varied with rurality (Figures 36-38, Appendix H Tables H8-H10). While there were increases in the number of GP providers per 100 people in urban and regional areas there was very little change in remote areas.
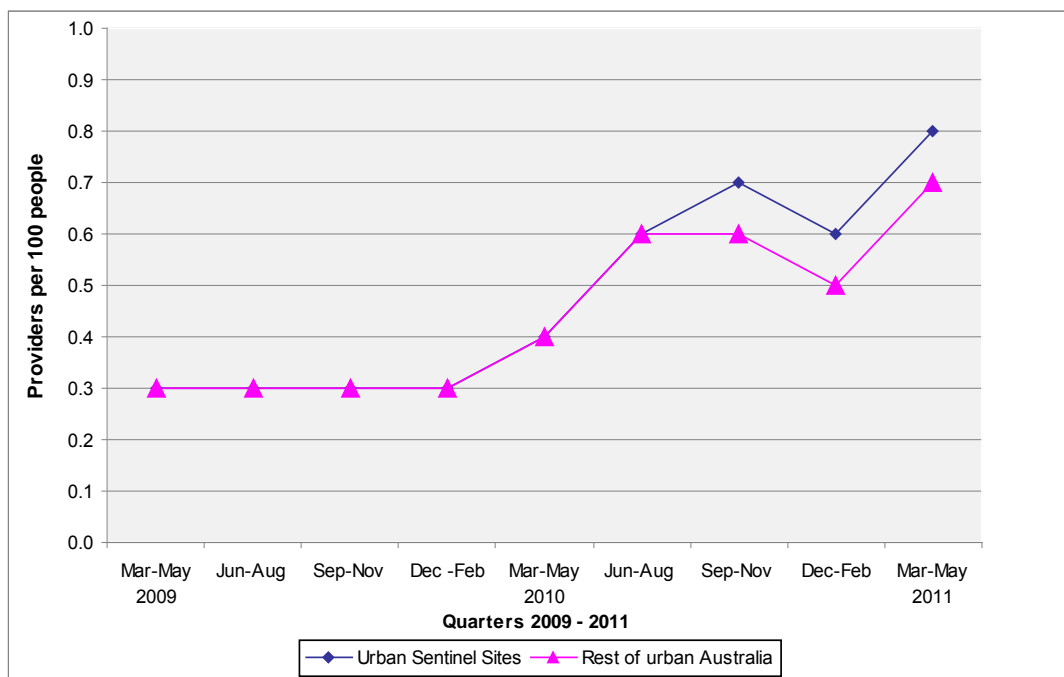
Figure 36: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - May 2011
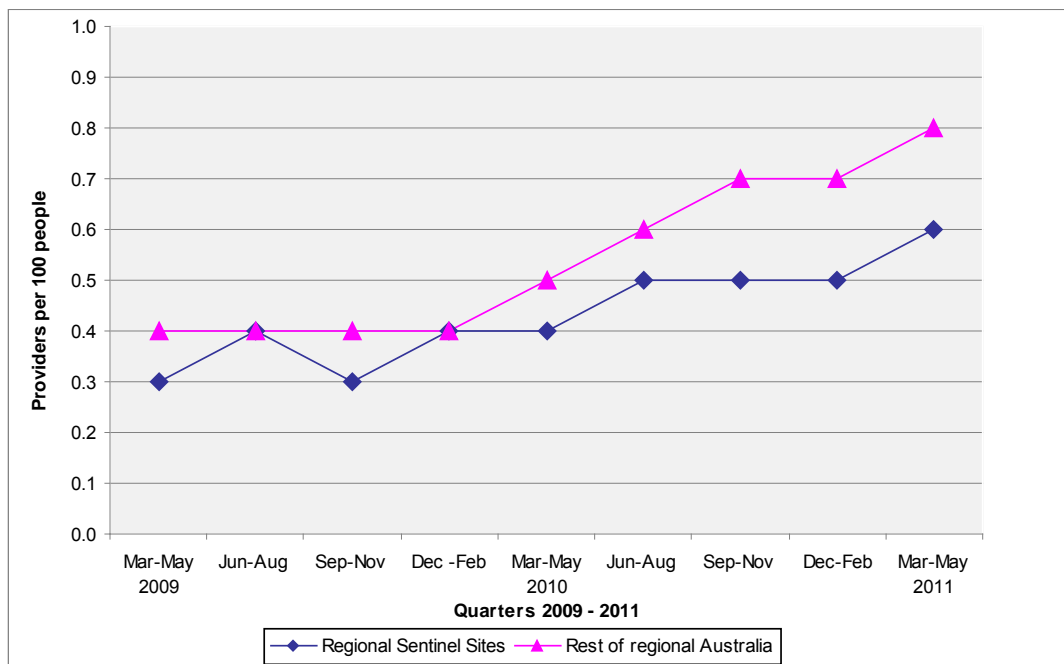
Figure 37: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - May 2011
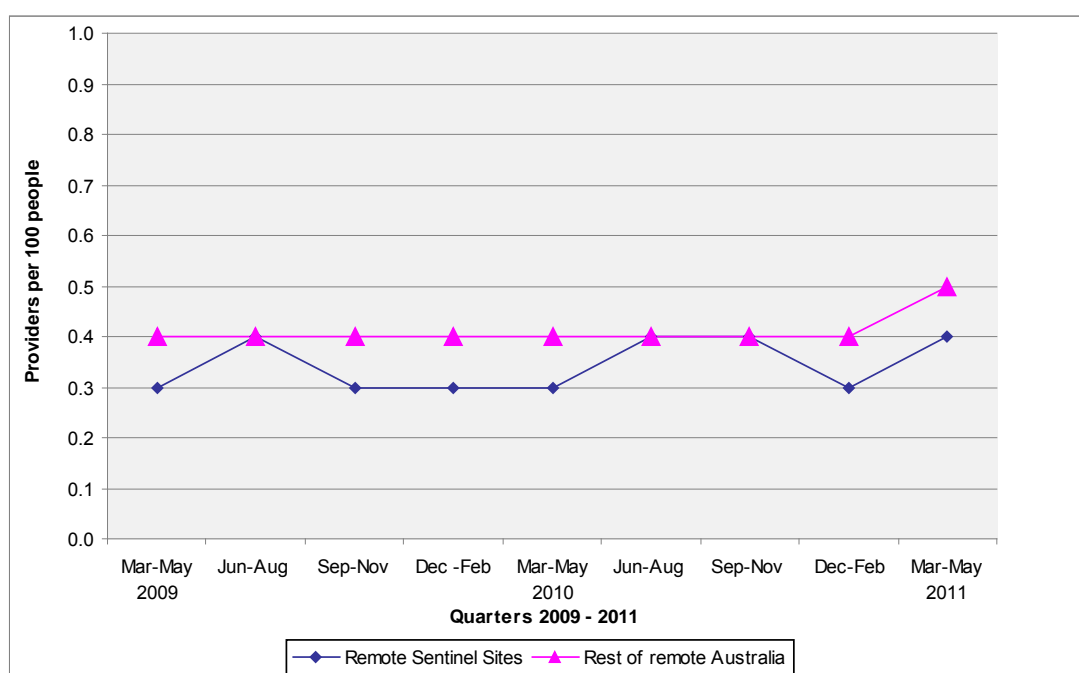
Figure 38: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - May 2011

At the individual Sentinel Site level, the number of GP providers claiming adult health assessments per 100 people at commencement of the baseline period (March 2009 - February 2010) varied widely, from 0 to slightly over 1. The variation increased with the implementation of the ICDP (March - May 2010) with GP provider numbers ranging from 0 to 1.7 per 100 Aboriginal and Torres Strait Islander people. There was also a wide variation between Sentinel Sites in trends over the course of the period covered by this report (see below for description of patterns in specific Sentinel Sites (Figures 39-42).

Trends in numbers of GP Providers by Rurality

In urban Sentinel Sites, there were increases in the number of GP providers claiming adult health assessments per 100 people with the exception of Campbelltown were rates were relatively stable (Figure 39). In Elizabeth, Logan/Woodridge and North Lakes/Caboolture the rate of increase in GP providers claiming adult health assessments was greater than for the rest of urban Australia with Logan/Woodridge having a much greater increase than the other sites throughout the reported period. In all other urban Sentinel Sites the rate of increase was lower than for the rest of urban Australia.
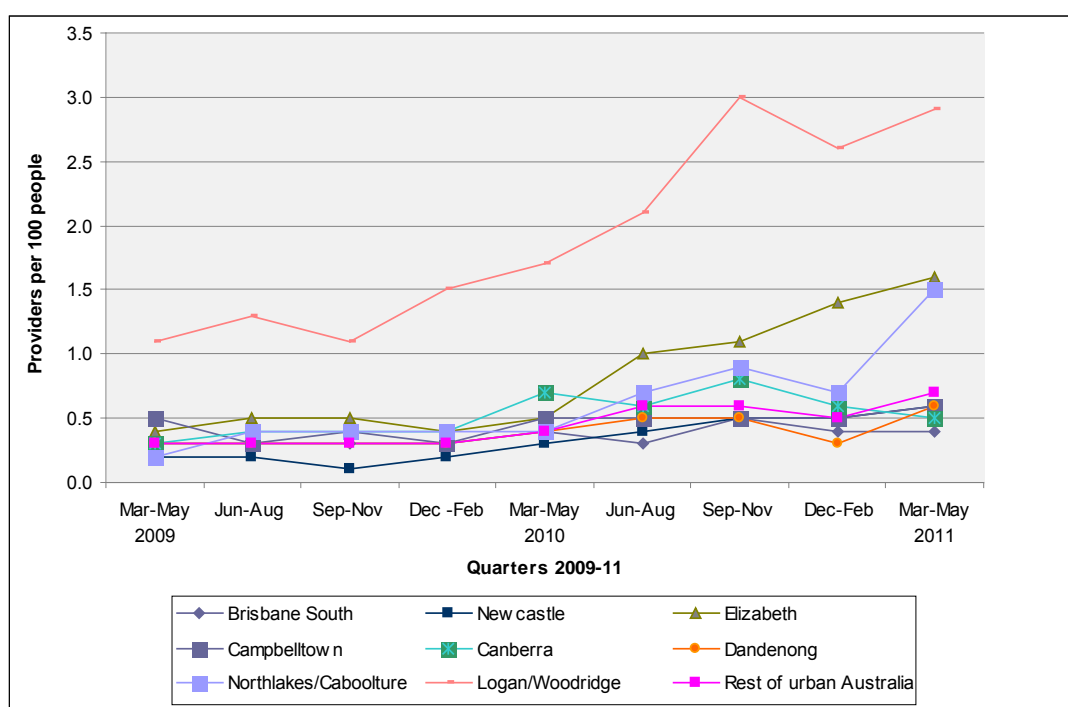
Figure 39: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites, by quarter, March 2009 - May 2011

In regional Sentinel Sites, the prevailing pattern was one of increasing numbers of GP providers claiming adult health assessments per 100 people. However, there was a high degree of variability amongst regional Sentinel Sites (Figures 40-42). The number of GP providers claiming adult health assessments per 100 people increased at a higher rate than the rest of regional Australia in Geraldton in March - May 2011. Rates of GP providers claiming health assessments per 100 people increased more rapidly than for the rest of Australia for Grafton and Swan Hill/Mildura but the rate slowed and declined slightly in the March - May 2011 quarter for Grafton and the June - August 2010 quarters for Swan Hill/Mildura. A similar pattern was observed in Dubbo. Bairnsdale, Hobart, Port Augusta and Tamworth experienced similar increases to the rest of regional Australia due to growth in the March - May 2011 quarter. Cairns and Kalgoorlie showed earlier increases that were in line with the rest of regional Australia. The number of claiming GP providers per 100 people was relatively stable in Darwin and Gladstone.
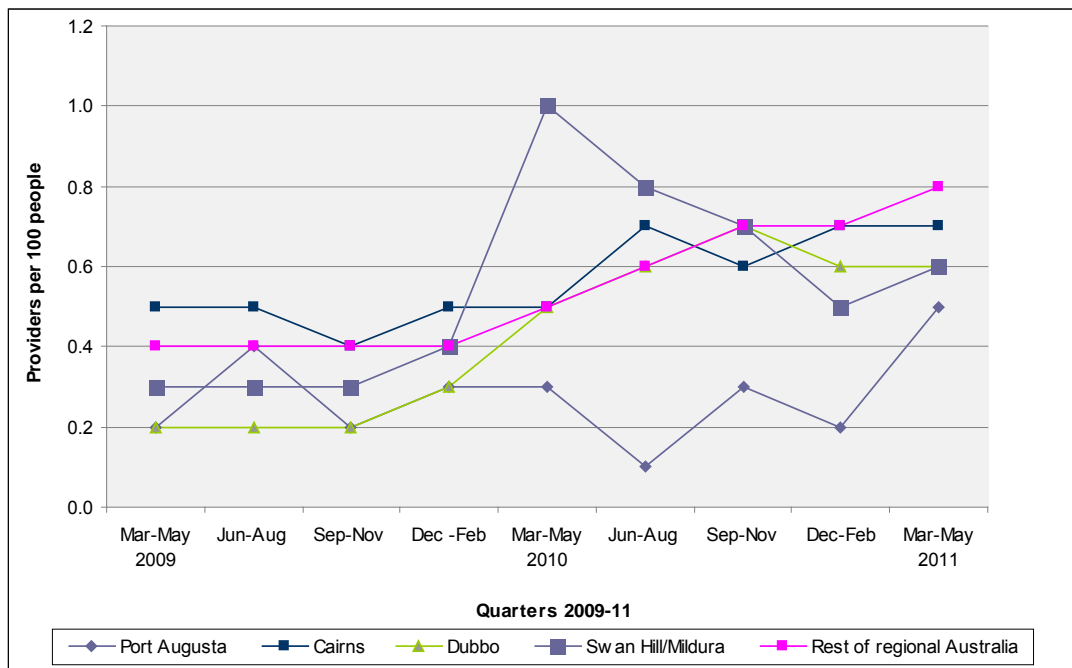
Figure 40: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 1 Sentinel Sites, by quarter, March 2009 - May 2011
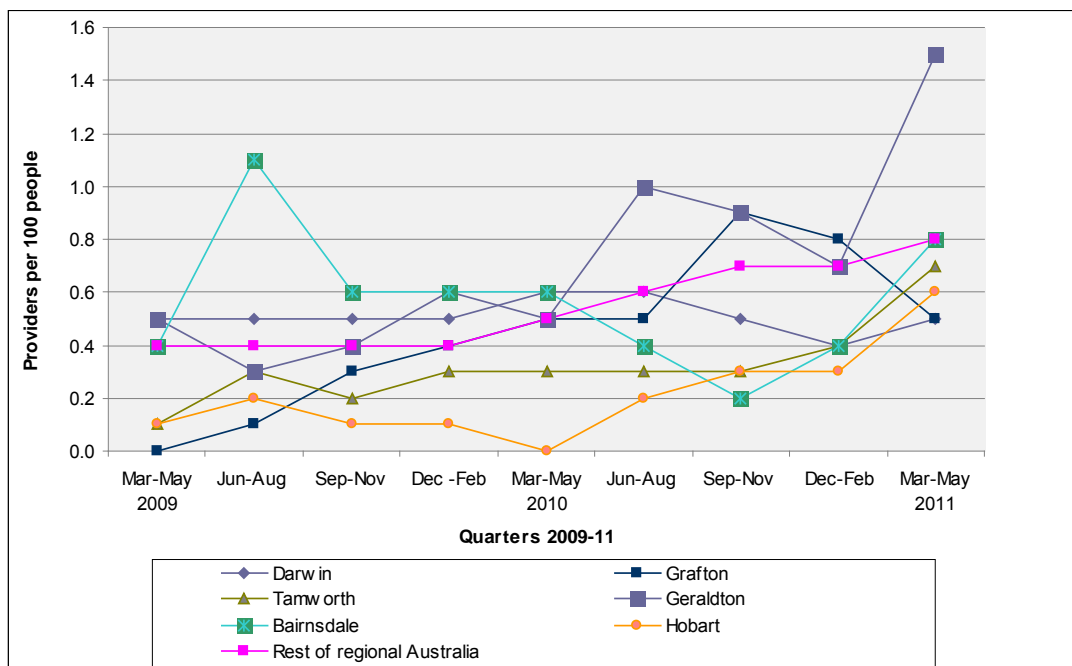
Figure 41: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 2 Sentinel Sites, by quarter, March 2009 - May 2011
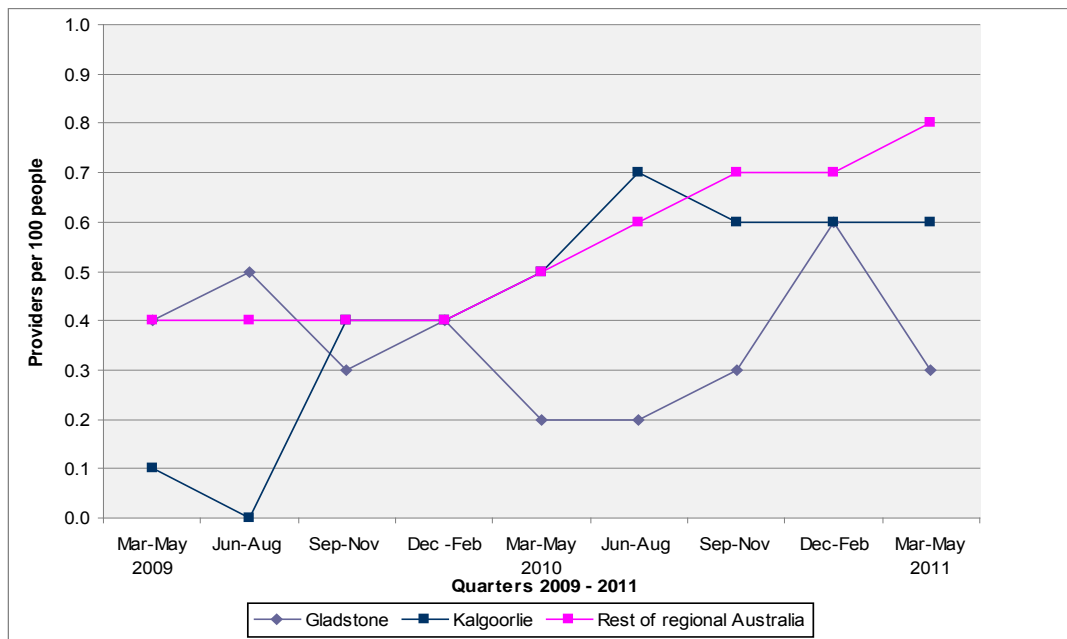
Figure 42: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 3 Sentinel Sites, by quarter, March 2009 - May 2011

In remote Sentinel Sites, Katherine West remained relatively stable, while there was an increase in the number of providers claiming health assessments per 100 people in Derby. Trends were less clear in Barkly and East Pilbara. The relatively smaller increase in providers in remote areas is likely to reflect generally lower levels of available GP providers in these areas. Barkly was the only remote site to consistently show increases greater than the rest of remote Australia (Figure 43).
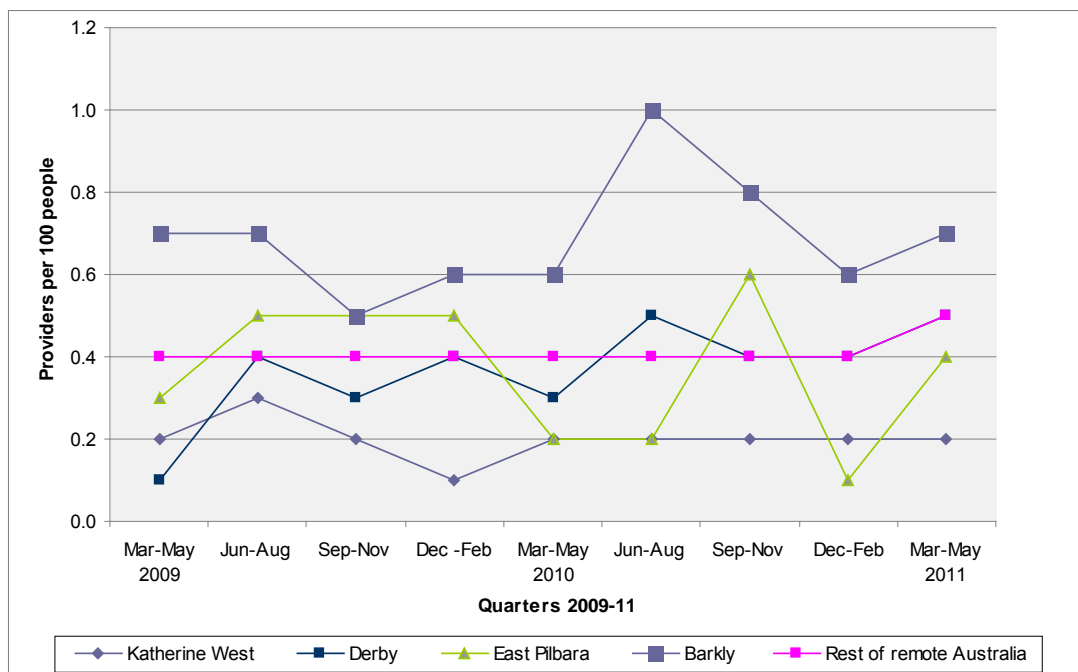
Figure 43: Number of GP providers who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites, by quarter, March 2009 - May 2011

12.7. Adult health assessments per GP provider

The success of the ICDP not only depends on increasing numbers of GP providers involved, but also on an increase in the number of ICDP relevant MBS items (such as adult health assessments) each GP provider completes.

For the Sentinel Sites, Figure 44 (and Appendix H Table H11) shows that the average number of adult health assessments per GP provider fluctuated between about 5 and 6 adult health assessments per quarter for the baseline period (March 2009 - February 2010). There was an increase following the implementation of the ICDP (March - May 2010). This increase was more evident in Sentinel Sites with the average number of adult health assessments reaching 7.5 per GP provider. The average number of health assessments per provider for the rest of Australia was relatively stable in the observed period.
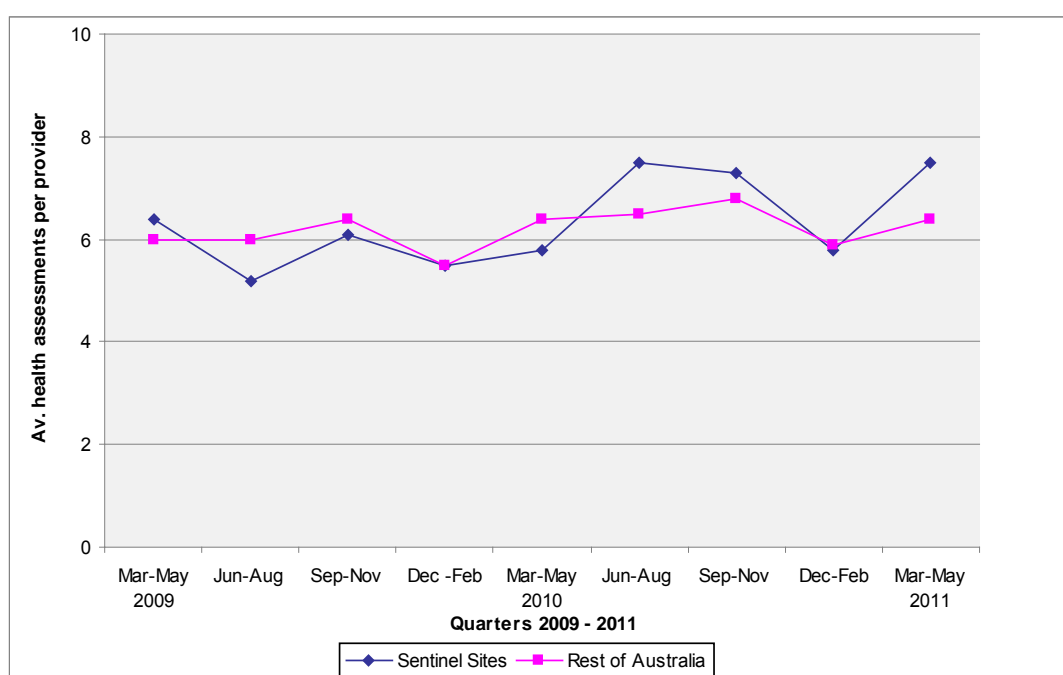
Figure 44: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in Sentinel Sites and the rest of Australia, by quarter, March 2009 - May 2011

Trends in the average number of adult health assessments conducted per GP provider varied by rurality (Figures 45-47, Appendix H, Tables H12-H14). The average number of adult health assessments in the baseline period (March 2009 - February 2010) was greatest in remote areas (remote Sentinel Sites=8; rest of remote Australia=9), followed by regional (regional Sentinel Sites=6; rest of regional Australia=6) and urban areas (urban Sentinel Sites=5; rest of urban Australia=4). Higher rates of health assessments per provider in remote areas is probably at least in part a result of relatively smaller numbers of providers, with these providers being more heavily involved in providing care to Aboriginal and Torres Strait Islander people.

There was very little change in the average number of adult health assessments conducted per GP provider in urban Sentinel Sites following the introduction of the ICDP (March - May 2010) (Figure 45).
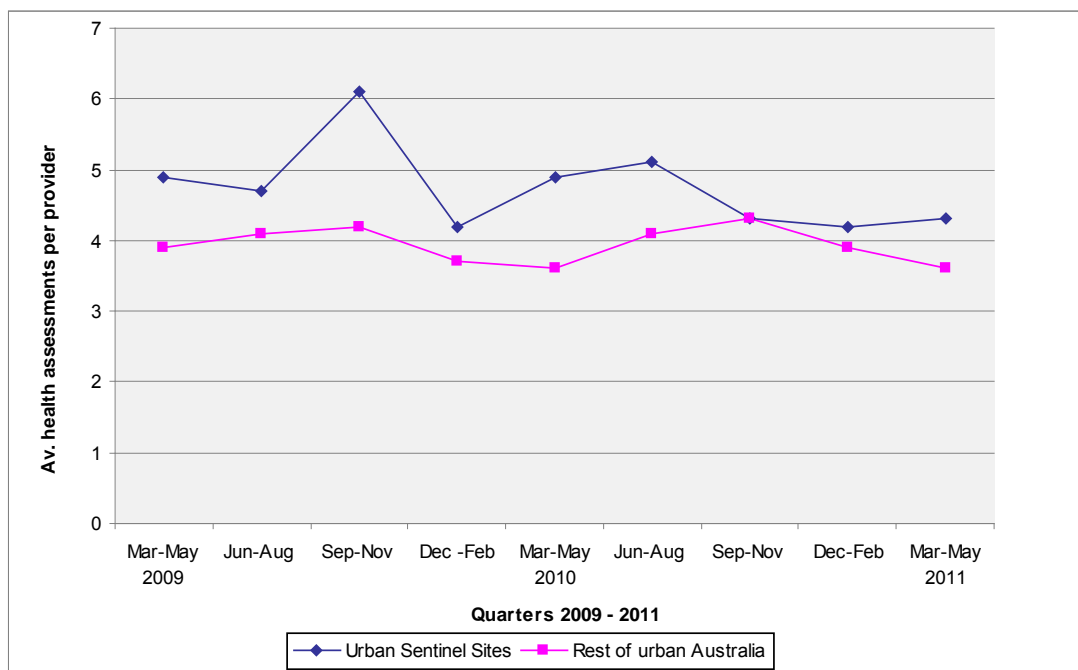
Figure 45: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - May 2011

In regional Sentinel Sites the number of adult health assessments per GP provider increased from an average of about 6 per GP over the baseline period to slightly over 10 per GP in the final quarter of the period covered by this report (March - May 2011). The rest of regional Australia showed little or no change in the average number of health assessments per GP over the period covered by this report (Figure 46).
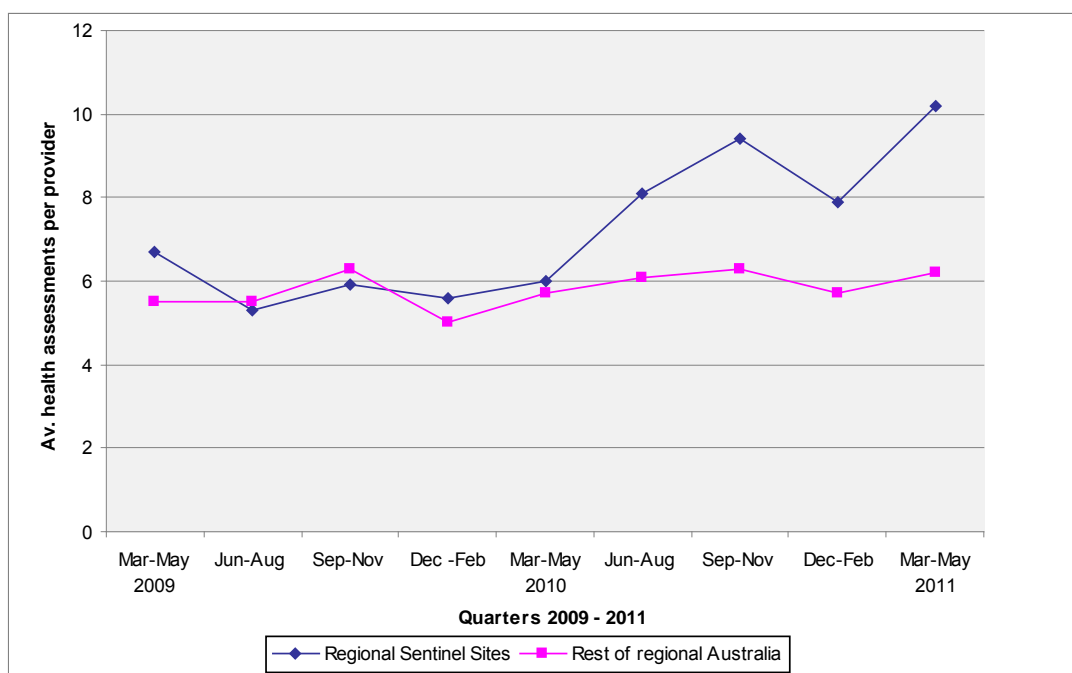
Figure 46: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - May 2011

In remote areas, both Sentinel Sites and the rest of Australia showed increases in the average number of adult health assessments per GP provider. In remote Sentinel Sites there was wide fluctuation, but there appears to be a positive trend from an average of around 8 per GP over the baseline period to around 12 to 14 per GP over the past four quarters, with the exception of a marked dip over the Dec 2010 - Feb 2011 quarter. For the rest of remote Australia there appears to have been an increase from an average of between 8 and 9 per quarter over the baseline period to an average of between 11 and 12 since the March - May 2010 quarter (Figure 47).
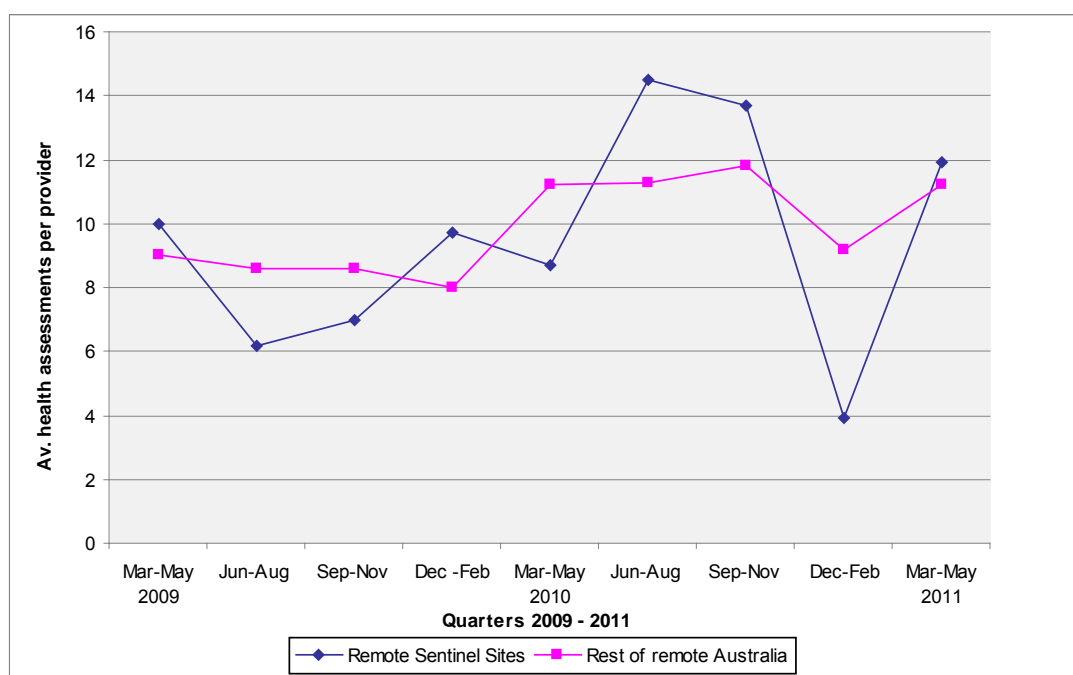
Figure 47: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - May 2011

12.8. Specific Sentinel Sites – adult health assessments per GP provider

Most urban Sentinel Sites, like the rest of urban Australia, showed very little change in the average number of adult health assessments per GP provider from the March - May 2010 quarter (the commencement of payments for the PIP Indigenous Health Incentive) (Figure 48). However, Brisbane South and Campbelltown showed some changes in the pattern of average number of health assessments per GP. The average number of adult health assessments per GP provider in Brisbane South (14) was high compared to the rest of urban Australia (4) in the baseline period (March 2009 - February 2010) and remained high to March - May 2011 quarter. There was a large increase in activity per GP provider in Brisbane South in the June - August 2010 quarter (21). However, this activity subsided in the following quarters, such that rates for March - May 2011 were around the same level as baseline (14). Campbelltown showed a steady increase following the commencement of payments for the PIP Indigenous Health Incentive. While the increase had levelled off and there was a dip in activity in the December 2010 - February 2011 quarter, the general level since commencement of the ICDP appears higher than for the baseline period. Dandenong showed some variability in the average number of health assessments per GP provider in the baseline as well as the following quarters.
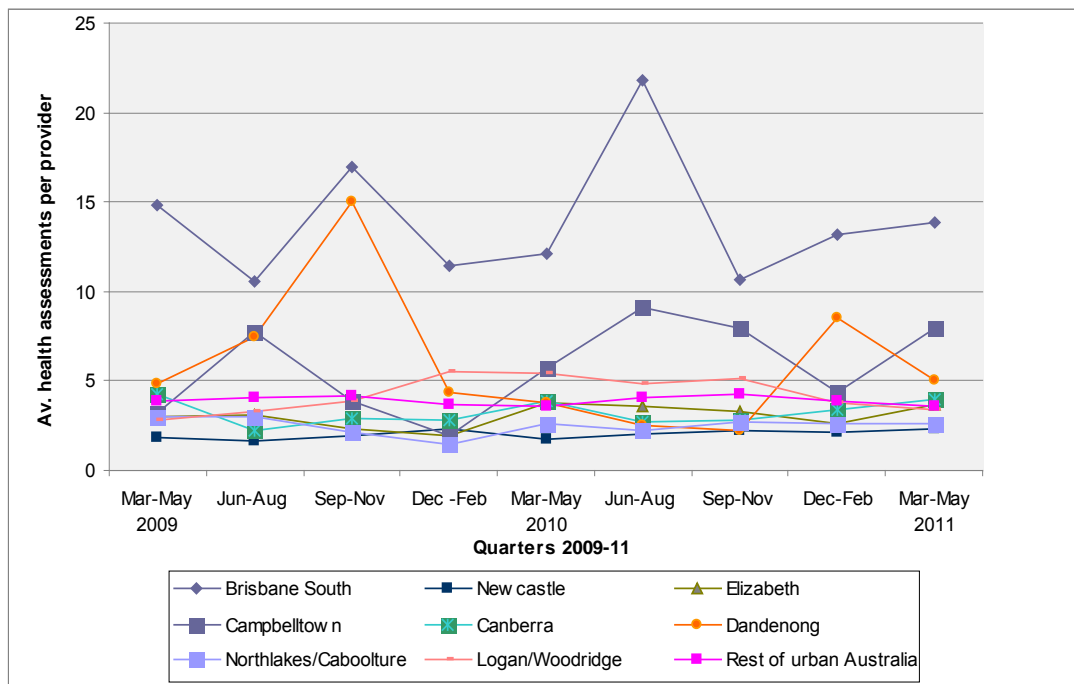
Figure 48: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in urban Sentinel Sites, by quarter, March 2009 - May 2011

For the regional sites, Dubbo showed a marked and sustained increase in the average number of adult health assessments per GP provider following May 2010, with higher activity than the rest of regional Australia. Cairns showed a large increase in the average number of health assessment per GP provider in the March - May 2011 quarter, nearly equalling Dubbo. The increase in the average number of adult health assessments in these two sites was greater than for the rest of Australia (Figure 49).
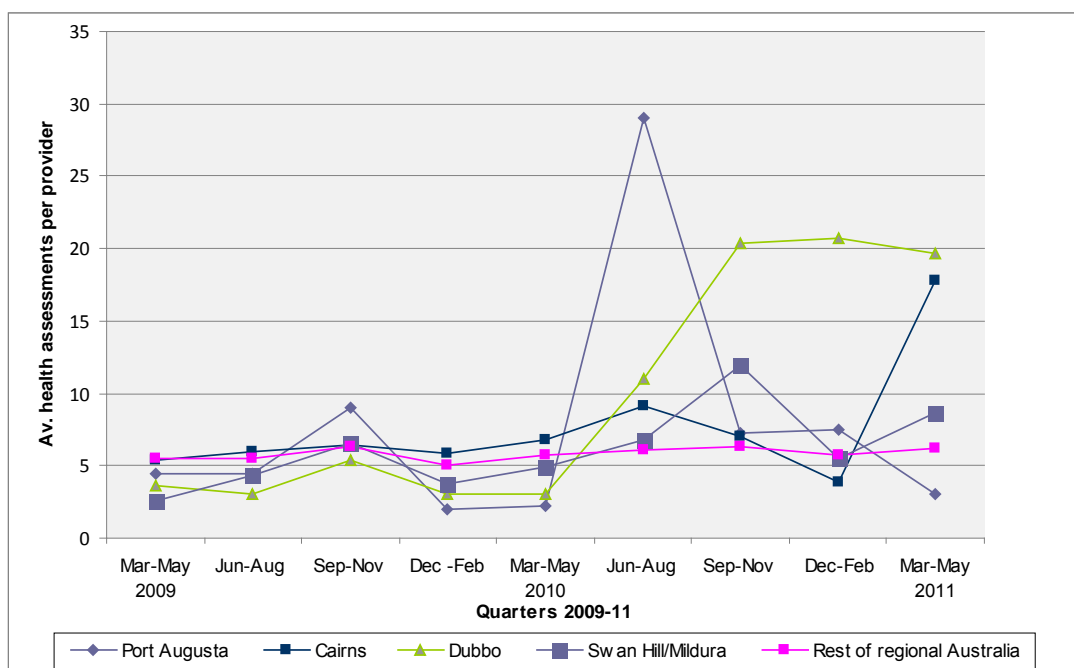
Figure 49: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in regional stage 1 Sentinel Sites, by quarter, March 2009 - May 2011

Swan Hill/Mildura, Bairnsdale, Geraldton, Gladstone and Hobart showed some evidence of an increase in the March - May 2011 quarters compared to the average of the baseline. Kalgoorlie, Tamworth and Port Augusta had average health assessments per GP provider at lower levels than baseline in the March - May 2011 quarters. There was a high degree of variability in most sites (Figures 49-51).
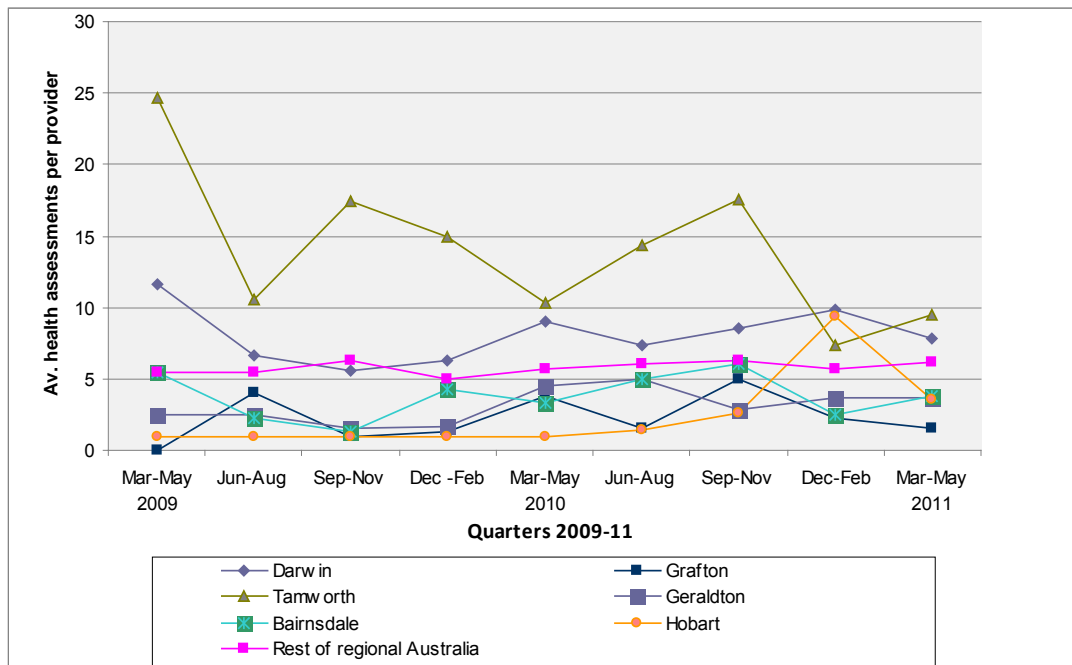
Figure 50: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in regional stage 2 Sentinel Sites, by quarter, March 2009 - May 2011
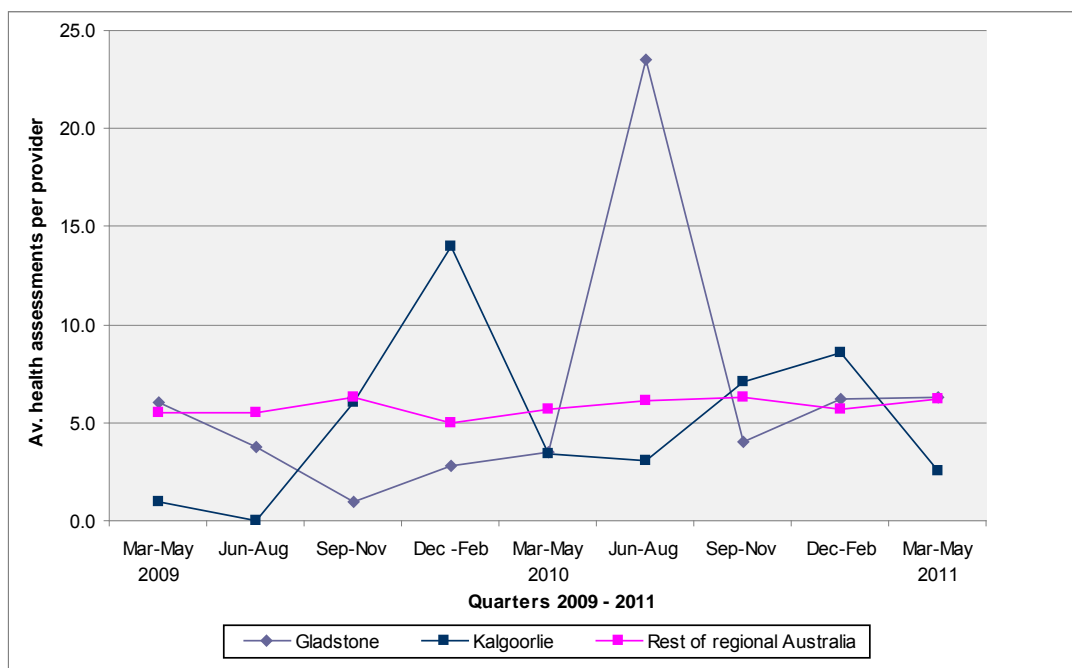
Figure 51: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in regional stage 3 Sentinel Sites, by quarter, March 2009 - May 2011

In most remote Sentinel Sites, the overall pattern, despite fluctuations, was of an increase in the average number of adult health assessments per GP provider (Figure 52). In Katherine West there were increases to September - November 2010 followed by a decline in the subsequent quarter and some recovery in March - May 2011. In East Pilbara there was a dramatic increase in the average number of health assessment per GP provider in March - May 2011.
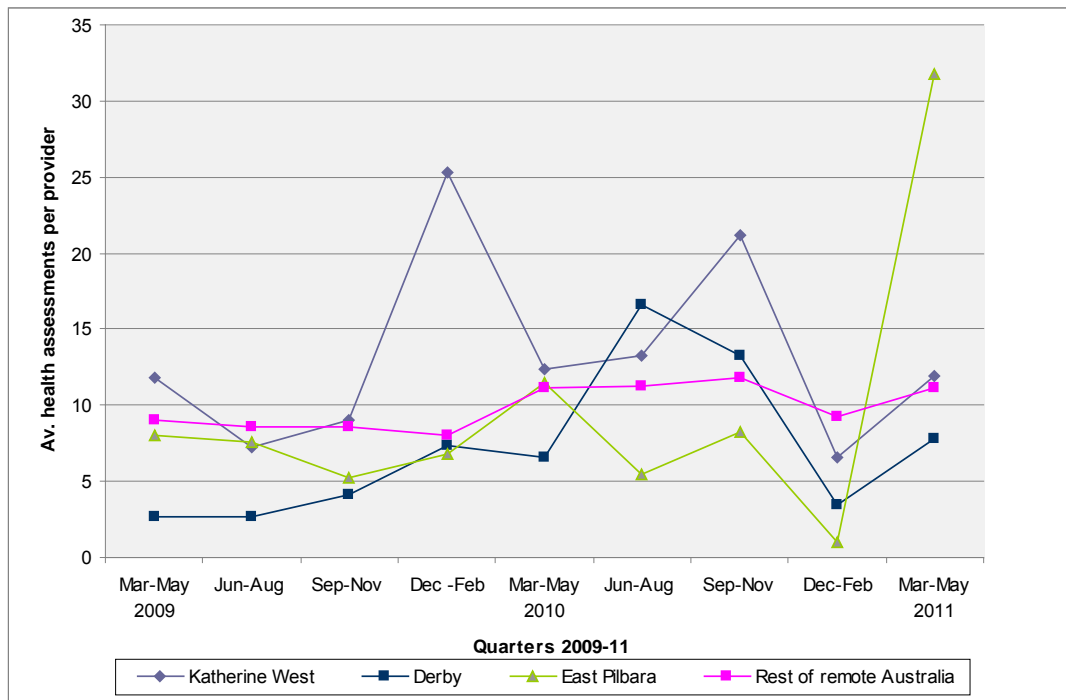
Figure 52: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per GP provider in remote Sentinel Sites, by quarter, March 2009 - May 2011

12.9. Implications

There are two possible mechanisms for changes in the number of adult health assessments associated with introduction of the ICDP: 1) increases in the number of GP providers claiming adult health assessments and 2) increases in the number of adult health assessments completed by GP providers. The drivers of these two mechanisms for increasing health assessments probably overlap, with incentives and awareness raising affecting both to some extent. However, the relative importance of each mechanism appears to vary between different regions and between sites. The results suggest that:

- Increase in the number of claiming providers was the main factor underlying increases in adult health assessments in urban areas in sites like Elizabeth and Logan/Woodridge.

- In regional Sentinel Sites, an increase in the number of GP providers occurred in a number of sites and may have been a particular factor in the increased number of adult health assessments claimed in Geraldton, Grafton and Swan/Hill Mildura. Increases in the average number of adult health assessment per GP provider were less common in regional areas but did occur in Cairns, Dubbo and Swan/Hill Mildura.

- In remote areas, increases in adult health assessments appeared to be driven by changes in the number of adult health assessments completed per GP provider. There was no evidence of an increased number of claiming providers. This suggests that increases in remote areas will be very dependent on the capacity of existing providers.

13. Supporting Primary Care Providers to Coordinate Chronic Disease Management (*Measure B3 Part A*)

13.1. Description of measure

The Australian Government is providing payments through the Practice Incentives Program (PIP) Indigenous Health Incentive to support accredited General Practices and Aboriginal Health Services to provide better health care for Aboriginal and Torres Strait Islander people, including best practice management of chronic disease.

Health Services and patients began signing on to this incentive in March 2010, and the first payments were made to Health Services in May 2010.[71]

The PIP Indigenous Health Incentive has three components:

- 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

- patient registration payment: an annual payment to Health Services of $250 for each Aboriginal and Torres Strait Islander patient 15 years and over, registered for chronic disease management with the Health Service over the course of the calendar year

- outcomes payments:

    – 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).[72]

    – 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.[73] Majority of care refers to the provision of the majority of eligible MBS services, with a minimum of 5 eligible MBS services expected through the calendar year. Items such as commonly used GP attendance items and Chronic Disease Management items are included. [74]

13.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure B3 Part A, and relevant to the current stage of implementation, include:

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[71] DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet [website], (accessed 28 November 2011).
[72] DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010 [website], (accessed 28 November 2011).
[73] DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet [website], (accessed 12 February 2013)
[74] DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010 [website], (accessed 28 November 2011).

Expected 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.

- Eligible practices register for the measure.

- Registered practices attend cultural awareness training within 12 months.

- Registered practices have measures in place to encourage the registration of eligible Indigenous people.

- Eligible people consent to participate.

Expected early results for years 2-4:

- Registered patients receive the target level of care.

- Practices offer care management plans and team care coordination as per the requirements of the incentive.

- Participating patients receive additional and complementary Health Services.

Expected medium term result 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.

13.3. State of implementation

The following information was provided by DoHA in September 2011 and gathered from other sources about the state of implementation of the PIP Indigenous Health Incentive at a national level (relevant to SSE):

- From 1 July 2011, PIP Indigenous Health Incentive patient consent forms were required to be sent, by practices, to the PIP processing area in Medicare. Previously only the registration form was sent and the consent form was held at the practice.[75] This change was communicated through the February 2011 and May 2011 PIP News Updates and the patient consent forms were updated to reflect the changed requirements,[76] which were necessary to comply with privacy legislation. Consent forms can be faxed, mailed, or practices can use the Department of Human Services 'HPOS' online system. Patient consent forms signed before 1 July 2011 did not need to be submitted to Medicare, but are to be kept on file at the practice for auditing purposes.[77]

- The DoHA contracted the Royal Australian College of General Practitioners (RACGP) in 2010 to develop an online cultural awareness training module that would assist practices to meet the cultural awareness training requirements. The training was

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[75] PIP News Update-February 2011. (accessed 13 November 2011).
[76] DoHA, B3A report, 2 September 2011.
[77] PIP News update August 2011 [website], (accessed 13 November 2011).

available online in April 2011. The Australian College for Rural and Remote Medicine has also made available an online module since February 2011[78]

In December 2011, DoHA/Medicare Australia advised the Australian General Practice Network that Medicare Australia had developed a register of PIP Indigenous Health Incentive registered Health Services. The register was developed in response to feedback regarding access by patients to Health Services. It had been clearly identified that some patients were having difficulty locating PIP Indigenous Health Incentive registered Health Services when they are away from their regular Health Service area.

DoHA/Medicare Australia wrote to Health Services signed on for the PIP Indigenous Health Incentive, to seek permission to be included on the register. The register includes the name, phone number and location of the Health Service. It will only disclose basic Health Service contact details to assist patients to locate a Health Service they can visit to receive treatment and PBS Co-payment scripts.

This is to be an opt-in register as some Health Services may not want to be listed. The list of PIP Indigenous Health Incentive registered Health Services will not be published for public use, but will be available to patients, practices and Divisions of General Practice/Medicare Locals by phoning the PIP enquiry line on 1800 032 222. The practice register consent form for list inclusion has been uploaded onto the Medicare Australia website.[79]

The development of the register was also communicated from the Australian General Practice Networks Indigenous Health Care Coordinator to State Based Organisations for dissemination.[80]

The Department of Health and Ageing provided national statistics for the number of Tier 1 and Tier 2 payments triggered for people registered for the PIP Indigenous Health Incentive in the 2010 calendar year. They found that around 31 000 people were registered in 2010 and of those, 1382 (4%) triggered a Tier 1 payment and 24 796 (80%) triggered a Tier 2 payment.[81]

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[78] PIP News update May 2011 [website], (accessed 13 November 2011).
[79] Medicare Australia – PIP Indigenous Health Incentive [website], (accessed 12 February 2013).
[80] General Practice NSW, PIP Indigenous Health Incentive e-communication, 6 December 2011.
[81] DoHA, B3A report, 28 November 2011.

13.4. Findings from the Sentinel Sites

Notes on collection, analysis and interpretation of data

- Stakeholders in eight case study and five enhanced tracking sites were interviewed about their awareness and perceptions of the PIP Indigenous Health Incentive.

- Community focus groups were asked their perceptions of the standard of care available at General Practices and AHSs, and of the influence of the PIP Indigenous Health Incentive on the standard of care. The findings reported here are based on information gathered from seventeen community focus groups held in seven case study sites.

- While the administrative data presented in this report is for a period up to May 2011, the timing of the interviews (August - October 2011) and of when Medicare data becomes available to the SSE team, means that the data that interviewers have available for discussion with key informants at each site relate to a period of about one year previous to the interview (i.e. for this report the data available to the interviewers for discussion at the time of the interviews were data from the reporting period up to November 2010). The time lapse between the period for which interviewers have data and the time of the interviews is a constraint on the potential for interviewees to provide a clear explanation of factors underlying patterns in the administrative data.

- For a variety of reasons beyond the control of the SSE team, the data from Medicare were not available until late in the analysis period for this evaluation cycle. This has constrained the potential to undertake analysis of site level factors that may have influenced uptake of various items.

- For the Tier 1 payment analysis the period being observed is March 2010 - May 2011, the same as the rest of the PIP Indigenous Health Incentive data. The Tier 1 payments however, began in the June - August 2010 payment quarter for services delivered in the previous quarter.

- In the PIP Indigenous Health Incentive data included in the report a small number of Aboriginal Health Services were miscoded as private General Practices (<2%). Consequently the number of PIP payments attributed to Aboriginal Health Services will be slightly underestimated. It should also be noted that in a small number of cases (2) PIP services were delivered within Sentinel Sites boundaries but the payments were made outside the boundary (e.g. where the service located in a Sentinel Site is a branch office of a service where the central office is outside the site). This will mean that PIP payments made will underestimate services delivered in these Sentinel Sites.

Awareness of the measure

There is a high level of awareness of the PIP Indigenous Health Incentive amongst key informants. This question was only asked of interviewees who were in positions where they would be expected to become aware of the measure as implementation progresses. Awareness has been steadily increasing over reporting periods, with 97% (83/86) of interviewees in the current evaluation cycle reporting they were aware of the PIP Indigenous Health Incentive (Table 15). Awareness of the measure amongst key informants in remote sites tended to be lower (86%) than for regional and urban sites (100%). This lower level of

awareness amongst key informants in remote sites is likely to be related to the major service provider in one of the remote sites not having proceeded with registration for the measure during the period covered by this report, because of lack of capacity among administration staff to manage the required paperwork.

Table 15: Managers', Clinicians' and Practice Managers' awareness of PIP Indigenous Health Incentive (% who responded 'yes'), overall and by rurality

Interview question	Rurality	December 2010	June 2011	December 2011
Are you aware of the new PIP Indigenous Health Incentive? MS, CS, PM[a]	Overall	85% (n=40)	91% (n=81)	97% (n=86)
	Remote	58% (n=12)	75% (n=16)	86% (n=22)
	Regional	93% (n=15)	95% (n=40)	100% (n=33)
	Urban	100% (n=13)	96% (n=25)	100% (n=31)

[a] Type of interview respondent, see Appendix D 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'.

Informing organisations of the PIP Indigenous Health Incentive

Similar to the previous reporting period, more than half [62% (23/37)] of interviewees agreed with the statement that *'stakeholder organisations were clearly informed of the new PIP Indigenous Health Incentive',* while 25% disagreed and 14% responded 'don't know/can't say'. Responses to this statement from interviewees in urban, regional and remote sites were similar.

The Indigenous Health Project Officers (IHPO), particularly those based in Divisions of General Practice, were again noted by General Practice staff as being helpful in raising awareness of the PIP Indigenous Health Incentive. This awareness raising was often done in tandem with providing information on the PBS Co-payment. Stakeholders in two sites indicated that the recently recruited Care Coordinators have been assisting with the awareness raising of the ICDP measures.

The following strategies were being employed by IHPOs, in particular, when raising awareness of both the PIP Indigenous Health Incentive and the PBS Co-payment measure: practice visits, linking with established practice support teams in the DGPs to incorporate the PIP information with their 'suite of information', development of flow charts and further explanatory type information sheets, incorporating information into existing education workshops for clinical and practice staff. A number of stakeholders indicated that linking with the established practice support teams within the DGPs (which have a pre-existing relationship with General Practices and whose role has been to raise awareness of new initiatives and systems development in General Practice) was contributing to increased awareness raising.

A number of practice managers and clinicians referred to the GP practice kits developed by DoHA that provided information on the new measures. These were generally perceived to be helpful in understanding the measures.

As previously reported, it was perceived by interviewees to be important to continue awareness raising activities for the PIP Indigenous Health Incentive. In the context of this discussion, interviewees referred to emerging issues regarding re-registration of patients, ways to optimise Tier 1 and Tier 2 payments and ongoing staff turnover within Health Services.

While there has been an improvement in interviewees feeling the services have been clearly informed of the PIP Indigenous Health Incentive, there remains a substantial proportion of stakeholders who either feel the services have not been clearly informed, or that they are not able to comment on this issue. This also points to a need for further effort in informing services about the PIP Indigenous Health Incentive.

Health Services registering for the PIP Indigenous Health Incentive by location

Table 16 shows the number of Health Services that received the sign-on payment for the PIP Indigenous Health Incentive in Sentinel Sites (354) and the rest of Australia (1774) by Health Service type (Aboriginal Health Service/General Practice).

In Sentinel Sites, 79% (22/28) of Aboriginal Health Services received the sign-on payment for the PIP Indigenous Health Incentive. [82] The corresponding figure for General Practices in Sentinel Sites is difficult to estimate, because the number of accredited General Practices in the Sentinel Sites is not known. Using data on the total number of General Practices in the DGPs in which the Sentinel Sites are located, we can provide a rough estimate that approximately 27% (332/1225) of the total number of accredited General Practices in the Sentinel Sites have received the sign-on payment.[83]

Table 16: Number of Health Services registered for the PIP Indigenous Health Incentive sign-on payment for Sentinel Sites and the rest of Australia by types of services, rurality and quarter, March 2010 - May 2011

Sentinel Sites/ Rest of Australia by rurality	Health Service type	Mar-May 2010	Jun-Aug 2010	Sep-Nov 2010	Dec 2010- Feb 2011	Mar-May 2011	Total
Urban Sentinel Sites	General Practice	85	42	31	33	34	225
	AHS	4	1	0	0	0	5
	Both	89	43	31	33	34	230
Rest of urban Australia	General Practice	366	224	140	99	99	928
	AHS	7	1	1	1	0	10
	Both	373	225	141	100	99	938
Regional Sentinel Sites	General Practice	36	17	24	11	14	02
	AHS	11	2	1	1	0	15
	Both	47	19	25	12	14	117
Rest of regional Australia	General Practice	242	161	117	75	75	670
	AHS	35	4	4	4	1	48

[82] Not all Aboriginal Health Services may be eligible for the PIP Indigenous Health Incentive because of lack of accreditation. If some AHSs are not eligible then the reported proportion would underestimate the true proportion of those that are eligible.

[83] Total number of General Practices is estimated at 7119 based on PHCRIS 2009/10 data, taking into account that approximately 80% of practices meet RACGP accreditation standards. Number of accredited practices for Sentinel Sites is estimated at 1225. This will slightly overestimate the number of General Practices because Sentinel Site boundaries and Division of General practice boundaries do not coincide exactly. Primary Health Care Research & Information Service (PHC RIS), Key Division of General Practice characteristics 2008-2009 [website], (accessed 9 December 2011).

Sentinel Sites/ Rest of Australia by rurality	Health Service type	Mar-May 2010	Jun-Aug 2010	Sep-Nov 2010	Dec 2010-Feb 2011	Mar-May 2011	Total
	Both	277	165	121	79	76	718
Remote Sentinel Sites	General Practice	5	0	0	0	0	5
	AHS	0	1	1	0	0	2
	Both	5	1	1	0	0	7
Rest of remote Australia	General Practice	49	6	14	8	5	82
	AHS	13	13	6	4	0	36
	Both	62	19	20	12	5	118
Total Sentinel Sites	General Practice	126	59	55	44	48	332
	AHS	15	4	2	1	0	22
	Both	141	63	57	45	48	354
Total Rest of Australia	General Practice	657	391	271	182	179	1680
	AHS	55	18	11	9	1	94
	Both	712	409	282	191	180	1774

Overall around 6 Health Services per 1000 Aboriginal and Torres Strait Islander people received the PIP Indigenous Health Incentive Health Service sign on payment in the Sentinel Sites, compared to 7 Health Services per 1000 Aboriginal and Torres Strait Islander people in the rest of Australia.

The total number of Health Services (Aboriginal Health Services and General Practices) receiving the sign-on payment for the PIP Indigenous Health Incentive was higher in urban areas than regional areas, and higher in regional areas than in remote areas (see Figure 53 and Appendix I, Table I1):

- In urban areas, about 9 Health Services per 1000 Aboriginal and Torres Strait Islander people received the sign-on payment in Sentinel Sites and about 12 Health Services per 1000 people received the sign-on payment in the rest of urban Australia.

- In regional areas, about 4 Health Services per 1000 people received the sign-on payment in Sentinel Sites and about 7 Health Services per 1000 received the sign-on payment in the rest of regional Australia.

- In remote areas there was approximately 1 Health Service registered per 1000 people that received the sign-on payment in Sentinel Sites and 2 in the rest of remote Australia.

Thus, 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 remote locations, and in the rest of Australia in general compared to Sentinel Sites.

Sentinel Sites are clearly not typical of Australia in general, in terms of available primary health care services. All Sentinel Sites have an AHS located within the site boundary, whereas there are many locations in the rest of Australia where there is no AHS. A possible reason for lower

sign-on by General Practices in Sentinel Sites may be an expectation that, in locations where there is an AHS, the AHS has a lead role in delivering care to Aboriginal and Torres Strait Islander people and that some General Practices may therefore tend to be reticent about signing on for the PIP Indigenous Health Incentive.
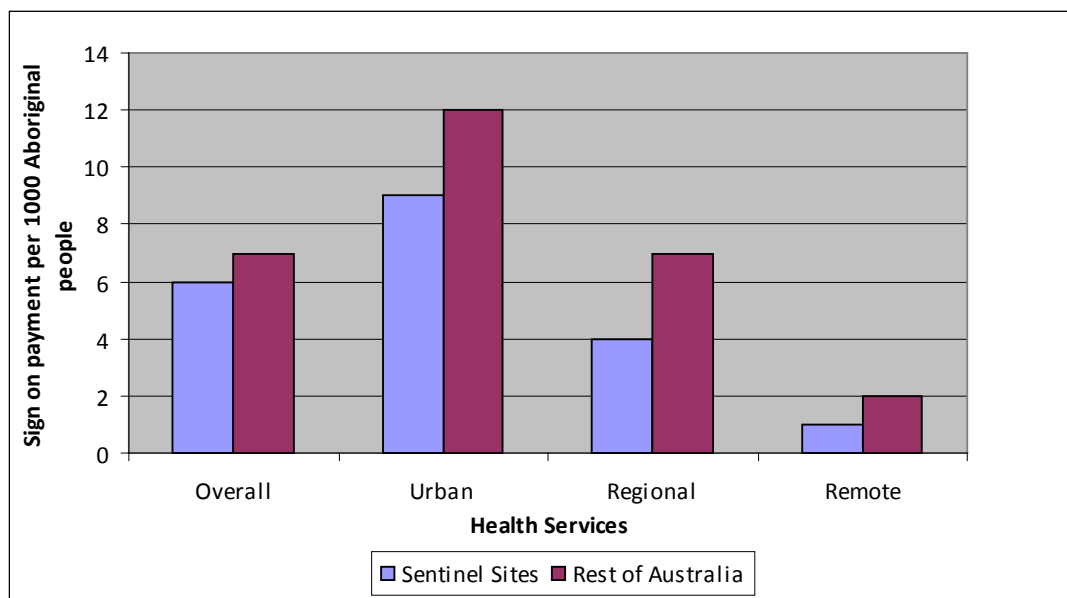
Figure 53: Number of Health Services registered for the PIP Indigenous Health Incentive sign-on payment for Sentinel Sites and the rest of Australia per 1000 Aboriginal and Torres Strait Islander people by rurality.

The higher number of General Practices within urban areas that are eligible for sign-on (and that are signed) shows that the IHPOs and OWs may be expected to provide support to a relatively large number of practices.

Timing of Health Services registering for the PIP Indigenous Health Incentive

Figure 54 shows that most Health Service registrations occurred in the first quarter with relatively few new Health Service registrations in the subsequent quarters:

- Close to 70% of the total current registrations among Aboriginal Health Services in Sentinel Sites and close to 60% of the total current registrations for Aboriginal Health Services in the rest of Australia occurred before the end of May 2010.

- The corresponding figures for General Practices in both Sentinel Sites and the rest of Australia were about 40%.
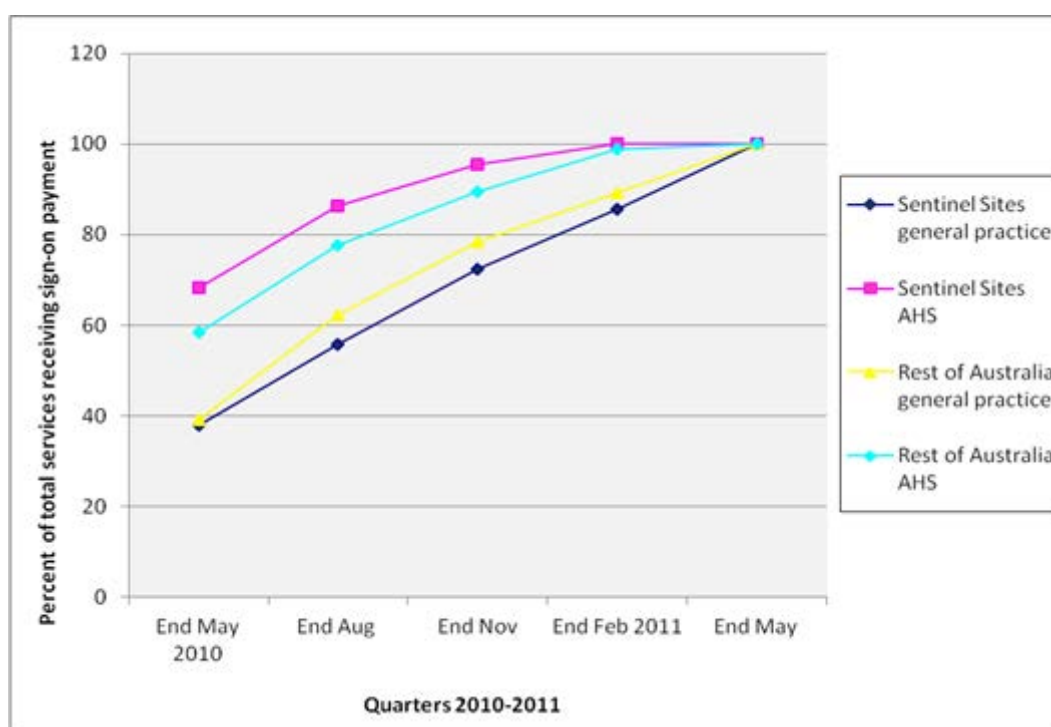
Figure 54: Health Services which have received the PIP Indigenous Health Incentive sign-on payment (as a percentage of the total number which received the sign on payment during the period covered by this report) for Sentinel Sites and the rest of Australia, by sector and quarter

While there were very few additional Aboriginal Health Services registered after the end of February 2011, there was a continuing steady stream of General Practices becoming registered through to the end of May 2011. As described above, the data from the Sentinel Sites shows a relatively high proportion of Aboriginal Health Services registered and a relatively low proportion of General Practices registered.

These figures indicate substantial potential for a continuing increase in registration of General Practices for the PIP Indigenous Health Incentive, and relatively little potential for a continuing increase in registration of Aboriginal Health Services.

Barriers to Health Service participation in the PIP Indigenous Health Incentive

Despite the high number of Health Services receiving sign-on payments and the level of awareness amongst stakeholders of the PIP Indigenous Health Incentive, a range of barriers to Health Service participation in the incentive was identified. As in the previous reporting period, interviewees spoke more about barriers faced in implementing the PIP Indigenous Health Incentive than about uptake of the incentive. This finding may be related to more services being registered and consequently a higher awareness of the challenges of ongoing participation in the incentive.

Barriers to Health Service registration for the PIP Indigenous Health Incentive were similar to those identified in the previous two reporting periods. These included the perceived administrative burden, and importantly, the requirement for the Health Service to be accredited. Notably, stakeholder interviewees in remote case study sites indicated that the

administration burden was a major barrier to participation. One remote site in particular noted this as a significant barrier to participation.

Constraints on workforce capacity continued to be highlighted, particularly for GPs and administrative staff, as a barrier to supporting the implementation of this incentive. Stakeholder interviewees expressed concern that acute care demands, together with the shortage of GPs in regional and remote sites, affect the ability of GPs to deliver chronic illness care. Community focus group participants in a regional site also raised the issue of lack of GPs to deliver services.

Perceptions of administrative burden

Similar to the previous reporting period 45% (37/83) of interviewees agreed with the statement *'the PIP Indigenous Health Incentive has caused a large administrative workload'.* Twenty-nine per cent (24/83) of stakeholder interviewees responded 'don't know/can't say' in response to the question of whether they agreed with this statement, leaving about a quarter of respondents who disagreed with the statement.

In the previous reporting period, perceptions of administrative burden tended to be higher in remote sites, with 8 out of 12 (67%) compared to 37% (7/19) in this reporting period. Despite this positive shift, administrative burden in remote sites continued to be an issue of concern among interviewees. This may be related to relatively poor availability of administrative staff and lack of administrative staff capacity in remote locations, and to the challenges of managing administrative staff in remote locations, particularly in relation to providing the support required for introduction of new programs that require additional administration. The positive shift may be in part related to one remote case study site using ICDP funding to support an administrative position whose role is primarily to register patients for the incentive. In this site, it is evident that registrations for the incentive for patients are increasing, and it is likely that this strategy is contributing to the increase.

In another remote site the approach has been to concentrate the efforts of all staff to register patients over a specific five-week period, with no clients being signed up after this period. This approach was due to a misunderstanding of the program initially, and a perception that patients needed to be signed up in the first quarter of commencement of the program.

In another remote site, patient registration had not commenced due to the lack of administrative staff to support the process.

Half (14/28) of clinicians interviewed agreed that the incentive has caused a large administrative burden, in comparison to 35% (6/17) of practice managers (about a third (9/28) of clinicians also indicated that they 'don't know/can't say') (see Figures 55 and 56). In general, clinician interviewees indicated that the administrative burden falls on reception staff and therefore felt that for them, personally, the incentive was not an administrative burden. Views on administrative burden were more polarized among practice managers than among clinicians, with more than half disagreeing with the statement that the incentive had caused a large administrative burden, and almost one third strongly agreeing that it had caused a burden. This polarization may reflect the different views of practice managers in AHSs compared to General Practices (see below). Interviewees indicated that it was practice managers generally who were undertaking the paperwork and developing systems to manage the registration process for patients.
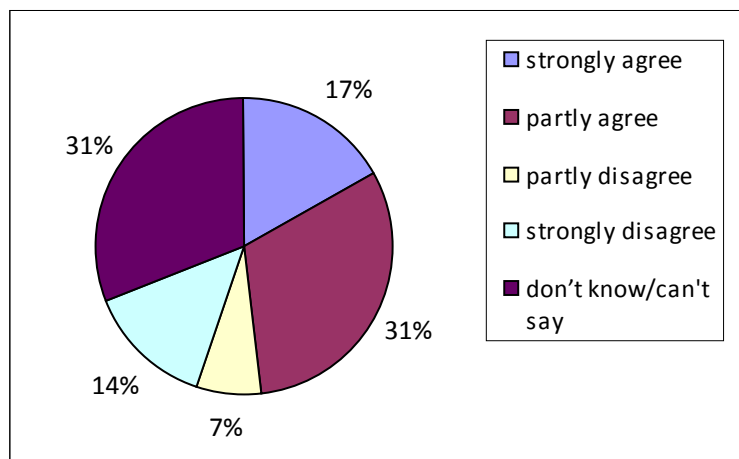
Figure 55: Clinicians' responses to the statement: 'The PIP Indigenous Health Incentive has caused a large administrative workload.' (n=28)
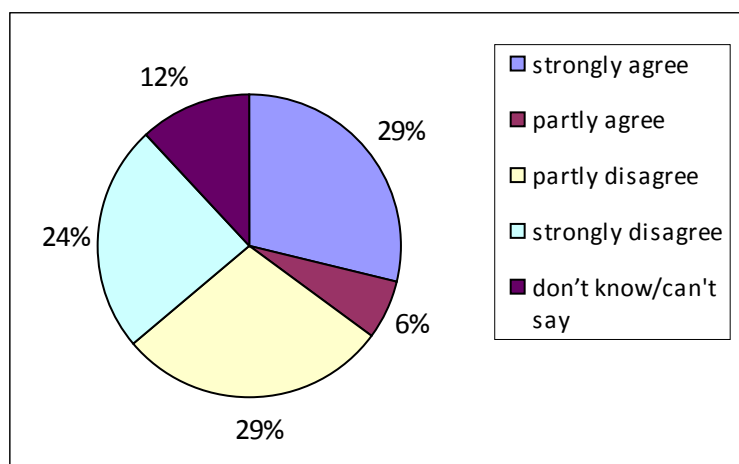
Figure 56: Practice Managers' responses to the statement: 'The PIP Indigenous Health Incentive has caused a large administrative workload.' (n=17)

Within Aboriginal Health Services 55% (11/20) and within General Practice 35% (9/26) of practice managers and clinicians agreed that the incentive has caused a large administrative burden.

This burden may be related to a generally much larger number of eligible clients in Aboriginal Health Services and a relatively small number of Aboriginal and Torres Strait Islander clients in General Practices. Clinicians in the AHSs are therefore required to complete paperwork for a larger number of clients than clinicians in General Practices. There have been some instances, particularly earlier on in the implementation process, where the GPs have been undertaking the administrative work, such as filling in the forms, rather than just signing them. Though there was evidence of reorientation of systems within the practices to manage the registration and re-registration processes, it appears that systems for registration and re-registration are not yet well developed.

Interviewees associated the administrative burden with the paper work involved in registering and maintaining eligible patients, including completing and faxing patient PIP Indigenous Health Incentive forms. This paper work was seen to be particularly time consuming and administratively burdensome for practice administration staff.

Examples of administration burden included:

- Having to fax or send a hard copy of the consent and registration form to Medicare, rather than completing online or scanning then emailing the forms.

- A perception that there is only one fax machine to receive forms in some Medicare offices, and Health Service staff needing to set their fax machine to send forms at night to avoid getting a busy signal from the receiving fax.

- Fax machines at services jamming and services being unable to determine which forms had been transmitted, resulting in the need to resend all forms.

- Completing paperwork to register a client, and subsequently finding out that the patient had been registered elsewhere.

- Services having to photocopy registration forms and send by mail.

- Having to re-register patients each year – i.e. having to repeat what is perceived to be a frustrating process.

Systems being established

A number of interviewees within Aboriginal Health Services indicated that they were managing the re-registration process by using excel spreadsheets to track who had been registered on what date. The existing clinical information systems and patient recall systems were not being used in a number of services, apparently because service staff perceived these systems to be not functioning well in general and not suited to the purpose of recording registration and recall for the PIP Indigenous Health Incentive. It also appeared that patients were not being registered on disease registers in the services' clinical information systems. The interview data on these points is backed up by the clinical indicator data provided from General Practices (see Chapter 7). The data on Tier 1 payments for the PIP Indigenous Health Incentive similarly indicates low utilisation of GPMPs and TCAs.

The lack of efficient information systems that could be used to identify clients for re-registration appeared to be a barrier in the re-registration process.

A number of stakeholder interviewees in Health Services indicated that there was no place on clinical information systems to clearly mark if patients were PIP registered. Stakeholders indicated that the focus by software providers appeared to have been on including a tick box for the PBS Co-payment registration. Health Services were using a variety of means to indicate if a patient was registered, including use of an excel spread sheet as explained above, marking PIP registration within the allergies section of the patient information system, or creating 'pop ups' that are displayed when a patient is identified as Aboriginal.

> *'The practice manager puts everyone onto the recall system and we have a system where when you open up a record we have developed pop ups in the system that say this person is Aboriginal. Every time you go into a chart it says Aboriginal or not Aboriginal. We also have it in the social section under demographics, it is there straight away.' (Interview, GP, General Practice)*

Strategies for promoting registration of patients varied between Health Services, and included:

- registering patients on an ad hoc basis as patients present

- undertaking a 'big push' and using staff of programs such as Healthy for Life and other existing workers, to promote and undertake registration of patients, including in community venues

- sending out letters asking patients to come in and register.

Generally, Aboriginal Health Services are utilising the first two strategies. The strategy of having a 'big push' is at times evident in the Medicare data for specific sites with a spike in quarters where the AHS has taken this approach.

General practices are not using the second strategy of sending staff out to register patients, but are registering patients on presentation at the practice for care, or inviting them to register when sending out recall letters. A number of General Practices indicated that, in the recall letter, they were mentioning access to the PBS Co-payment measure to encourage patients to attend for registration. As General Practices don't generally have the capacity to undertake community based work to register patients, DGPs were utilising IHPOs and OWs to increase community awareness of the incentive and to encourage community members to register at their usual General Practice. In one DGP, the OWs and IHPO were using community events to raise awareness, setting up stalls where the bulk of the paper work was completed and encouraging patients to take the paper work to their General Practice on their next visit.

Patient awareness of Health Services registered for the PIP Indigenous Health Incentive

As previously reported, the lack of information to identify which Health Services are registered for the PIP Indigenous Health Incentive is presenting some difficulties for patients and service providers.

The issue of IHPOs not having access to information about which Health Services are registered for the PIP Indigenous Health Incentive continues to be pervasive. In many DGPs, the IHPOs have begun to focus on Health Services that are interested and engaged, rather than on broad awareness raising, due to their limited capacity to support the large number of Health Services across the region covered by the DGP. Not knowing which practices are registered for the incentive limits the ability to target particular practices. Concern has also been raised by stakeholders about not being able to provide information to patients about practices registered for the PIP Indigenous Health Incentive. There was a common perception that if the IHPOs had the information for their region or for the state, they could inform Aboriginal patients who travel away from home about where they can access a service for care and have a script annotated for the PBS Co-payment.

Some stakeholder interviewees highlighted that follow-up care is particularly difficult for patients who are moving around, and this is likely to limit the potential for such patients to benefit from the incentive. This point was also raised by interviewees in the previous two reporting periods. Interviewees suggested that having access to information about whether patients were already registered with a service would potentially facilitate access for patients when they move or travel.

A number of DGPs indicated that they had developed credit card size cards which are intended to be patient held and which indicate that patients are registered for the PIP Indigenous Health Incentive, which practice they are registered with and their registration status for the PBS Co-payment. It appeared that these initiatives were just being introduced at the time of the evaluation visits, and no community focus group participants referred to initiatives of this type.

As explained above, DoHA/Medicare Australia have recently advised that this issue is being addressing by the establishment of a register of PIP Indigenous Health Incentive registered Health Services across Australia. The practice register will include the name, phone number and location of PIP Indigenous Health Incentive registered practices.

Vignette – attracting more patients

An urban General Practice in a capital city employs four doctors and a practice nurse. The PIP Indigenous Health Incentive was embraced by the practice manager as a business expansion opportunity.

The practice initially felt it was well placed, as a fully bulk-billing practice, to increase services to existing Aboriginal and Torres Strait Islander patients and to the broader population. A good relationship was established with the Outreach Worker (OW) based at the DGP, who introduced the practice manager to Aboriginal and Torres Strait Islander community representatives. He attended a 'meet the community' event organised by the DGP (and was dismayed by the lack of attendance by any other GPs or community members). He displayed culturally appropriate resources at the practice.

Despite the interest and efforts of the practice manager, no patients have been signed up for PBS Co-payments or the PIP Indigenous Health Incentive and no health assessments have been done. '*At the start we had 20 Aboriginal patients on the books and we contacted every single one and got no results.*'

Aboriginal and Torres Strait Islander patient numbers have increased by only ten. The manager is questioning the worth of investing further time. '*I have spent a lot of time trying to get more Aboriginal patients but I'm disappointed … I am driven by the dollar and time as we are bulk-billing. I saw the initiative as good business [but it is] not proving to be fruitful.*'

Registration of patients at more than one Health Service

Interviewees continued to express frustration about the time spent registering patients, to later discover they were already registered with another Health Service. The issue of eligible patients being registered at more than one Health Service suggests there may be some confusion by Health Services over who is considered a regular patient, particularly for the purpose of implementing the PIP Indigenous Health Incentive. The financial incentives associated with registration are likely to have driven some inappropriate registration of patients. The finding may also, in part, be related to the ongoing lack of patient awareness and understanding of the incentive and associated restrictions and entitlements (see focus group participant comments below) or lack of patient knowledge of PIP registered practices.

> '*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 … should be some way they can tell who is their regular practice.*' (Interview, GP, General Practice)

> *'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.'* (Interview, GP, General Practice)

> *'I had a situation the other day where a patient said that they were not signed up but then registered and it got rejected as they were signed up elsewhere.'* (Interview, GP, General Practice)

> *'Just go to the doctors and told to sign this.'* (Community focus group)

Generally it was General Practices that expressed frustration at having people they perceived to be their regular clients being registered at the AHS. This issue was also raised in regards to Health Services doing health assessments (and to a lesser extent in regards to GPMPs and TCAs), only to have their claims for payment rejected by Medicare as another service had already claimed the payment.

In a number of AHSs there were instances where they had registered patients who had already been signed up within the Health Service. This reflects the lack of systems to monitor registration of patients within the services.

> *'Yes [we have had] a few challenges, 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.'* (Interview, GP, AHS)

In addition, a number of Health Services were not keeping copies of the registration form for the incentive, as they were not aware they needed to. In the absence of an established system to identify registered patients within the clinical information system, this oversight may have contributed to uncertainty about who was registered.

> *'Initially we didn't keep a record of who was signed up, we have that now.'*
> (Interview, GP, General Practice)

There were a number of suggestions to establish a process whereby health professionals can check if a patient is registered. The generally preferred suggestion was for an on-line system, but there were also suggestions for a telephone-based system. Many recognized the need for improved systems within their practices and services.

Organising access to the PIP Indigenous Health Incentive

Similar to the previous reporting period, about half [51% (46/91)] of interviewees agreed with the statement *'organising access for Aboriginal and Torres Strait Islander people to the new PIP Indigenous Health Incentive has been easy'.* About one third [31% (28/91)] disagreed with the statement and about one fifth [19% (17/91)] responded that they didn't know or couldn't say.

Figure 57 demonstrates that interviewees in urban sites were more likely to agree with the statement and those in remote sites were least likely to agree (71%, 44% and 25% for urban, regional and remote sites respectively).
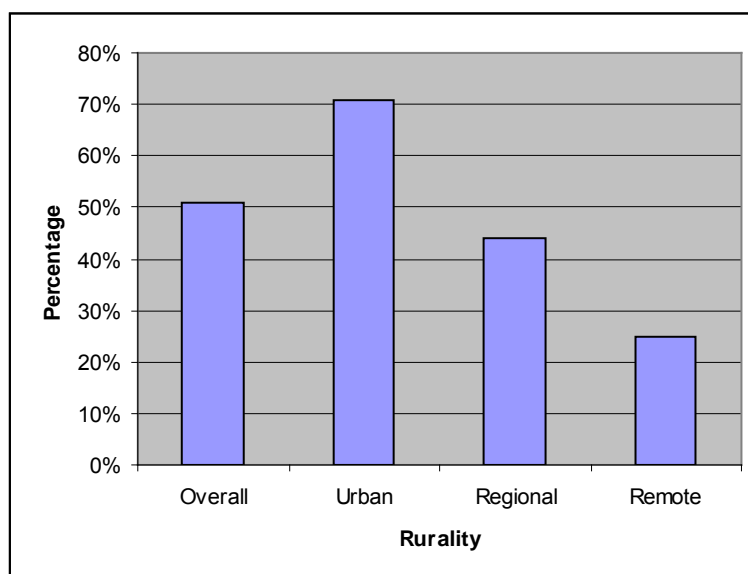
Figure 57: Interviewees' perceptions of ease of access (% who strongly or partly agreed), overall and by rurality

Practice managers [70% (12/17)] felt more positive than clinicians [59% (17/59)] about the ease of organising access. Clinicians and practice managers in Aboriginal Health Services [75% (15/20)] felt more positive than those based in General Practice [54% (14/26)].

These data show that while the majority of interviewees who were able to comment felt that organising access to the PIP Indigenous Health Incentive has been easy, there remains a significant proportion of stakeholders in the case study sites, particularly in General Practices, who do not believe this to be the case. These stakeholders identified the need for ongoing effort to streamline processes for access to the PIP Indigenous Health Incentive.

The re-registration process of patients has raised some concern, not only due to poorly developed systems to identify eligible patients, but also because there is a perception that the incentive for initial sign up was access to the free or subsidised medications under PBS Co-payment arrangements. Because there is no need to re-register patients for the PBS Co-payment, opportunities to re-registering clients for the PIP Indigenous Health Incentive may be less than for initial registration, and we may see lower rates of coverage over the coming year.

Registration of Aboriginal and Torres Strait Islander people for the PIP Indigenous Health Incentive

Patients are required to register for the PIP Indigenous Health Incentive in each calendar year. Registration of patients for 2011 commenced in November 2010. This is the first reporting period where data on re-registration of patients have been available. The data on re-registrations presents some complications for analysis, as the available data do not allow for analysis of unique registrations by site. Therefore, registrations for 2011 included new patients and existing patients. The data at a national level indicates:

- There have been 41 977 unique registrations for the PIP Indigenous Health Incentive from May 2010 - February 2011.

- There were 26 122 registrations to November 2010 and around 23 619 registrations for 2011 by the end of May 2011.

- About a third of the people registering for 2011 had previously been registered (in 2010).

Most of the registrations up to February 2011 were new registrations rather than re-registrations. This suggests that there will be positive growth in the program in 2011, provided that people registered in 2010 re-register throughout the year. Re-registration rates were around 30% in both Sentinel Sites and the rest of Australia (Table 17). This is consistent with what might be expected if re-registrations are spread relatively evenly throughout the year (i.e. approximately 25% a quarter). However, higher levels of re-registration early in the year would increase the likelihood that patients receive, and practices are paid for, services associated with the PIP Indigenous Health Incentive within the 2012 calendar year.

Table 17: Number of people registered (PIP Indigenous Health Incentive patient registration payment) per 100 Aboriginal and Torres Strait Islander people in 2010 and their rate of re-registration in 2011 in the Sentinel Sites and the rest of Australia by rurality

Rurality	Sentinel Sites Registrations per 100 Aboriginal &Torres Strait Islander people	Rest of Australia Registrations per 100 Aboriginal &Torres Strait Islander people	Sentinel Sites % people registered by February 2011 who were also registered in 2010	Rest of Australia % people registered by February 2011 who were also registered in 2010
Urban	6.7	7.4	30.8	24.0
Regional	15.9	10.2	33.9	35.6
Remote	5.7	5.5	35.5	37.1

The number of unique registrations included 10 101 people in Sentinel Sites (an average of 29 people per eligible Health Service, 11 per 100 Aboriginal and Torres Strait Islander people) and 31 876 (an average of 18 people per eligible Health Service, 8 per 100 Aboriginal and Torres Strait Islander people) in the rest of Australia. The higher average number of people per Health Service in Sentinel Sites compared to the rest of Australia may reflect earlier registration in the Sentinel Sites, related to more intensive activity to encourage registration in these locations. However, it may also be at least partly related to other possible differences between Sentinel Sites and the rest of Australia (for example proportion of the population who are Aboriginal or Torres Strait Islander, number of Health Services oriented to providing care for Aboriginal and Torres Strait Islander people, and average size of Health Services).

Figure 58 shows the number of people registered for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres Strait Islander people aged 15 years and over for Sentinel Sites

compared to the rest of Australia by Health Service type from May 2010 - May 2011. Included in the 2011 data are both people who became registered for the first time in 2011 and people who were registered in 2010 and re-registered for 2011. On average, almost 3 per 100 people registered for the PIP Indigenous Health Incentive per quarter in AHSs in Sentinel Sites. This was more than double the corresponding figure for General Practices (just over 1 per 100 people). In the rest of Australia, there was little difference in the number of people registered per 100 people per quarter for the PIP Indigenous Health Incentive by Aboriginal Health Services compared to General Practices (about 1.5 per 100 people in both settings). These data indicate that, in general, AHSs are registering at least as many Aboriginal and Torres Strait Islander people per 100 people as General Practices. These data also indicate there is a stronger orientation towards registering Aboriginal and Torres Strait Islander people for the PIP Indigenous Health Incentive in AHSs in Sentinel Sites, compared to both AHSs and General Practices in the rest of Australia, probably because of greater availability of AHSs in Sentinel Sites.

From May 2010 to the end of November 2010, there were much larger increases in registrations in Sentinel Sites AHSs in each quarter than the other three groups (Sentinel Sites, General Practice and the rest of Australia AHS and General Practice), which showed more steady growth. All three groups showed a dip in registration, as registration for 2011 began. However, this was more marked for Sentinel Sites AHSs, although levels of registrations in this group remained higher than the other groups.
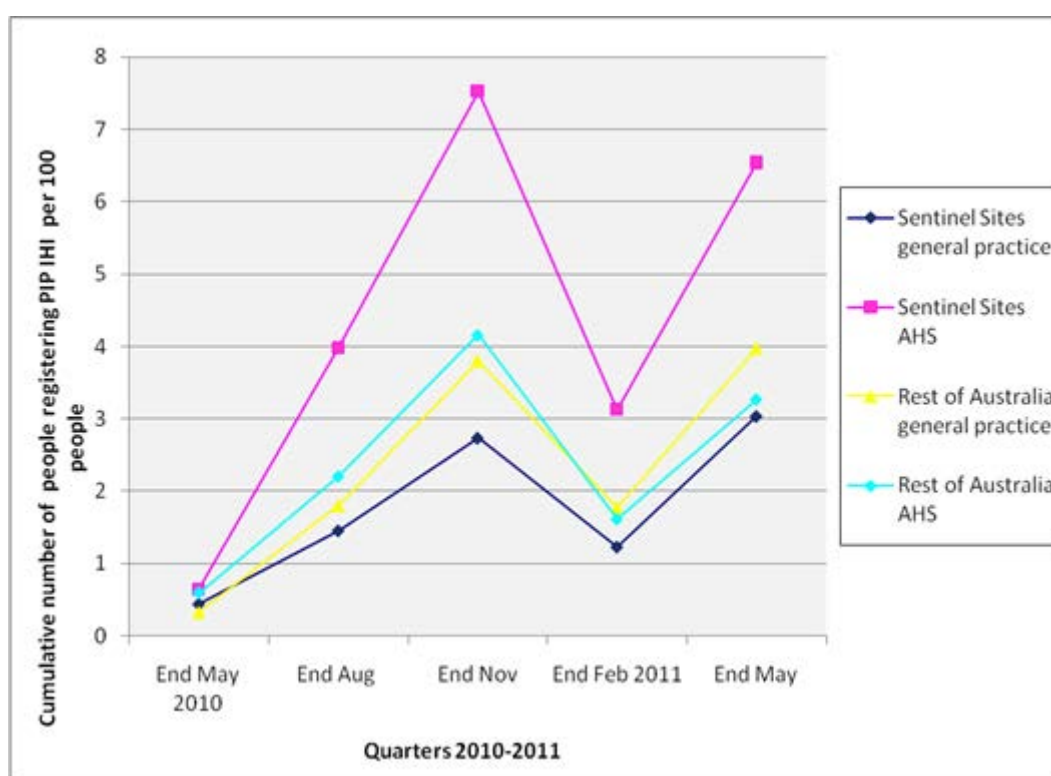
Figure 58: Cumulative number of people registering for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by service type and quarter March 2010 - May 2011

Registration by Health Services in different settings and AHSs compared to General Practice

The trends in registrations per 100 Aboriginal and Torres Strait Islander people varied according to rurality, as well as varying between AHSs and General Practice (Figure 59-61). Registrations per 100 Aboriginal and Torres Strait Islander people were higher in regional areas

and lower in remote areas compared to urban areas. This pattern was evident in registrations through both General Practices and AHSs (Appendix I, Tables I2 and I3).

Higher levels of registration in Sentinel Sites compared to the rest of Australia were due to higher numbers of registrations per 100 Aboriginal and Torres Strait Islander people in some regional Sentinel Sites compared to rest of regional Australia. Differences were much smaller for urban and remote sites (Figure 59, Appendix I, Tables I2 and I3).
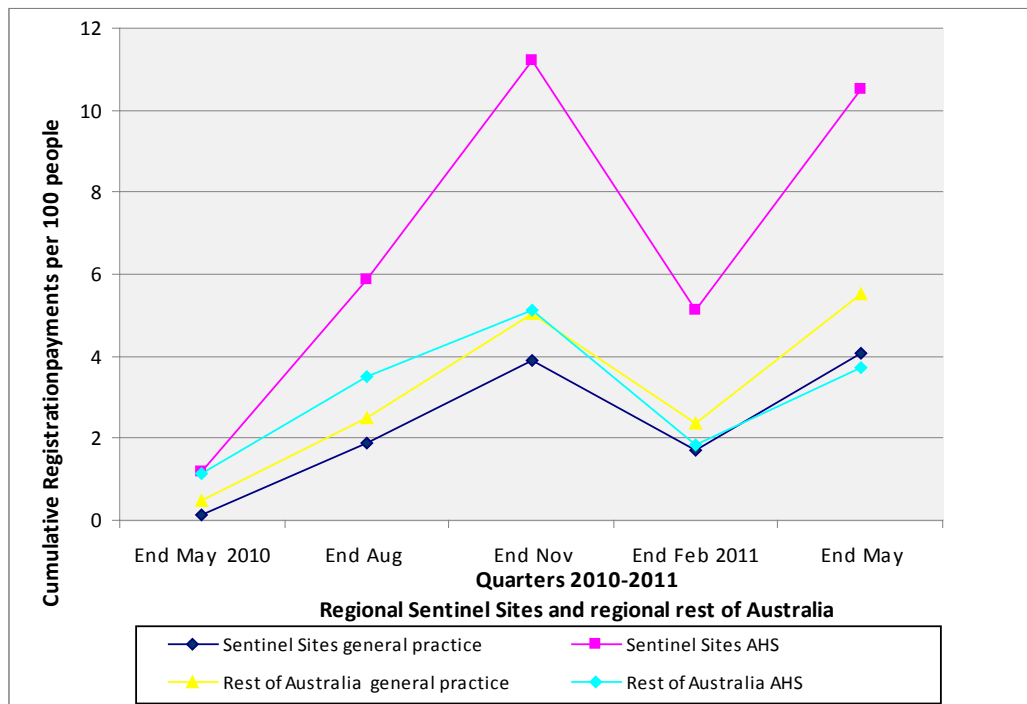
Figure 59: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 people for regional Sentinel Sites and the rest of regional Australia by service type and quarter March 2010 - May 2011

In urban Sentinel Sites there were about two times the numbers of registrations per 100 Aboriginal and Torres Strait Islander people for AHSs compared to General Practices. In regional Sentinel Sites there were about three times the numbers of registrations per 100 Aboriginal and Torres Strait Islander people for AHSs compared to General Practices. These higher levels of registration in AHSs were not apparent in the data for the rest of Australia (Appendix I, Tables I2 and I3).
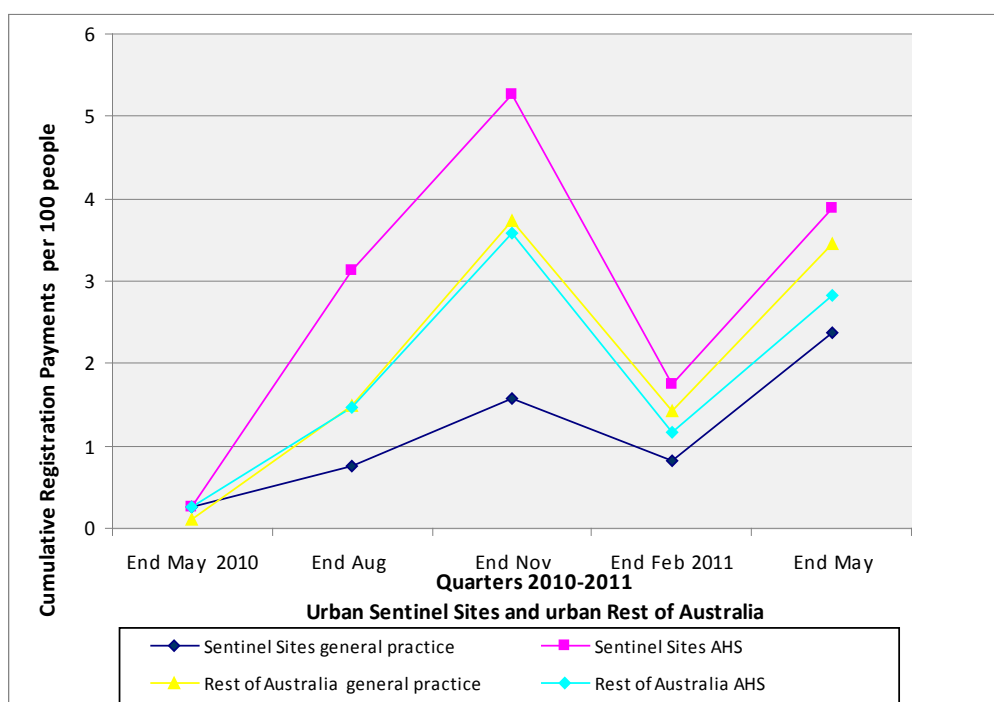
Figure 60: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by service type and quarter March 2010 - May 2011

For AHSs in remote Sentinel Sites there were lower levels of registration than for General Practices in remote Sentinel Sites (Figure 61, Appendix I Tables I2 and I3). However, for the rest of remote Australia there were higher levels of registration in AHSs compared to General Practice.
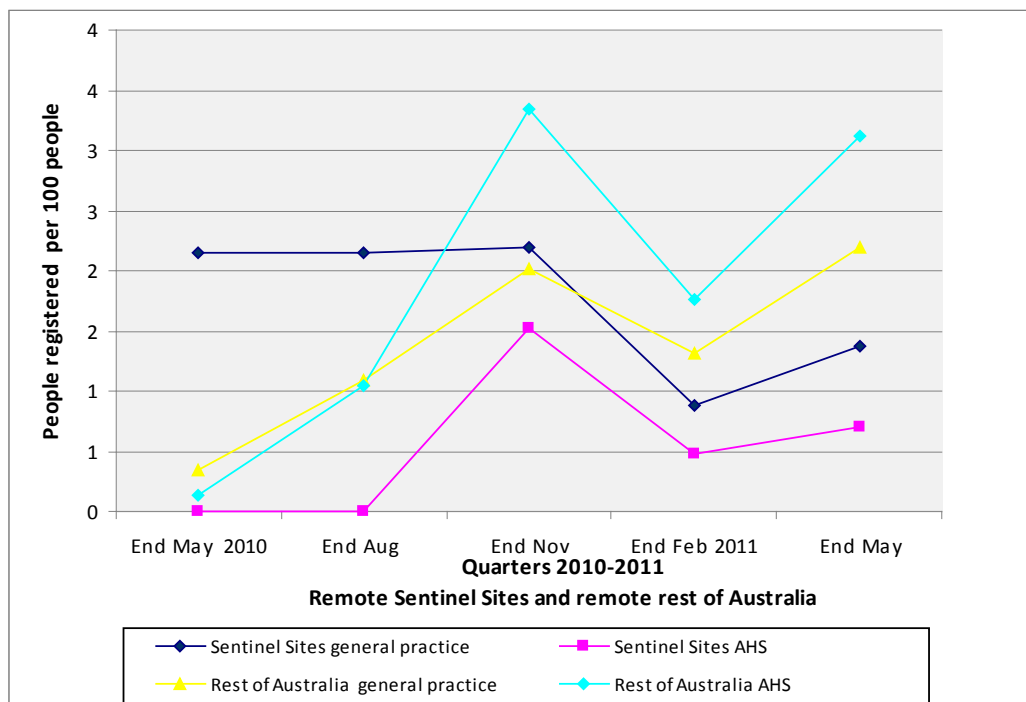
Figure 61: Patients registered (PIP Indigenous Health Incentive patient Registration Payment) per 100 people for remote Sentinel Sites and the rest of remote Australia by service type and quarter March 2010 - May 2011

The contrasting patterns evident in these data are also reflected in the data for specific sites.

Urban Sentinel Sites

For the urban Sentinel Sites of Brisbane South, Campbelltown and Canberra the level of registration and re-registration was greater than for the rest of urban Australia (Figures 62-64). All three sites showed early rapid increases in registration with stabilization in subsequent quarters. The level of registration was lower in Logan/ Woodridge than the rest of urban Australia until the December 2010 - February 2011 quarter and higher in the two subsequent quarters. This was due to a particularly large increase in March - May 2011 (Figure 64). All other urban sites had lower levels of registration than the rest of Australia (Figures 62 and 64).
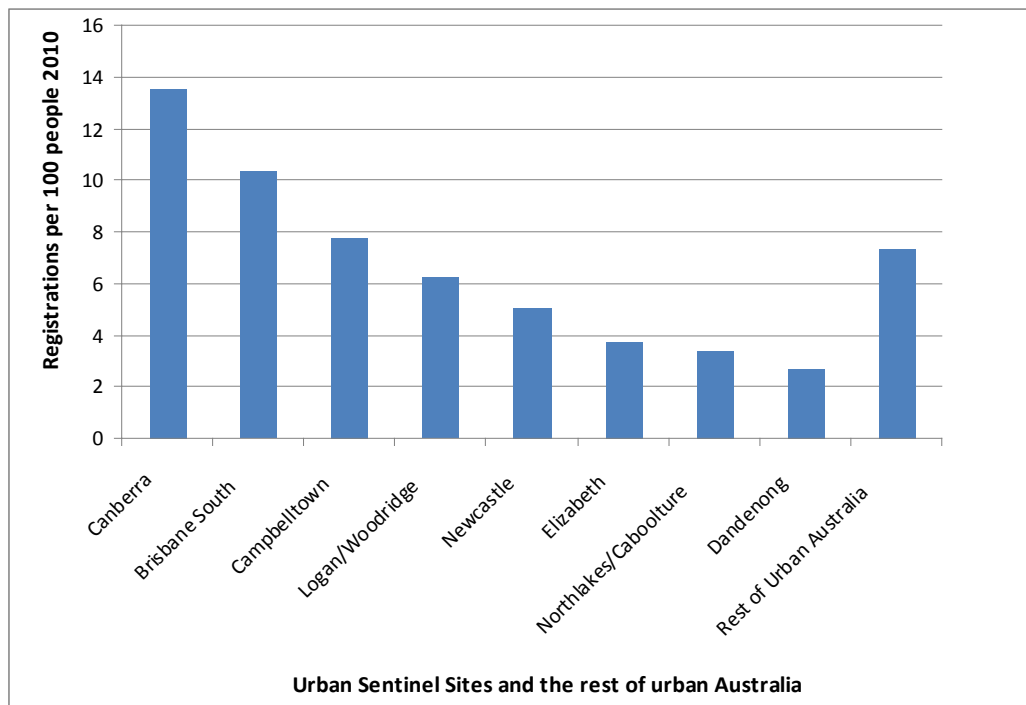
Figure 62: Patients registered (PIP Indigenous Health Incentive payment) in 2010 per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia
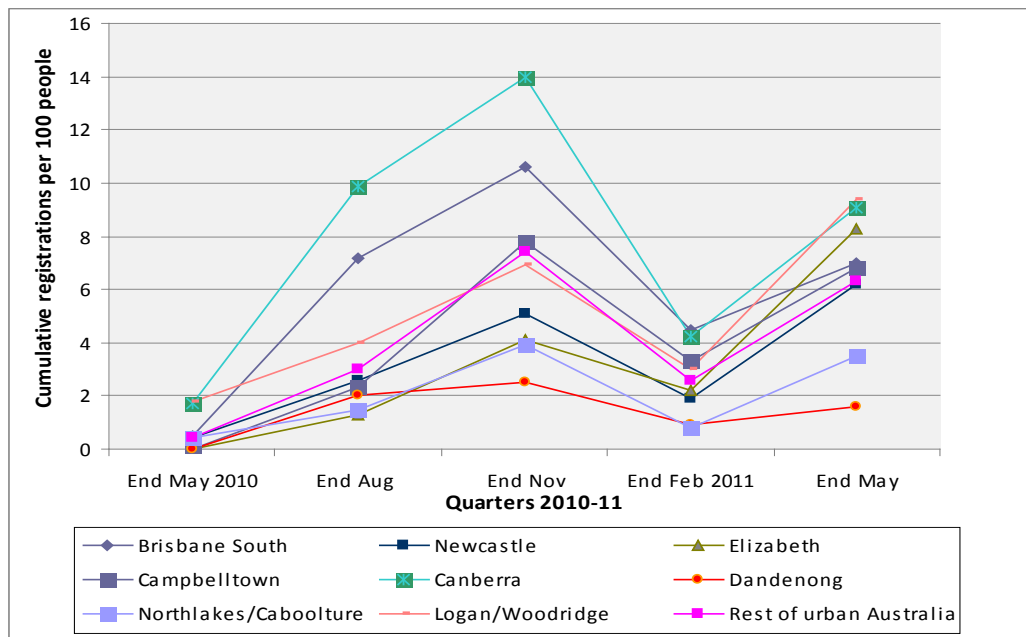
Figure 63: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia and quarter, March 2010 - May 2011

All urban Sentinel Sites had higher rates of re-registration than the rest of urban Australia with the exception of Dandenong (Figure 64).

Figure 64: Percentage of patients registered (PIP Indigenous Health Incentive payment) in 2010 who registered in 2011 for urban Sentinel Sites and the rest of urban Australia, February 2011

Regional Sentinel Sites

For regional areas, level of registrations was greater in most Sentinel Sites than the rest of regional Australia (exceptions were Darwin, Gladstone, Hobart and Tamworth sites) (Figure 65). Bairnsdale, Geraldton, Port Augusta and Swan/Hill Mildura showed particularly

high levels of registrations over the observed period (Figures 65 and 66). Higher rates of registrations in Sentinel Sites were largely driven by high levels of registration in the June - August 2010 quarters (Figures 66-68). Exceptions were Dubbo, which had very high levels of registration in the December 2010 - February 2011 quarter, and Cairns, where rates were relatively steady.
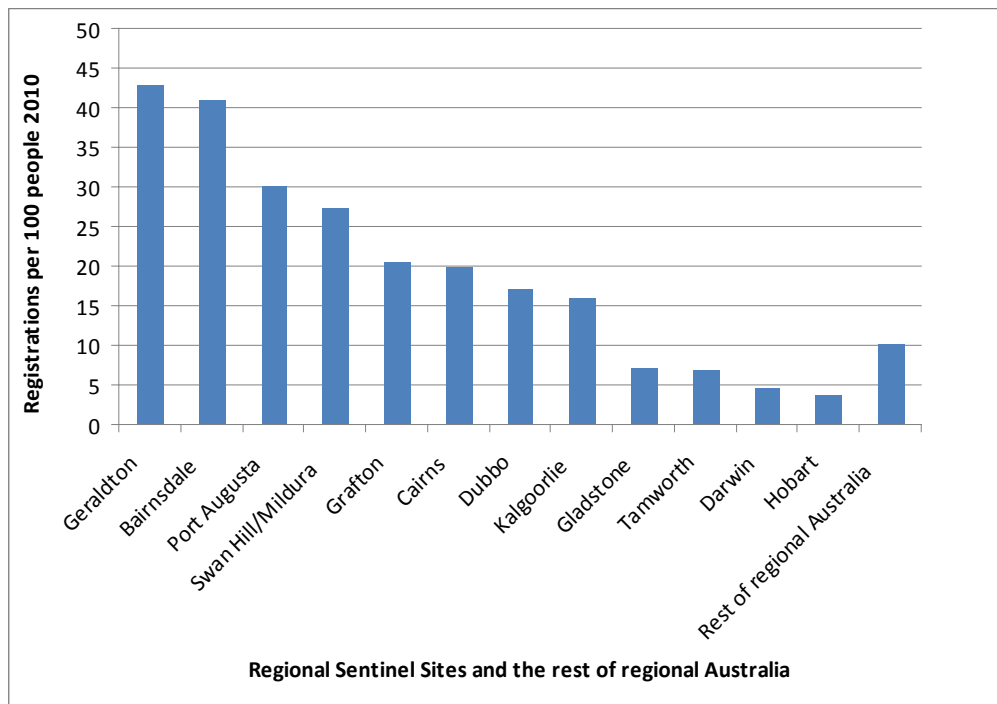
Figure 65: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia
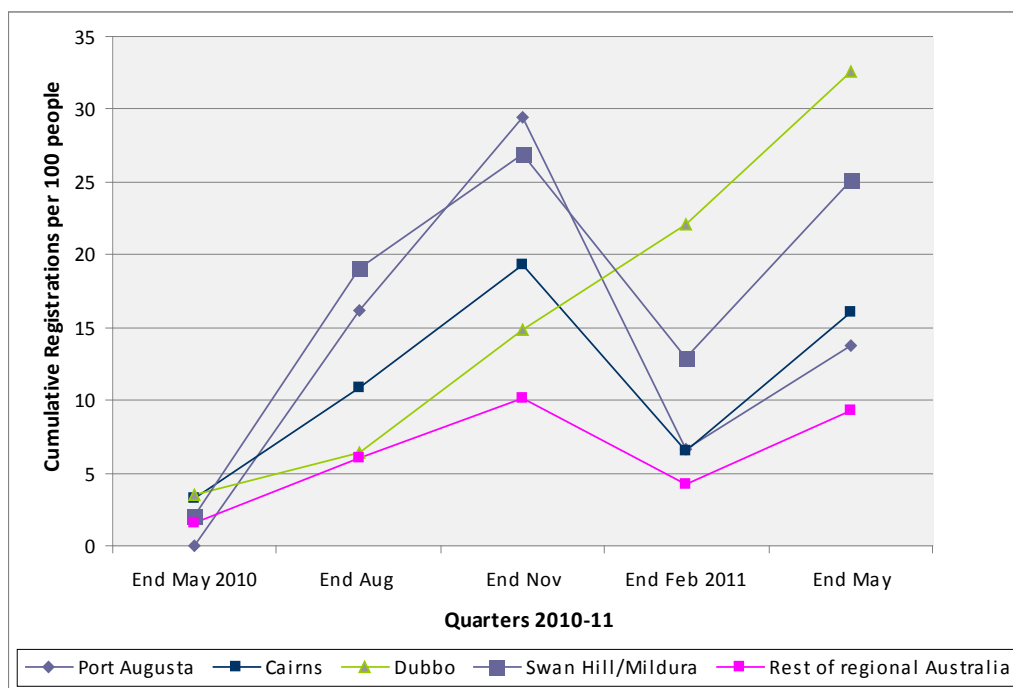
Figure 66: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 1 Sentinel Sites and the rest of regional Australia by quarter, March 2010 - May 2011
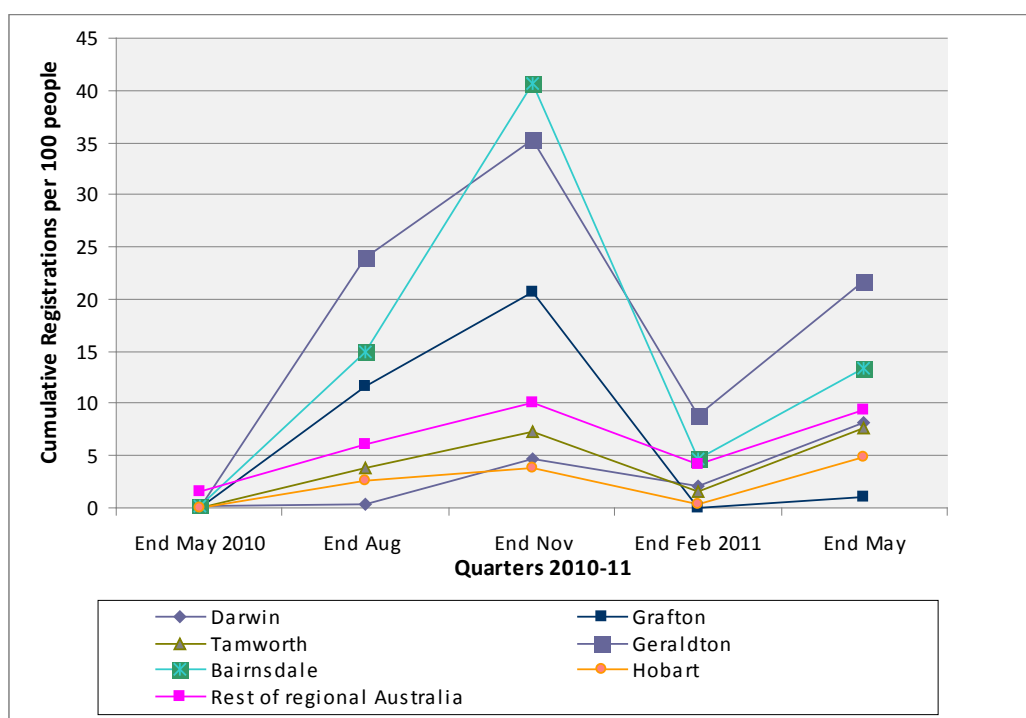
Figure 67: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 2 Sentinel Sites and the rest of regional Australia, by quarter, March 2010 - May 2011

Figure 68: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 3 Sentinel Sites and the rest of regional Australia by quarter, March 2010 - May 2011

Re-registration rates were higher in Cairns, Dubbo, Hobart, Kalgoorlie and Tamworth than for the rest of regional Australia (Figure 69). These sites tended to have relatively lower levels of registration per 100 people for 2010 (Figure 65). Re-registration rates were lower in all other regional Sentinel Sites than the rest of regional Australia (Figure 69).

Figure 69: Percentage of patients registered (PIP Indigenous Health Incentive payment) in 2010 that registered in 2011 for regional Sentinel Sites and the rest of regional Australia, February 2011

Remote Sentinel Sites

In remote areas, levels of registration were driven by a small number of Health Services and identifying trends is therefore more difficult. Rates of registration were higher than the rest of remote Australia in Derby and East Pilbara and lower in Barkly (Figure 70). No data are available for Katherine West, as services in this site have not been registering patients for the incentive due to lack of administrative capacity to complete the required paperwork.
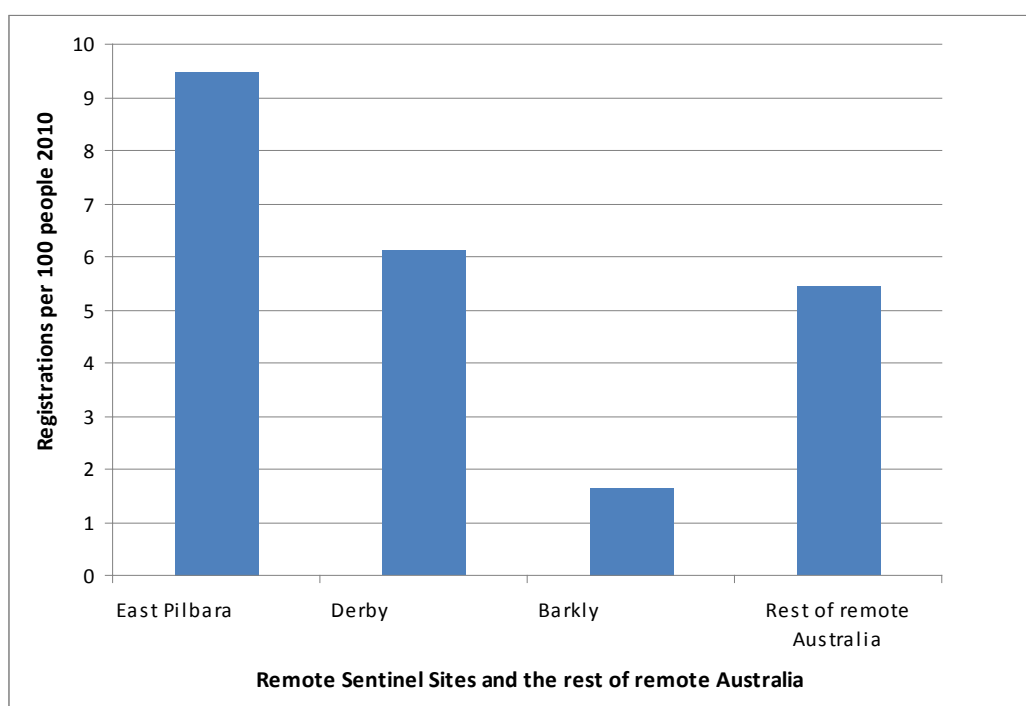
Figure 70: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia

Registrations did not occur in Barkly or East Pilbara until the September 2010-November 2010 quarter (Figure 71).
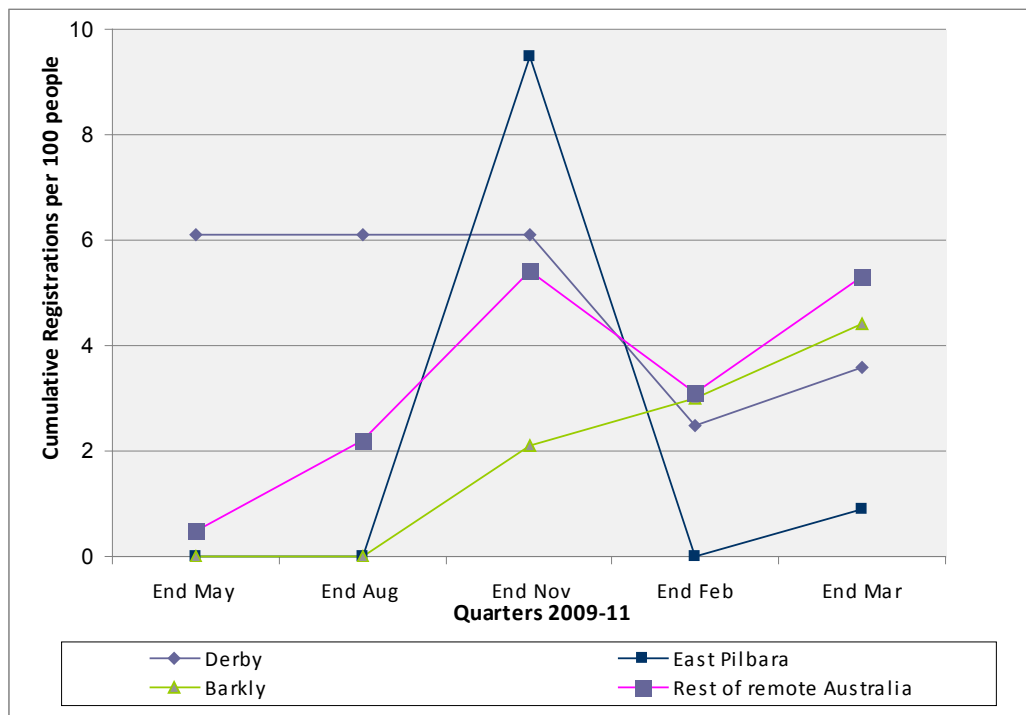
Figure 71: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia by quarter, March 2010 - May 2011

Rates of re-registration were lower in all remote Sentinel Sites than in the rest of remote Australia (Figure 72).

Figure 72: Percentage of patients registered (PIP Indigenous Health Incentive payment) in 2010 who registered in 2011 for remote Sentinel Sites and the rest of remote Australia, February 2011

Eligibility criteria for the PIP Indigenous Health Incentive

As reported in both previous reporting periods, there was a good level of understanding of the PIP Indigenous Health Incentive eligibility criteria amongst stakeholders, with 73% (61/83) of interviewees agreeing with the statement '*patient eligibility criteria for PIP Indigenous Health Incentive are workable in practice'.* Interviewees in urban sites continued to be more likely to agree with this statement than those in regional or remote sites (84% compared to 70% and 63% respectively), even though registrations per 100 people tended to be higher in regional areas. There was a high level of agreement to this statement from both clinicians and practice managers in both General Practices and Aboriginal Health Services.

A small number of interviewees in this reporting period expressed concern that they were unable to register patients with a chronic disease who were under 15 years of age.

As previously reported, a number of stakeholder interviewees from both the AHS and General Practice sectors raised some issues related to the application of the criteria. These concerns ranged from difficulty or discomfort in asking about Aboriginal or Torres Strait Islander descent, to concerns about self-identification of Aboriginal and Torres Strait Islander status.

These concerns to some extent reflect the need for increased 'cultural competence' of Health Service staff, and the need to enhance cultural safety in the Health Service environment. However, these data may also reflect a concern that people who are not Aboriginal or Torres Strait Islander are identifying as Aboriginal or Torres Strait Islander in order to access benefits under the ICDP.

Potential for suspicion and inappropriate questioning regarding Aboriginal or Torres Strait Islander status to present barriers in the process of registering clients for the PIP Indigenous Health Incentive, and limit the potential for the program to benefit Aboriginal and Torres Strait Islander people, is likely to be much greater than problems related to leakage of funds from the scheme to people who are not eligible. This issue highlights the importance of programs to promote cultural competence and cultural safety in relation to access for Aboriginal and Torres Strait Islander people to health care services.

Barriers to registration from the community perspective

As reported previously, while community focus group participants appeared to generally understand the implications for registering for the PBS Co-payment and were often aware they had signed forms related to another related initiative, they were generally unaware of what the PIP Indigenous Health Incentive was about. They did not appear to be aware of the need for, or implications of, re-registering.

Thus the major barriers from the perspective of community members continue to be as reported previously: inadequacy of processes and skills for identification of Aboriginal or Torres Strait Islander status, and limitations of processes for informing community members and obtaining appropriately informed consent.

Provision of appropriate care to PIP registered patients

Figure 73 shows the number of Tier 1 outcome payments for services provided in 2010 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 Health Services that have both developed and reviewed a GPMP or TCA within the calendar year. Only a relatively small number of Tier 1 payments were made per 100 Aboriginal and Torres Strait Islander people (less than 1 per quarter) over the reporting period (March 2010 - May 2011, with the PIP Indigenous Health Incentive Tier 1 payments commencing in June - August 2010 quarter).
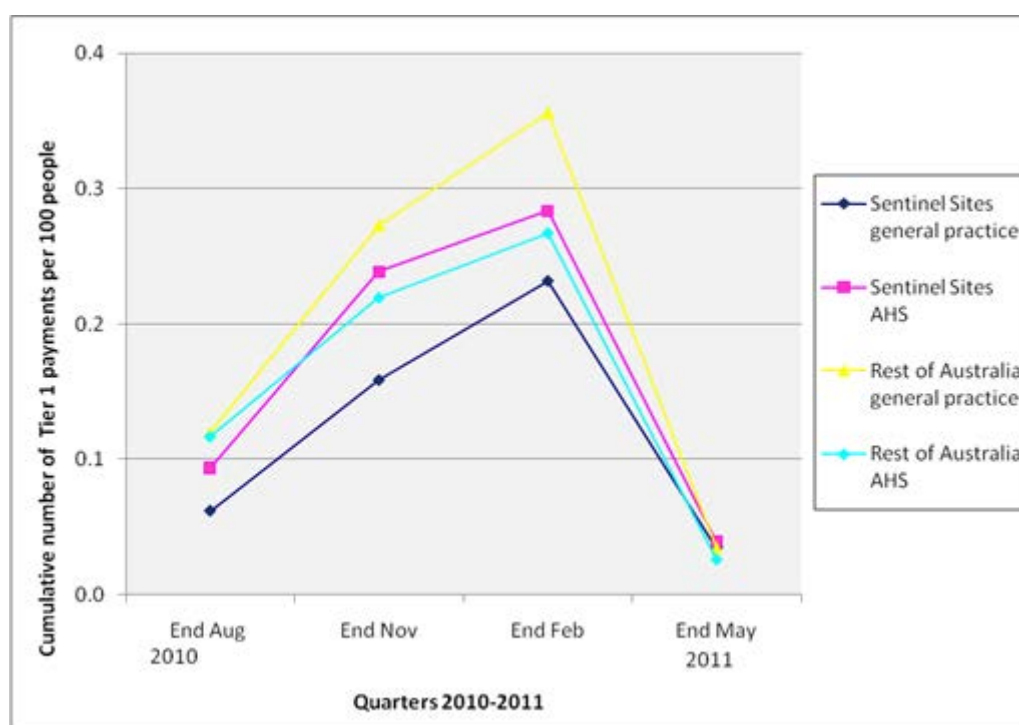
Figure 73: Cumulative number of Tier 1 payments per 100 Aboriginal and Torres Strait Islanders aged ≥15 years for Sentinel Sites and the rest of Australia by service type and quarter, June 2010 - May 2011

Tier 1 payments were higher in the population for General Practices than AHS in the rest of Australia. However the reverse was true in Sentinel Sites. There was quite steady growth in Tier 1 payments in both sectors and in both the Sentinel Sites and the rest of Australia over the reporting period. The increase in payments was lower in the period from September - November 2010 than in the period from June - August 2010. This was more marked for AHSs than General Practices in both Sentinel Sites and the rest of Australia. The number of Tier 1 payments initially increased and then decreased from the second quarter in each quarter in both sectors, and in both the Sentinel Sites and the rest of Australia (Appendix I, Table I4). Tier 1 payments can only be made once each calendar year and therefore can only cumulate over the year (NB: payments made December 2010 - February 2011 are for services delivered in the previous quarter). The decline in Tier 1 payments at the end of May 2011 reflects the start of Tier 1 payments for 2011.

The precision of comparisons between Sentinel Sites and the rest of Australia, and between AHSs and General Practices, is limited by the possibility that people may register at one practice (in or outside a Sentinel Site, at an AHS or a General Practice) and that the Tier 1 payment may be made to another practice that is different with respect to location in or outside a Sentinel Site, or to being an AHS or a General Practice. The extent to which such changes are made is likely to be too small to have a major effect on the comparisons made in this analysis.

Tier 1 payments by services in different settings and AHSs compared to General Practice

Trends in Tier 1 payments were similar across rurality with some variation in relative difference (Figures 74-76, Appendix I, Table I5).

In urban Sentinel Sites, the number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people was higher in AHSs than General Practices in Sentinel Sites while the reverse was true in the rest of urban Australia. General practices in urban Sentinel Sites showed a

steady increase in the number of Tier 1 payments per 100 people from the end of June 2010 to the end of February 2011. In all other groups the increase in the number of Tier 1 payment per 100 people slowed to the end of February 2011, compared to that observed at the end of November 2010. This effect was particularly marked for the AHSs in Sentinel Sites. In urban areas there was also a decrease in the number of Tier 1 payments from the end of June 2010 to the end of 2010 in absolute terms.
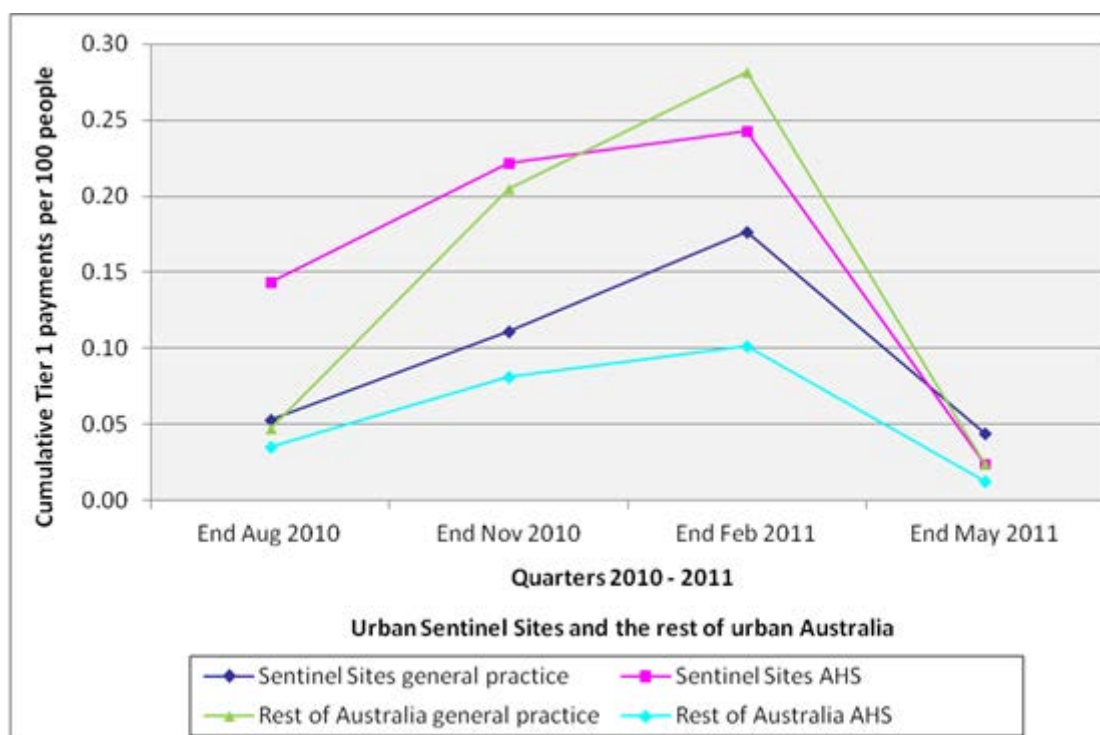
Figure 74: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia by service type and quarter, June 2010 - May 2011

Regional areas reflected the general trends. However, Tier 1 payments per 100 people were initially higher in AHSs in the rest of Australia than AHSs in Sentinel Sites, but this pattern had reversed by the end of November 2010. Numbers of Tier 1 payments decreased from the end of August 2010 to the end of May 2011 in the rest of regional Australia in both sectors. In Sentinel Sites, Tier 1 payments increased from the end of August 2010 to the end of November 2010 and subsequently declined.
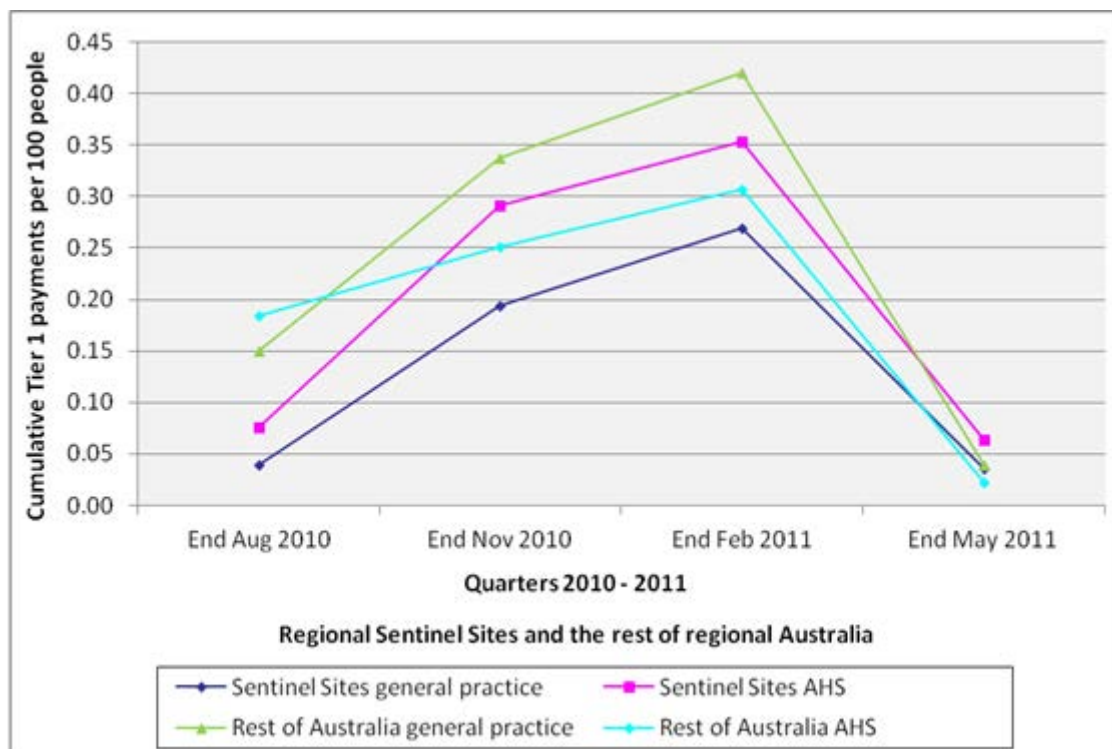
Figure 75: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia by service type and quarter, June 2010 - May 2011

In remote areas, Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher in the rest of Australia than in Sentinel Sites. In the rest of remote Australia Tier 1 payments per 100 people were higher among AHSs than General Practices. The reverse was true in Sentinel Sites. Numbers of Tier 1 payments in Sentinel Sites fluctuated because of quite small numbers. The number of Tier 1 payments in the rest of remote Australia decreased from the end of November 2010 to the end of May 2011.
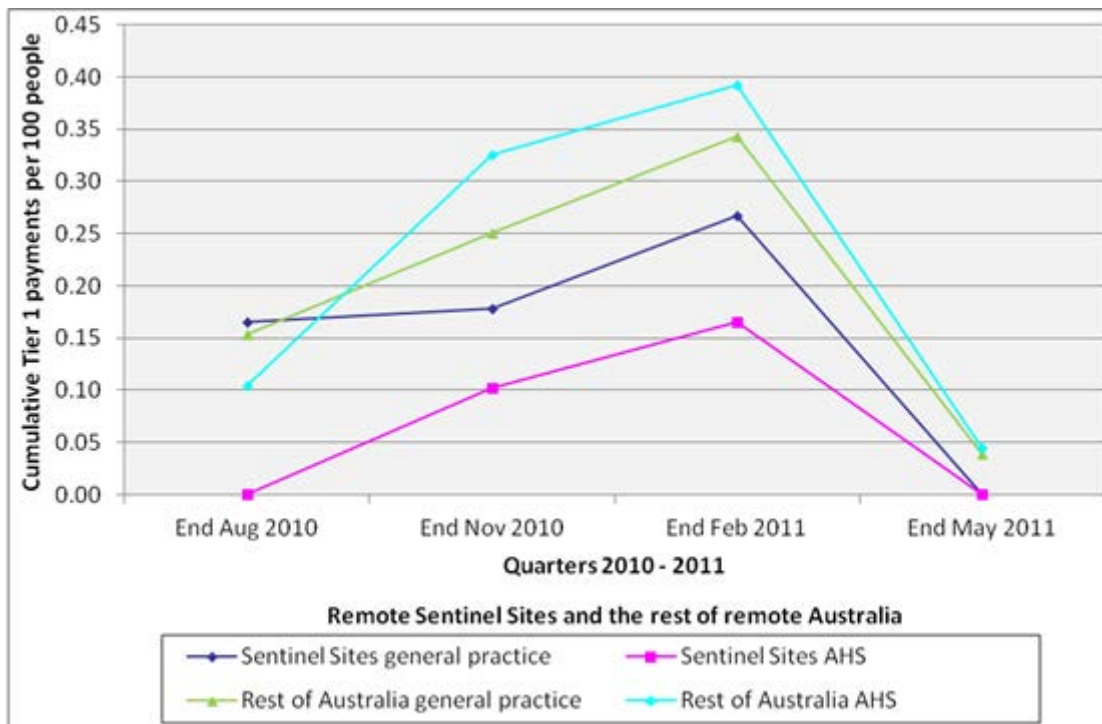
Figure 76: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia by service type and quarter, June 2010 - May 2011

Levels of Tier 1 payments were relatively low in the first year of the program, making it difficult to identify trends at a site level. Among urban Sentinel Sites, 2010 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher in Brisbane South and Elizabeth than in the rest of urban Australia. Similar numbers of claims were made in Logan/Woodridge and North Lakes/Caboolture. The number of Tier 1 payments per 100 people was lower than the rest of Australia than all other Sentinel Sites (Figure 77).
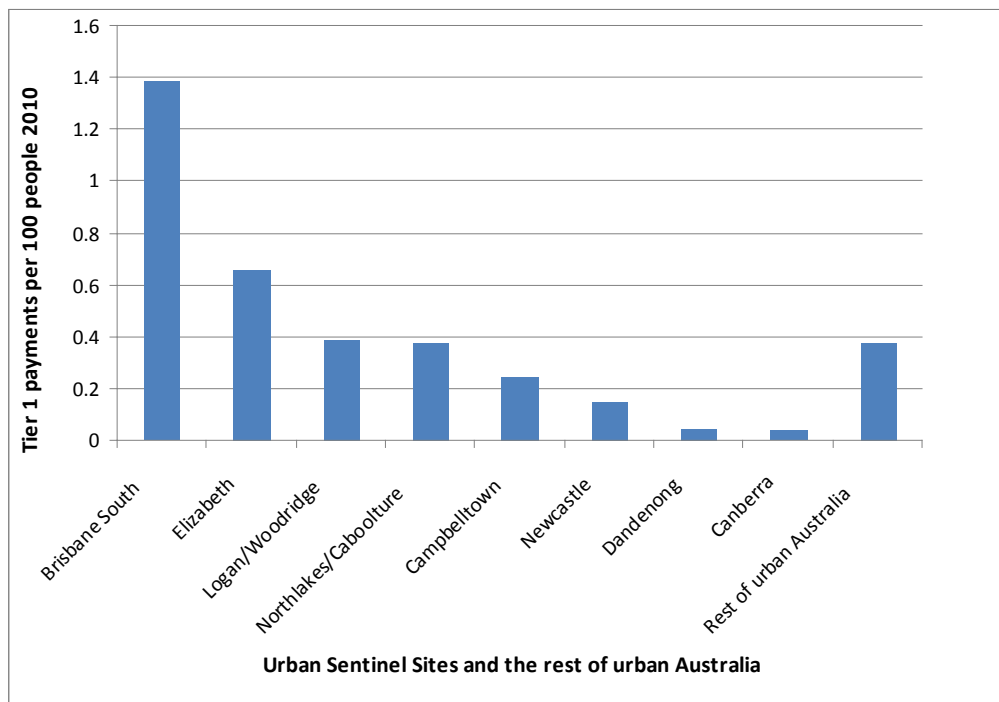
Figure 77: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, Tier 1 payments June 2010 - February 2011

Among regional Sentinel Sites, 2010 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher than the rest of regional Australia in Cairns, Darwin and Geraldton, and lower in all other regional Sentinel Sites (Figure 78).
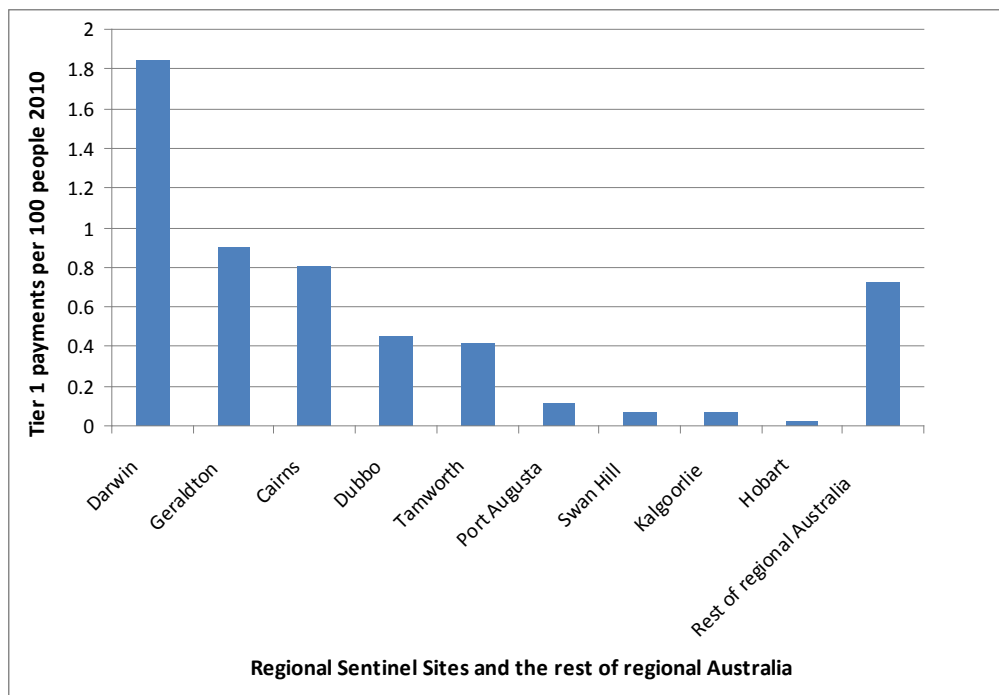
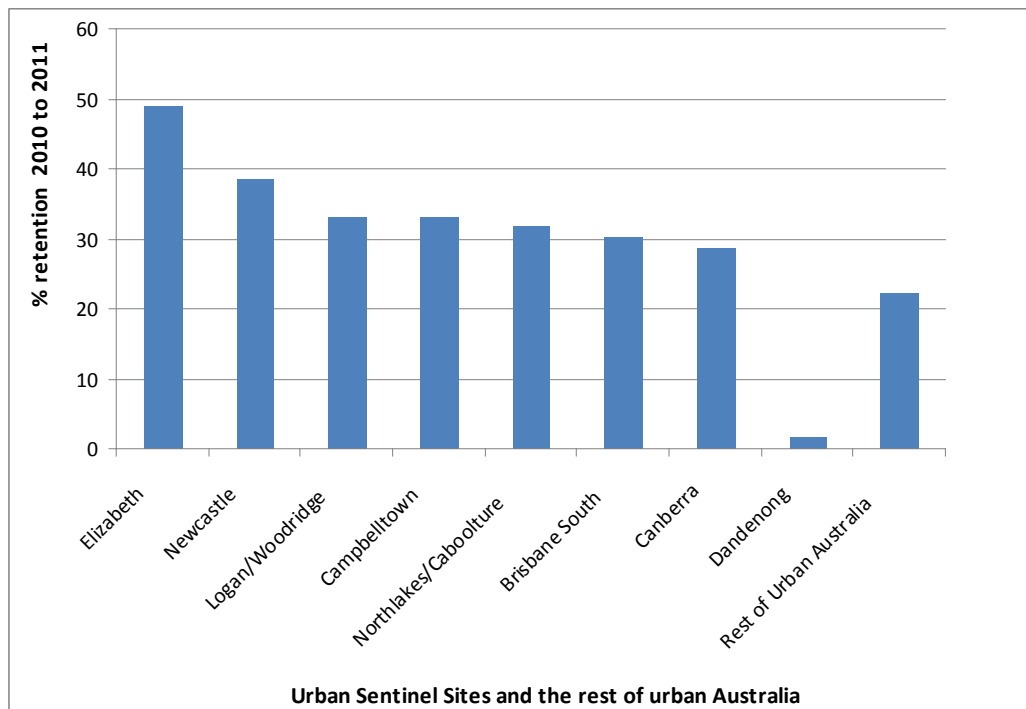***Figure 78: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia, Tier 1 payments June 2010 - February 2011***

Among remote Sentinel Sites, 2010 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher than the rest of Australia in Barkly and around the same as the rest of Australia in Derby (Figure 79).
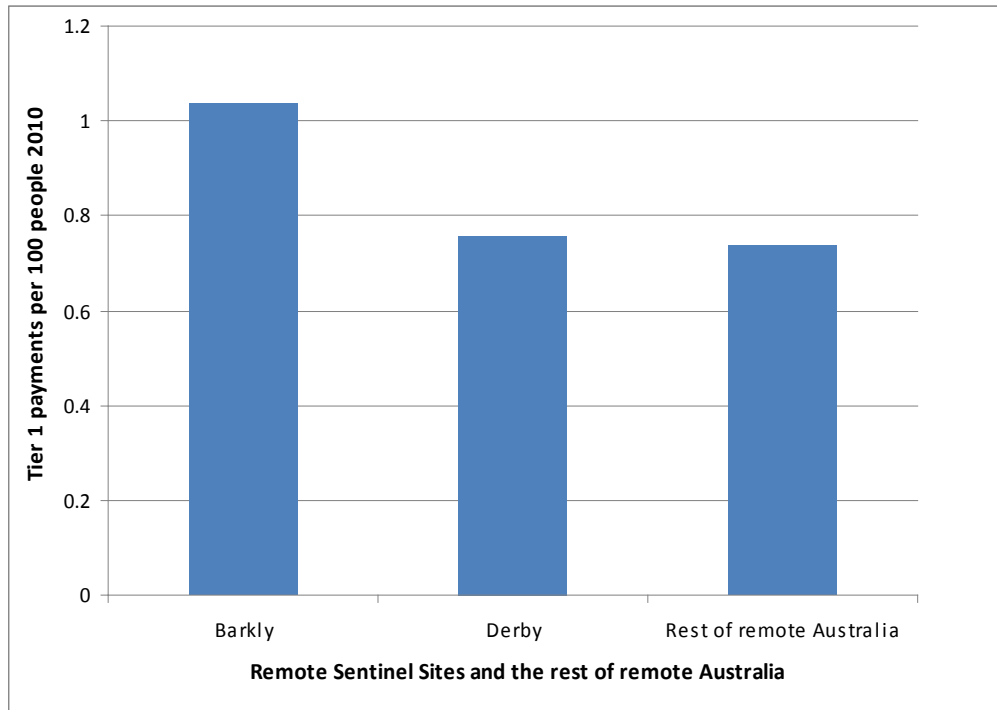
Figure 79: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, Tier 1 payments June 2010 - February 2011

Provision of majority of care to PIP Indigenous Health Incentive registered patients

Figure 80 shows the number of Tier 2 outcome payments per 100 Aboriginal and Torres Strait Islander people aged >15 years. The number of Tier 2 payments received by AHSs in Sentinel Sites (6 per 100 people) was around twice that received by General Practices in Sentinel Sites and by both types of Health Services in the rest of Australia (3-4 per 100 people).
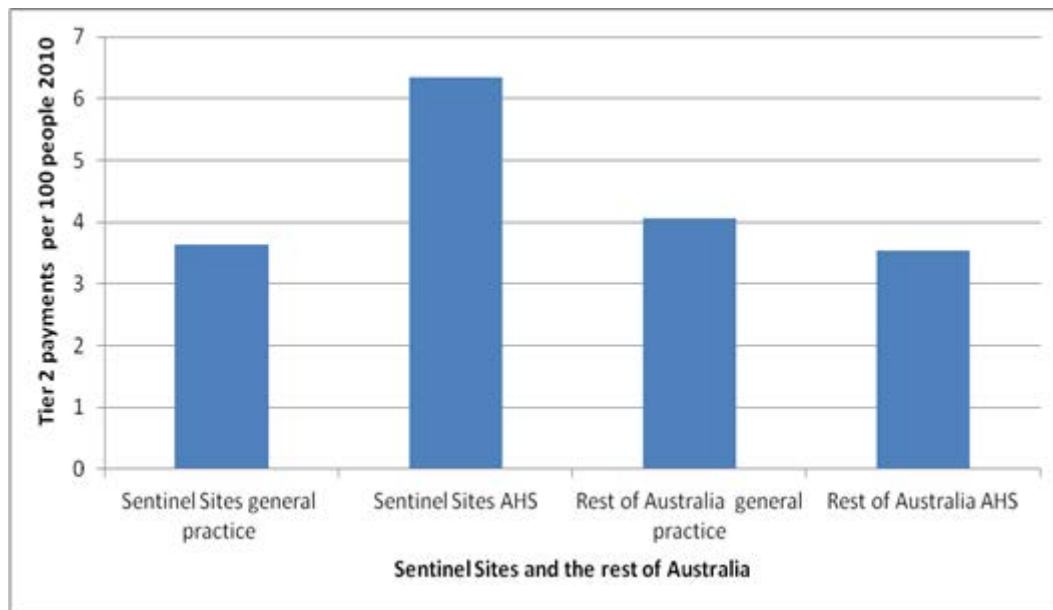
Figure 80: 2010 Tier 2 payments per 100 Aboriginal and Torres Strait Islander people aged >15 years for Sentinel Sites and the rest of Australia

Tier 2 payments by services in different settings and AHSs compared to General Practices

Tier 2 payments varied by rurality. Numbers of Tier 2 payments per 100 Aboriginal and Torres Strait Islander people were higher in regional areas than urban and remote areas (Appendix I, Table I6). This pattern was particularly evident in the Sentinel Sites.

In urban areas the number of Tier 2 payments received by AHSs per 100 people in the Sentinel Sites population was slightly higher than for General Practices (Figure 81).
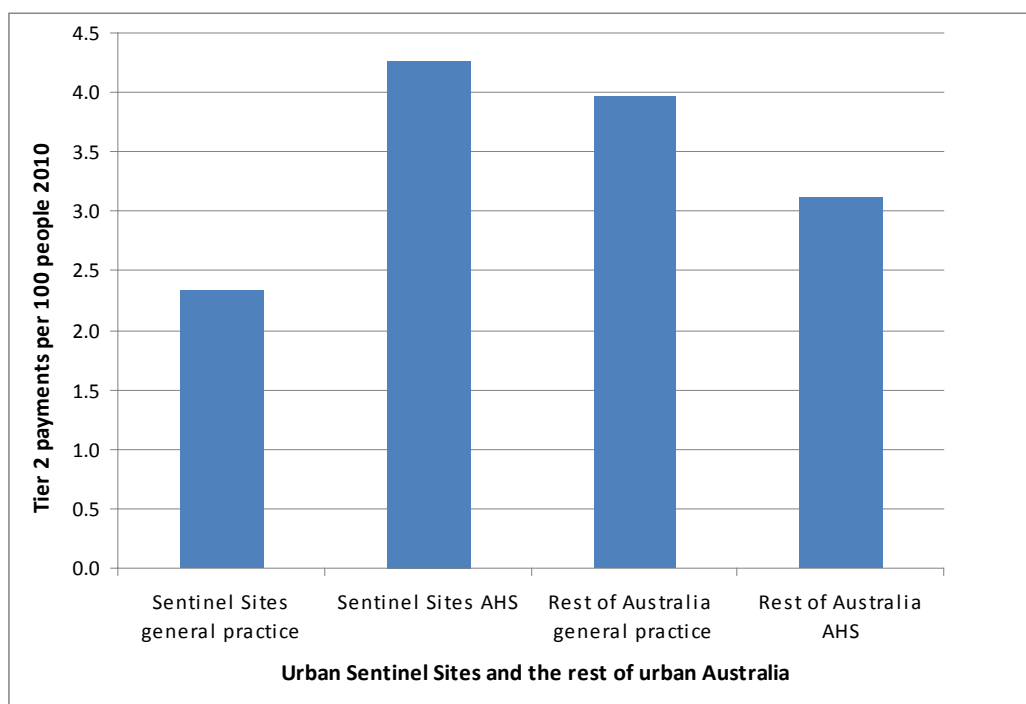
Figure 81: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia

In regional areas, the number of Tier 2 payments received per 100 people at AHS in Sentinel Sites was nearly double that for General Practices in Sentinel Sites and for both sectors in the rest of Australia (Figure 82).
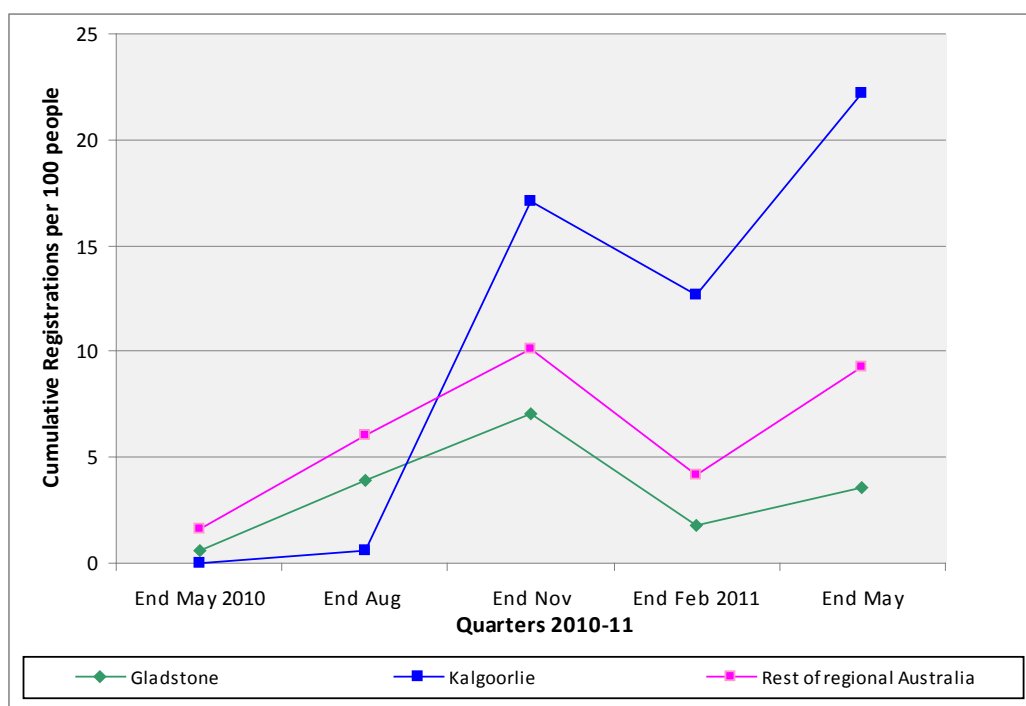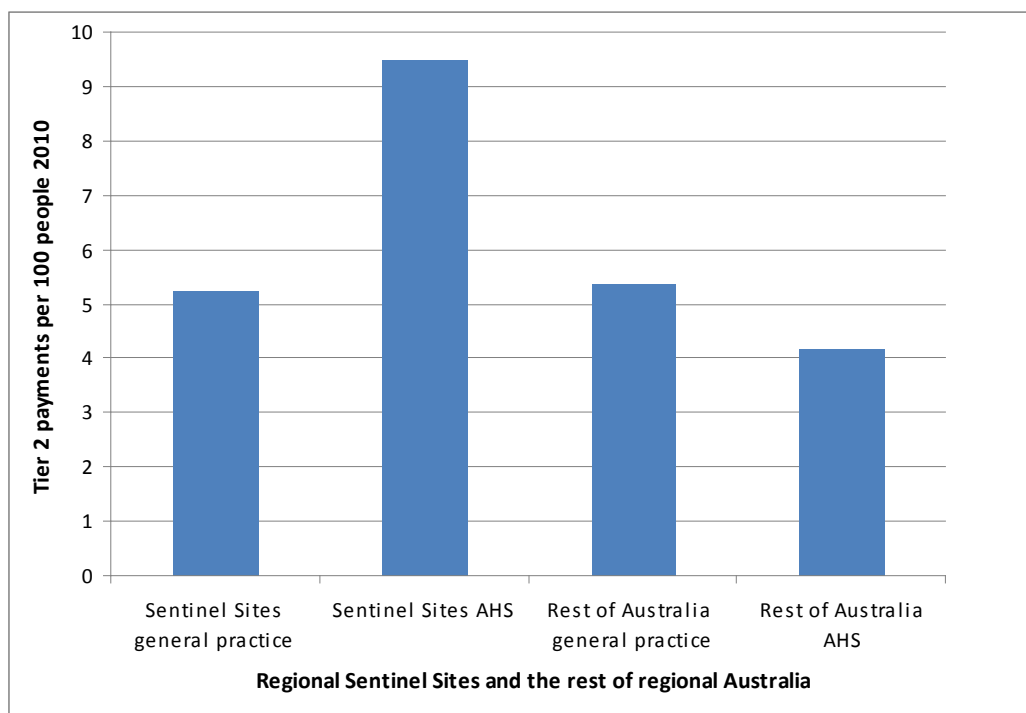

Figure 82: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia

The number of Tier 2 payments received per 100 people was higher in AHSs than in General Practices in regional Sentinel Sites, but the reverse was true in the rest of regional Australia.

In remote areas, the number of Tier 2 payments per 100 people was generally lower than for urban and regional areas. The number of payments was higher amongst AHSs in the rest of Australia and lower in AHSs in Sentinel Sites, compared to General Practices in the rest of Australia and in Sentinel Sites (Figure 83).
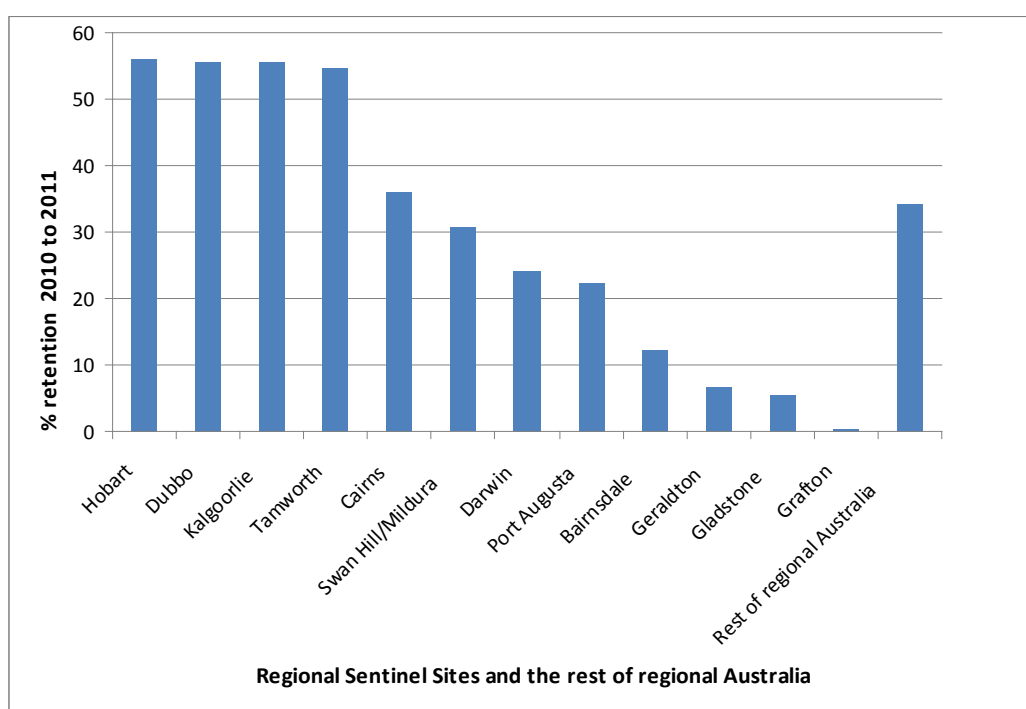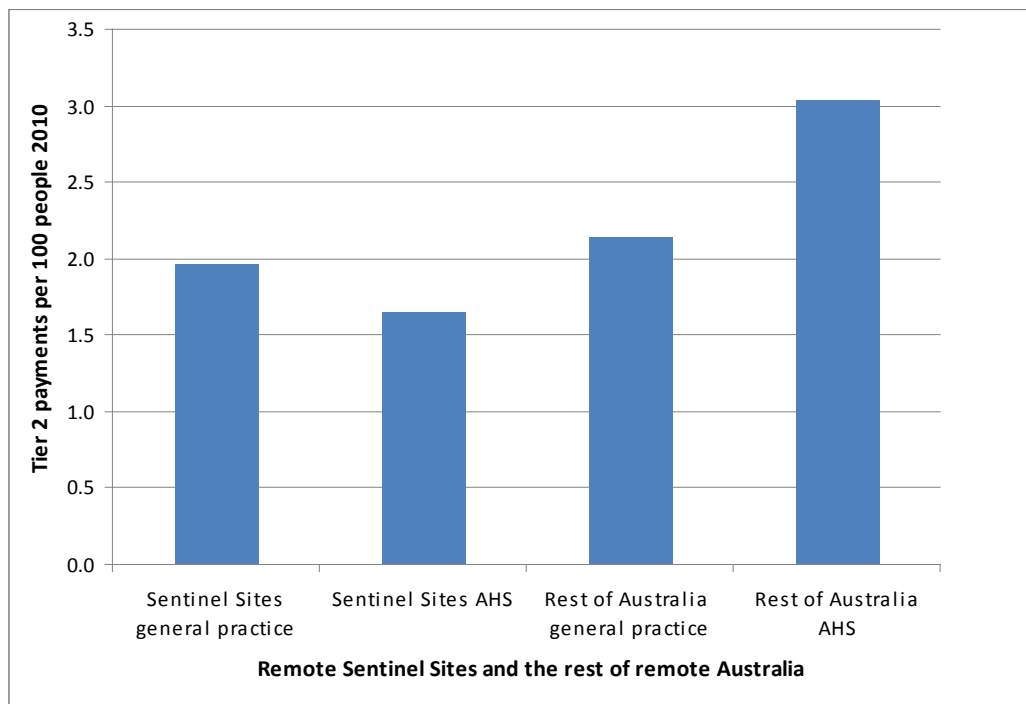
Figure 83: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia

- In urban areas, the number of Tier 2 per payments per 100 Aboriginal and Torres Strait Islander people was higher than the rest of urban Australia in Brisbane South, Canberra and Logan/Woodridge. The number of Tier 2 payments in all other Sentinel Sites was lower than for the rest of Australia (Figure 84).
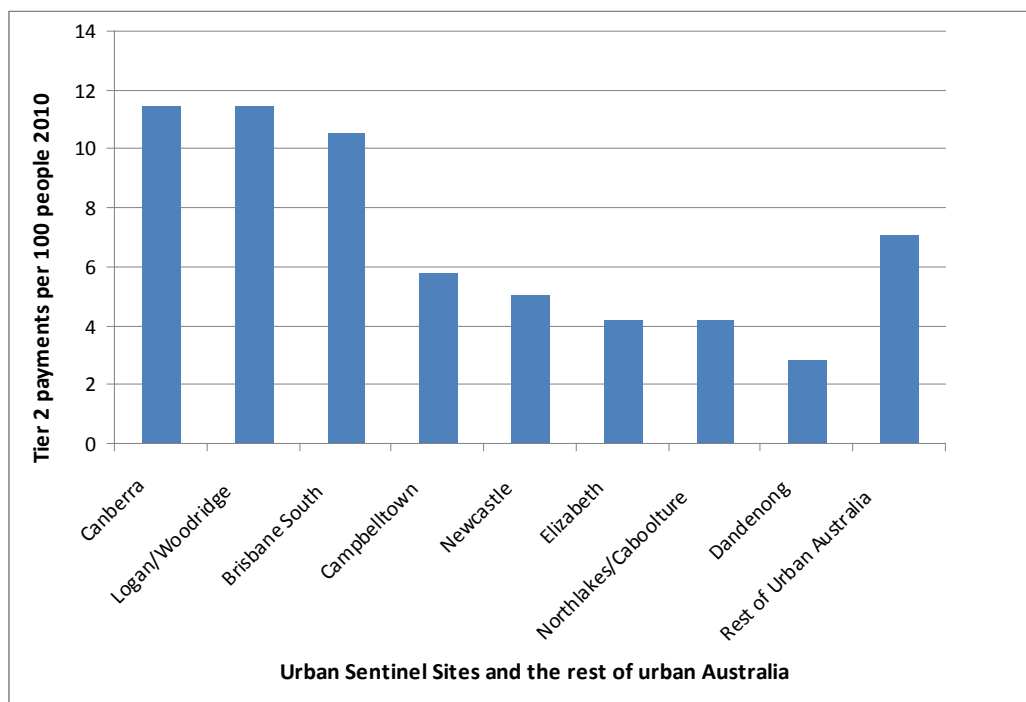
Figure 84: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia

In regional areas, the number of Tier 2 per payments per 100 Aboriginal and Torres Strait Islander people was higher in most Sentinel Sites than in the rest of regional Australia with the exception of Darwin, Gladstone, Hobart, and Tamworth (Figure 85).
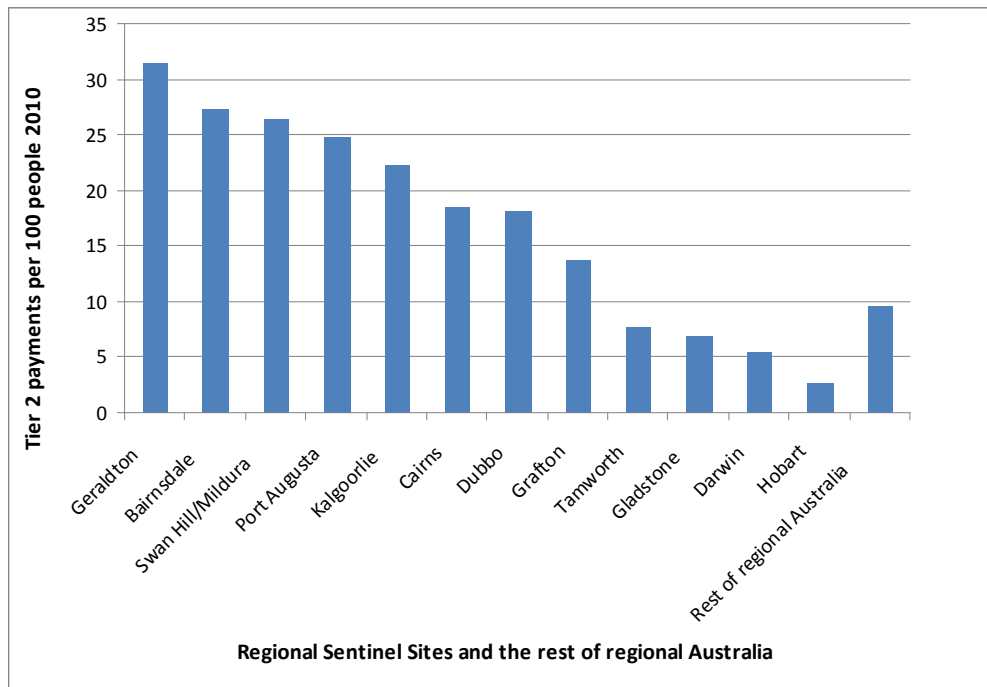
Figure 85: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia

In remote areas, the number of Tier 2 per payments per 100 Aboriginal and Torres Strait Islander people was higher in East Pilbara than in the rest of remote Australia (Figure 86).
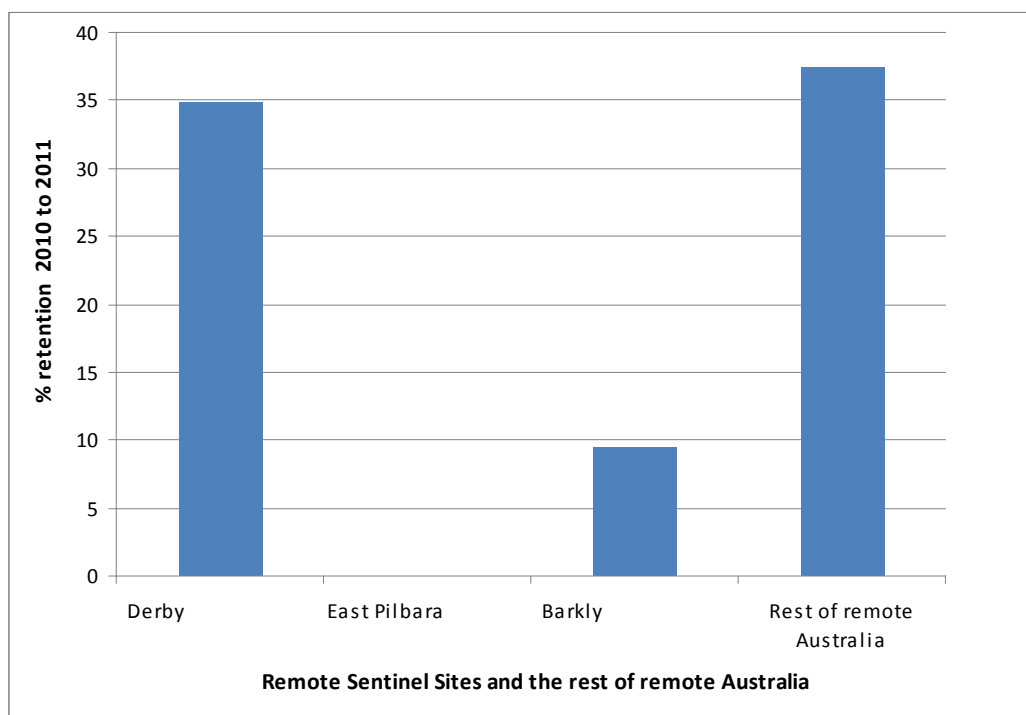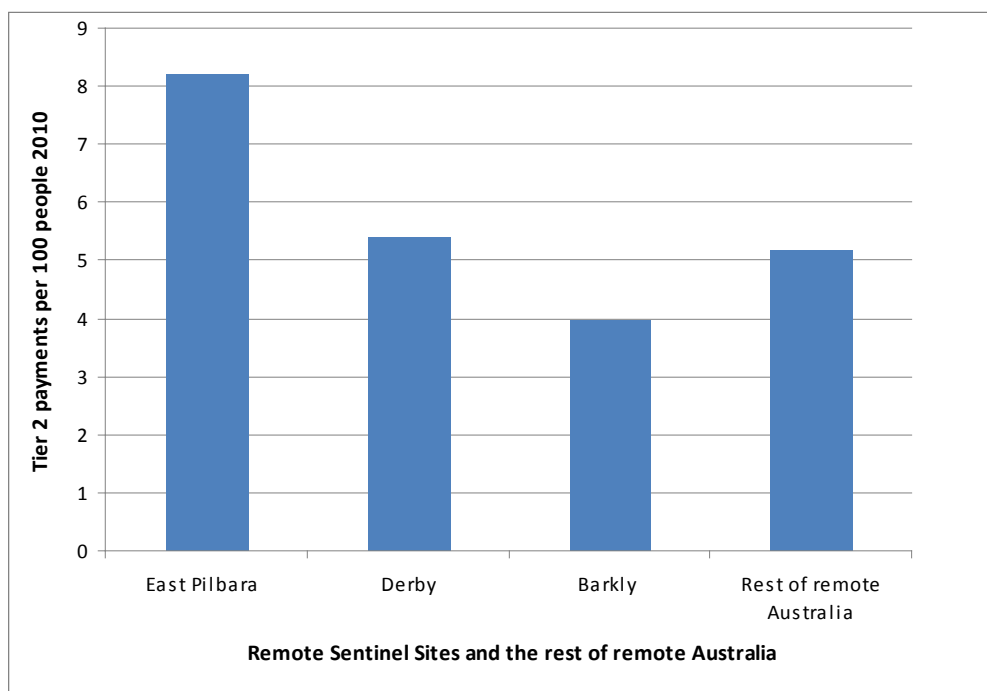

Figure 86: Tier 2 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia

Understanding of requirements to receive the tiered PIP Indigenous Health Incentive Payments

There was an increase from the previous reporting period in the proportion of interviewees who agreed that the Health Services had a clear understanding of what is required to receive the tiered payments from 55% (41/74) previously to 67% (56/83) in this reporting period (see Figure 87).
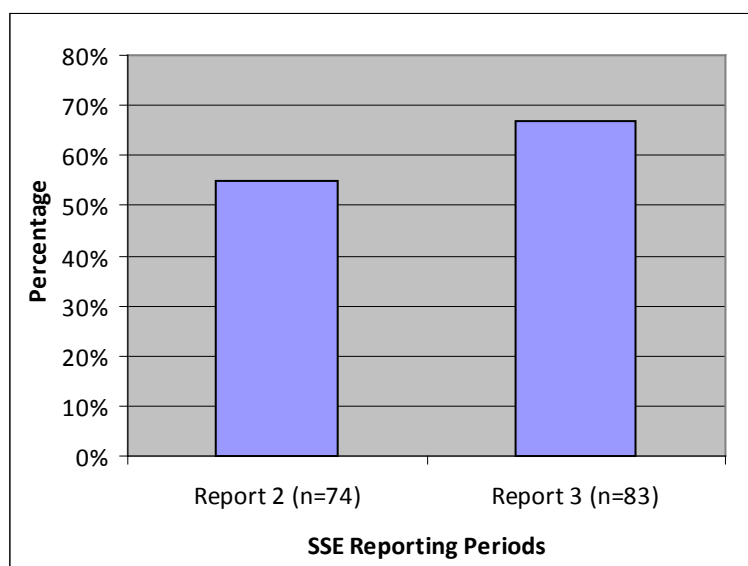
Figure 87: Interviewees' responses to the statement: 'Health Services have a clear understanding what is required to receive tiered payment' (% who strongly or partly agreed), overall by report period

The proportion of interviewees who either strongly or partly agreed with the statement *'Health Services have a clear understanding of what is required to receive the tiered PIP Indigenous Health Incentive payments'* was similar across urban, regional and remote sites. Agreement among interviewees in regional sites increased between reporting periods from 45% (17/38) to 64% (21/33).

There was a notable difference between sectors in clinicians and practice managers perceptions of level of understanding of the tiered PIP Indigenous Health Incentive payments, with 75% (15/20) in Aboriginal Health Services and 54% (14/26) in General Practices strongly or partly agreeing '*Health Services have a clear understanding of what is required to receive the tiered PIP Indigenous Health Incentive payments.*'

The data indicate a need for further effort to increase the understanding of requirements to claim the tiered payments, particularly in General Practices and among clinicians. Practice managers tended to be more aware of requirements to receive the tiered payments. This is not surprising given their role in systems development and in Medicare claiming.

Interviewees indicated that the awareness raising initiatives from DGPs and DoHA have been on signing up patients for the PIP Indigenous Health Incentive, with relatively limited focus on what is required to receive the tiered payments. There appears to be confusion among Health Service staff around what clinical services they are required to deliver, in order to receive a Tier 1 payment and a Tier 2 payment.

The Medicare data shows relatively strong uptake of the Tier 2 payments and low uptake of Tier 1 payments. This is consistent with data obtained from interviews with Health Service staff, who indicate they are continuing with 'business as usual', and that they are not necessarily undertaking the GPMP and/or TCAs that are required for the receipt of a Tier 1

payment. The reasons given for not undertaking activities to receive Tier 1 payment include: Health Service not undertaking reorientation of practice systems; GPMPs and TCAs perceived to be unnecessary paperwork and that care is being delivered in a coordinated fashion already; perceptions that there are a number of people who move between Health Services and who are not necessarily aware, when they 'sign up', that they are 'signing up' for a practice to provide the bulk of their care, and; challenges in recalling patients due to undeveloped recall and reminder systems and registers.

> *'No change in service delivery at practice level … not providing more care. Its business as usual.'* (Interview, SBO)

> *'Under PIP, the health assessments [MBS item] 715 and 5 visits to allied health has been really beneficial. However, doing [MBS items] 721s and 723s[GPMP and TCA] I do not think it increases patients' better outcomes from doing that. It seems to be doing more of the paper work rather than increasing health outcomes. Health Assessments (715) do actually pick up stuff. I will do the 721 and 723 only if I find a patient needed some allied health and physio support, but they do not value add in my everyday General Practice. Health assessments can change the clinical practice and the patients care better than 721 and 723. We do the follow-up on their visits to specialists and coordinated care anyway, so we do not find it necessary to go through all the paper works that is required for the GPMPs and TCAs. At the end of the day when the clinic is busy and I do not see the value I am not going to do it – but that's bad for [Service name] as [we are] missing out PIP incentive [payments] that could benefit our organisation.'* (Interview, GP, AHS)

There were a number of Aboriginal Health Services which, on signing up a patient for the PIP Indigenous Health Incentive, were at the same time undertaking an adult health assessment, billing for a consult and a follow item and trying to get as many services undertaken in that first engagement. This was more focused on general items, not GPMP and TCAs, which generally take more time.

Service provider perspectives on funding available through the PIP Indigenous Health Incentive

About two thirds [69% (20/29)] of clinicians interviewed agreed with the statement 'the new PIP Indigenous Health Incentive enables me to provide better health care to Aboriginal and Torres Strait Islander People with a chronic disease'. This perception was similar across the AHS and General Practice sectors.

As in the previous reporting period, clinician and practice manager interviewees had a positive perception of the funding made available to practices to enable them to offer additional or complementary services. However, there was a difference between the AHS and the General Practice sectors in response to the statement: *'The funding from the PIP Indigenous Health Incentive has enabled Health Services to offer additional and complimentary services that were not there previously'*, with 70% (14/20) of practice managers and clinicians from Aboriginal Health Services agreeing to the statement compared to 35% (9/26) from the General Practice sector (see Table 18).

Table 18: Clinicians' and/or Practice Managers' perceptions of the PIP Indigenous Health Incentive (% who responded partly or strongly agree), overall and by sector

Interview statements	Overall	Aboriginal Health Service	General Practice
The new PIP Indigenous Health Incentive enables me to provide better health care to Aboriginal and Torres Strait Islander people with a chronic disease.	69% (n=29)	69% (n=13)	69% (n=16)
The funding from the PIP Indigenous Health Incentive has enabled Health Services to offer additional and complementary services that were previously not being provided to Aboriginal and Torres Strait Islander people.	50% (n=46)	70% (n=20)	35% (n=26)

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

Discussion on this issue was generally consistent with the previous two reporting periods. There was a general reluctance among interviewees to discuss how they were using the funds obtained through this measure.

Examples of responses on how the funds were being used included:

- employment of an Aboriginal Health Worker (within a mainstream General Practice)

- purchase of a podiatrist chair and equipment such as a point of care testing machine for diabetes care within an Aboriginal Health Service.

Within General Practices and Aboriginal Health Services, the majority of interviewees indicated that the money was absorbed into the overall budget and not necessarily allocated to any specific purpose. In one AHS, the funding was used as a motivator to encourage staff to register patients as the money was put directly back into purchasing equipment for the service.

> *'If you want an immunisation fridge, Ok sign up so many patients. If you want an HbA1c machine, sign up XX [patients]. Bottom line, it is money from the 'feds' to buy the stuff we need or hire the staff we need. Money is ploughed back in, as we are not beholden to shareholders. [We] just brought a podiatry chair with funding and [we are] looking for a podiatrist. Sign up money is a perceived significant resource to the organisation.'* (Interview, GP, AHS)

The use of funding as an incentive for Health Service participation in the PIP Indigenous Health Incentive continued to receive some critical comment from some stakeholder interviewees. The comments were predominately from a small number of mainstream General Practices, who felt that they were already delivering this standard of care prior to the introduction of the ICDP, and that the money was not raising the standard. One clinician based in an AHS strongly felt that the registration payments should be retrospective payments once care had been delivered, to avoid people just signing up patients and not delivering care. *'At the moment it's a bit like McDonalds where you pay up front and hope you can drive through and get your food. It should be like a restaurant, where you sit down and enjoy your food then pay.'* (Interview, GP, AHS)

Vignette – employing an AHW within a General Practice

A regional practice illustrates how PIP funding is being used to offer additional and complimentary services to Aboriginal and Torres Strait Islander patients.

Thirty-five percent 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 client 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 … '.*

Community members' perspectives on the impact of the PIP Indigenous Health Incentive on their care

As for the previous two reporting periods, there were no comments from focus group participants to suggest that they had, or were receiving, additional or enhanced services as a result of signing up for the PIP Indigenous Health Incentive. There was significant confusion about the difference between the PIP Indigenous Health Incentive and the PBS Co-payment measure with participants. The majority of participants assumed that the PIP measure enabled access to the PBS Co-payment measure. There was no mention of care planning.

Cultural awareness training for General Practice staff

About one third (8/26) of clinicians and practice managers in General Practices agreed that the required cultural awareness training had been easy to organise (Figure 88). The majority of clinicians and practice managers indicated that they 'don't know/can't say' or disagreed that it had been easy to organise.
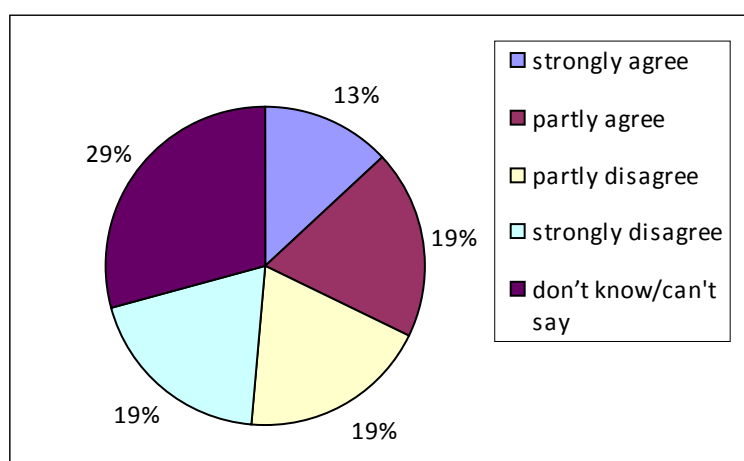
Figure 88: Clinicians' and practice managers' responses to the statement: 'Access to the required cultural awareness training for private General Practice has been easy to organise.' (n=31)

Further to this, only 19% (5/26) agreed that the cultural awareness training resulted in a change in practice. The majority of respondents indicated 'don't know/can't say' as they had not completed the training at the time of the interview.

> *'[We] accessed one developed by 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 just finding the time. I have heard it takes some time and [I'm] just struggling to find the time to do it. I know it is important to do and need to do and will try and do ASAP.'* (Interview, GP, General Practice)

One practice in which staff had completed both the cultural awareness online training and the training provided by the local DGP indicated that there had been a significant change to practice, and the practice now has Aboriginal flags in the surgery and the staff wear Aboriginal flag pins. When asked if displaying these items had made a difference, the GP responded:

> *'We didn't realise the extent it made a difference. Most of our reception staff and practice nurses have done the training now through the Division. We actually had one lady who was out of our area who came down to our practice and had been to other surgeries, but felt really comfortable here and was really quite impressed with the fact that we had done the training. She was an Aboriginal elder. That is how we have realised it is making a difference. She actually wrote to our state manager about it. [She] wrote about having all the services here and feeling comfortable coming in and knowing that they are not going to be treated like they are different. It made her feel welcome.'* (Interview, GP, General Practice)

There was one stakeholder interviewee who indicated that change to practice is unlikely as a result of the short cultural awareness course, and that the greatest gains will be seen in providing cultural awareness as part of GP registrar training.

> *'Not sure if [offering the training] makes a huge change to practice, the change of practice will come with incorporating this into registrar training as compulsory.'* (Interview, SBO)

During the previous reporting period the RACGP had launched the accredited cultural awareness training required as part of the registration of practices for the incentive. Despite the training being available for some months prior to the evaluation visits in the current reporting period, few clinicians or practice managers who were interviewed in Sentinel Sites had met this requirement. A number had commenced the RACGP online training, but had not completed the modules due to lack of time, frustration with the requirement to undertake this training, and/or difficulties with access (e.g. confusion with passwords).

> *'[I] started the cultural awareness training … only got a little way. Got to the last module … a tricky question with one question having two answers. By then I was over it.'* (Interview, practice manager, General Practice)

A number of interviewees expressed concern that the requirements to undertake the cultural awareness training would not be meet, as they believed there was no process to ensure it was being undertaken in a meaningful way.

In this reporting period a number of DGPs indicated that they would be running accredited cultural awareness training that had the potential to replace the online training developed by RACGP.

With the training only recently introduced when the current evaluation cycle commenced, and General Practice staff just starting to embark on the training, it was too early to obtain meaningful data on perceptions of the quality of the training based on the experiences of General Practice staff. Further information on this issue should be available in future reports.

Extended vignette – Tips for building and managing PIP Indigenous Health Incentive registrations

One long established AHS in a regional city has successfully increased patient registrations by motivating and training staff and improving clinical information systems. We have taken the experiences and ideas shared in one interview and shaped them into tips that may be useful for other services and Medicare Australia.

Tips for Health Services:

1.   Enthuse staff. This is about facilitating cheaper or free medications for our patients.

2.   Train and explain rationale to staff. Provided sessions on how to fill in forms. Talk about the benefits for everyone. *'Bottom line is - money from the [incentives tiered payments] … is ploughed back in'*. It can buy better services for patients and better resources for staff.

3.   Initially put a stack of registration forms in every room.

4.   Put a patient 'flow' system in place to reduce the administrative burden on GPs, so forms are filled out before the patient sees the GP and *'the doctor signs off'*.

5.   Downloaded the electronic version of the consent form from Medicare and set the computer to auto fill - *'we should not be paying educated humans to be writing name, age and date of birth'*. For auto fill to work, patient information needs to be in the computer - someone with good IT systems and practice knowledge can set this up. Then you will have no rejections based on bad handwriting or wrong Medicare numbers.

6.   Check patient details at every visit – name, birthdates, Indigenous identity, address, mobile number, Medicare concession card.

7.   No care plan without team care. What's the point of listing problems without having actions? *'[Being] serious about addressing [patients' health] problems [means doing] a team care arrangement too'.*

8.   Think about the availability of resource people from the ICDP. How can you help to maximise the benefits of their work? Be aware of your strengths and needs. *'The DGP person is so thinly spread on the ground I would rather do the right thing by the Aboriginal and Torres Strait Islander community and let her help the non-community controlled health sector practices achieve what they need to do.'*

9.   Ask for advice from the NACCHO affiliate and Medicare, especially for support on how to do the paper work. Let Medicare know if you are getting confusing advice or inconsistent messages. Feedback will help staff improve the quality of support.

Tips for Medicare Australia:

1.   Set up a website where Health Services can log on and see if a patient has been registered somewhere.

2.   Establish a telephone service through which Health Services can check whether a patient is PIP Indigenous Health Incentive registered, had a health check and/or a care plan.

3.   Develop a system to accept PIP Indigenous Health Incentive registrations by email.

4.   Provide retrospective payments, after care has been delivered. This could avoid the risk of services and practices signing up patients and not delivering care.

5.   Provide education on how to automate PIP Indigenous Health Incentive registration forms, so Health Services and General Practices only need to save the scanned signature each patient.

Summary

There is a continuing high level of awareness of the PIP Indigenous Health Incentive among stakeholders, but still with lower levels of awareness in remote sites. Most stakeholders feel their organisations have been well informed of the measure. IHPOs and various communication resources were again identified as contributing to the high level of awareness. The need for continuing communication and information was highlighted once more, particularly as some stakeholders continue to feel poorly informed, and new issues are emerging in relation to re-registration and the need to increase understanding of requirements to claim for tiered payments.

There is a continuing steady increase in General Practices registering for the PIP Indigenous Health Incentive, with substantial scope for further increases. In contrast, AHSs tended to sign on earlier and there has been a levelling off in the number of AHSs registering for the incentive during this reporting period, with relatively little scope for further increases.

Reported barriers to participation in the PIP Indigenous Health Incentive were similar to the previous reporting period, with administrative burden (especially in remote locations) and staff shortages (in remote and regional locations) highlighted as reasons for lack of engagement. Administrative burden tended to be more frequently identified as a barrier for AHSs, probably because of the considerably larger numbers of Aboriginal and Torres Strait Islander clients in these services and the consequent much greater workload involved in registering eligible clients. The comparative high burden indicates a need for proportionally greater support for individual AHSs, relative to individual General Practices, in implementing the PIP Indigenous Health Incentive.

Technical problems with communications in the registration process and patients registering at more than one practice (and lack of systems to overcome this) continue to cause frustration among Health Service staff.

There is evidence that poorly developed clinical information systems, which are not well suited to identification of PIP registered patients, are leading to the development of new stand-alone registers of PIP registered clients. This is leading to further fragmentation of already poorly functioning systems, with potential for consequent further compromise in the functioning of recall and reminder systems. There is also a clear lack of staff capability in the effective use of clinical information systems.

The understanding of community members of what the PIP registration process is about continues to be very limited, and is likely to be a significant barrier to effective implementation of the measure, and specifically to registration of clients. There was no evidence from the community focus groups of a change in practice as a result of the PIP Indigenous Health Incentive.

There continue to be mixed views on how easy it is for services to arrange access to the incentive for their clients, and the extent to which the incentive can enhance the quality of services to clients. Interviewees tended to be more positive in urban sites, and less positive in remote sites than in regional sites. Interviewees in AHSs tended to be more positive than those in General Practice with regard to ease of organising access. Thus, while staff of AHSs tend to

be more concerned about the high administrative work load, they appear to find the process of registration more easy than General Practice staff – most likely because of greater familiarity with the process due to the need to register larger numbers of clients. This finding is consistent with the data on registrations per 100 people being higher in AHSs in Sentinel Sites, compared to General Practices in Sentinel Sites and in the rest of Australia. Interestingly, AHSs in the rest of Australia showed levels of registration per 100 people that were more similar to levels of registration in General Practices. This reflects the greater availability of AHSs in Sentinel Sites than in Australia more widely.

The numbers of registrations per 100 people tended to be generally higher in regional than in urban and remote areas. However, there is wide variation in registrations per 100 people between specific Sentinel Sites in urban, regional and remote locations.

There continues to appear to be a strong focus on registering clients, with relatively limited emphasis on completing the requirements to claim Tier 1, and to a lesser extent Tier 2, payments. The requirement to complete GP Management Plans and/or Team Care Arrangements appears to be the major barrier to achieving the levels of care required for Tier 1 payments. General practices in the rest of Australia tended to claim more Tier 1 payments per 100 people than GPs in Sentinel Sites and AHSs in Sentinel Sites and in the rest of Australia. There were also higher levels of Tier 1 payments in regional and remote locations than in urban locations. However, as for registrations, there is wide variation in Tier 1 payments between specific sites.

In contrast to Tier 1 payments, there were more Tier 2 payments in AHSs in Sentinel Sites than in AHSs in the rest of Australia or General Practices more broadly. The number of Tier 2 payments is about ten times greater than the number of Tier 1 payments. This difference is evident in both AHSs and General Practices. Similar to Tier 1 payments, regional sites had the highest number of Tier 2 payments per 100 people. As for Tier 1 payments, there was wide variation in the number of Tier 2 payments between specific Sentinel Sites, with the widest range occurring between different regional sites.

The wide variation in registrations and Tier 1 and Tier 2 payments indicates that the factors that underpin the variations are more locally specific than can be explained by factors associated with rurality. The reasons for this variation relate to variations between sites, in terms of the barriers identified in this section of the report. The reasons for the variations between sites will be explored further in future evaluation cycles and as more data on progress with registration becomes available, and as the evaluation team are able to facilitate informants to reflect on the reasons for the variations in the data.

Interviewees continued to raise concerns related to identification of PIP registered practices and registration of clients with a single practice. Interviewees also raised concerns regarding re-registration of clients. The administrative data available for this report relates to a period in which it is too early to clearly assess progress with re-registrations, and there still appear to be a predominance of new registrations rather than re-registrations. The early data show that re-registrations are higher in regional and remote sites than in urban sites. However, as for registrations, there is wide variation in numbers of re-registrations between specific sites.

While there is evidence of an increase in the understanding of requirements to receive the tiered payments, and clinicians report that the PIP Indigenous Health Incentive has enabled them to provide better care, there is little evidence of a shift to a more planned or coordinated approach to care in terms of uptake of GP Management Plans or Team Care Arrangements. Service staff were not forthcoming on how funds from the PIP were being used. While there were a few exceptions, most indicated that the funds went into general funds rather than being directed towards funding specific items or initiatives.

Less than one in five interviewees indicated that there had been a change in practice as a result of cultural awareness training. Changes that were reported tended to be symbolic and a demonstration of interest by General Practices in providing care for Aboriginal and Torres Strait Islander people. These symbolic changes were seen to have had an important impact on processes for identification of Aboriginal or Torres Strait Islander status.

14. Supporting Primary Care Providers to Coordinate Chronic Disease Management *(Measure B3 Part B)*

14.1. Description of measure

The Care Coordination and Supplementary Services (CCSS) Program will contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through the following two components:[84]

- Care coordination provided by qualified healthcare workers to Aboriginal and Torres Strait Islander patients with a chronic disease; typically Aboriginal health workers or specialised nurses.[85] Patients must be referred by GPs in General Practices or Aboriginal Health Services participating in the Practice Incentives Program (PIP) Indigenous Health Incentive.

- Supplementary services provided by a flexible pool of funds that can be used to assist patients receiving care coordination under the CCSS Program. The funds can be used to access medical specialist and allied health services that are in accordance with the patient's care plan. The funds may also be used to assist with the cost of local transport to health care appointments.

It is anticipated that this funding will enable an improved patient journey due to enhanced coordination across and within health organisations, and that this enhanced coordination will remove or lessen barriers to meeting the goals of chronic disease care plans.[86]

Funds for the CCSS Program will be managed by the State Based Organisations (SBOs) of the Divisions of General Practice Network. The SBOs may sub-contract Divisions of General Practice or other organisations such as Aboriginal Health Services.[87] The CCSS Program will be implemented progressively through a staged approach and will not be available in all locations in the initial years of the program.[88]

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[84] DoHA, Care Coordination and Supplementary Services Program Guidelines April 2010 [website], (accessed 12 February 2013).
[85] DoHA, Support primary care providers with chronic disease management – factsheet (accessed 10 November 2011).
[86] DoHA, Support primary care providers with chronic disease management – factsheet (accessed 10 November 2011).
[87] DoHA, B3b report, 30 June 2011.
[88] DoHA, Care Coordination and Supplementary Services Program Guidelines April 2010 [website], (accessed 12 February 2013).

14.2. Program logic

Specified in the National Framework the following outputs and early results in relation to measure B3 Part B, and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond:

- There is collaborative development of local CCSS arrangements, strengthening linkages between General Practice, Aboriginal Health Services, Divisions, specialist and allied health.

- Care Coordinators are trained and established in their roles.

- Assistance is provided by the CCSS in line with measure guidelines.

14.3. State of implementation

The CCSS program commenced on 1 June 2010 with funding until June 2012[89]. As reported in the June 2011 report, funding agreements were in place with all 8 State Based Organisations (SBO) fundholders and recruitment of the workforce was under way.

CCSS services had commenced in NSW, Vic, Qld, WA, NT and ACT. Services had not commenced in SA and Tas.

In May 2011, funding was provided to the AGPN to employ a National Care Coordinator to provide national leadership and coordination for the CCSS Program. The position has been filled. The National Care Coordinator will work closely with the AGPN's National Coordinator for the Improving Indigenous Access to Mainstream Primary Care Program (C3).[90]

Table 19 shows the uptake of the CCSS measure by State and Territory. We do not have data on CCSS activity at the Sentinel Site level. CCSS activity varies between states in the number of patients enrolled, the utilisation of the supplementary funding and the numbers of care coordination services provided. The GP referral base is relatively small with between 2-12 GPs (mean of 6) engaged per state at this stage of implementation of the CCSS measure.

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[89] Funding is for 4 years but the agreement only goes to June 2012 as SBOs have no role or funding after that with the change to Medicare Locals. Recently there has been an extension for a further 6 months funding DoHA, B3part B personal communication, 22 November 2011.
[90] DoHA, B3a report, 26 October 2011.

Table 19: State Based Organisation Care Coordination and Supplementary Services Program reporting 1 October 2010 - 30 June 2011

SBO funded	No. of Care Coordination services provided	No. of patients receiving Care Coordination service only	No. of patients receiving both Care Coordination and Supplementary Services	No. of GPs who referred patients	No. and type of Supplementary Services purchased
GP NSW	49	32	4	12	Total 36 19 allied health 1 Respiratory CNC Asthma Education 2 budgeting support, accommodation 13 Respiratory Physician 1 Specialist - Neurologist
GP Victoria	Reporting tool being refined to collect this data	154	0	5	Total 30 15 allied health – 15 local transport
GP Queensland	32	11	0	3	na
WA GP Network	29	24	5	12	1 - Other – taxi voucher
GP Network NT	9	0	9	2	14 allied health
ACT Division of General Practice	75	37	0	6	74 allied health (28 group services included)

Note: na = Not applicable
Source: DoHA, B3a report, 26 October 2011.

In preparation for the Care Coordinator positions the SBOs and some DGPs have developed resources, which are distributed at training workshops and can be accessed on their websites or through membership communications. For example, General Practice NSW have a list of resources and topics such as case study scenarios, models of service delivery, job description templates, patient referral forms and question and answer sheets. [91]

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[91] General Practice NSW [website], (accessed 10 November 2011).

14.4. Findings from the Sentinel Sites

Interviewees were asked to comment on the CCSS measure in case study sites where the Care Coordinators positions were filled. For the period covered by this report, there were Care Coordinators with roles in three case study sites. Two of the three Care Coordinators were interviewed. The third had not commenced at the time of the evaluation visit. Two other Care Coordinators were appointed in geographic areas that included two further case study sites, however they do not work within site boundaries and therefore were not interviewed. SBOs were interviewed in relation to the CCSS measure. The early stage of implementation of the CCSS measure in case study sites, and the subsequent limited number of interviews, means the data presented on implementation at a site level is limited.

Seven community focus groups across four case study sites were asked about their awareness and perceptions of care coordination between service providers and if there had been any change over the past six months.

Development of local care coordination processes

Due to the early stages of implementation at the site level, it is too early to comment with any confidence on the development of local collaborative arrangements for the CCSS program.

Funded organisations are required to submit a detailed work plan to the SBO that outlines how the Care Coordination service will be developed and will operate within the DGP. As reported in the last reporting period, interviewees provided information on how local care coordination processes are being developed within their site. The key points from this discussion were the same as for the previous reporting period:

- considerable time is being spent identifying visiting and existing services and stakeholders in the region to ensure there is no duplication of service

- any Health Services registered with the PIP Indigenous Health Incentive, and which have Aboriginal and Torres Strait Islander patients on a care plan, will refer patients to the care coordinator service if it is considered by GPs that they would benefit from the service

- the existing practice support team at the DGP will play a role in implementing the CCSS, using their established links with General Practices to identify potentially interested General Practices and to inform practices of the CCSS service.

Recruitment to the Care Coordination positions

Table 20 lists the allocation and recruitment status of Care Coordinators as provided by DoHA as at 30 June 2011 and from information gathered at the evaluation visits.

Table 20: Recruitment and retention data for Care Coordinators by Sentinel Site at 30 June 2011

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment /retention Changes since the June 2011 report
Case study sites	Port Augusta	regional	Flinders and Far North Division of General Practice	1.0	1.0	Position filled since previous report
	Campbelltown	urban	Sydney South West GP Link (formerly Macarthur DGP)	1.0	1.0	Position filled
	Logan/ Woodridge	urban	Institute for Urban Indigenous Health	2.5	2.5	Positions filled, not servicing this site[a]
	Brisbane South	urban	Institute for Urban Indigenous Health	2.5	2.5	Positions filled, not servicing this site[a]
	Tamworth	regional	North West Slopes DGP	unknown	unknown	Position filled since previous report[b]
Enhanced tracking sites	Newcastle	urban	GP Access	1.0	1.0	Found to be still recruiting at evaluation visit [c]
	Dubbo	regional	Dubbo Plains DGP	unknown	0	Recruitment commenced[d]
	Swan Hill/Mildura	regional	Mallee Health Care Network (formerly Mallee DGP)	unknown	0	Recruitment commenced[d]
	Elizabeth	urban	Adelaide Northern Division of General Practice	unknown	0	Recruitment commenced[d]
	Derby	remote	Boab Health Services (formerly Kimberly DGP)	unknown	0	Recruitment commenced[d]
Tracking sites	Kalgoorlie	regional	Goldfields Esperance GP Network	0.5	0.5	Position filled
	Canberra	urban	Winnunga Nimmityjah Aboriginal Health Service	1.0	1.0	Position filled
	Geraldton	regional	Mid West General Practice Network	0.8	0.8	Position filled
	Grafton	regional	Mid North Coast	1.0	1.0	Position filled

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment /retention Changes since the June 2011 report
			Division of General Practice			
	Dandenong	urban	Dandenong Casey GP Association	unknown	0	Recruitment commenced[e]

[a] DoHA have reported 2.5 Care Coordinators are placed at the Institute for Urban Indigenous Health in Brisbane. This organisation covers three Sentinel Sites; Brisbane South, Logan/Woodridge and North Lakes/Caboolture. From the evaluation visits it was found that Care Coordinators were at this stage not covering Logan/Woodridge nor Brisbane South as these areas were covered by an existing State Government program. It is uncertain whether North Lakes/Caboolture would be covered by these positions.

[b] Due to the timing of reporting DoHA did not report any allocation or recruitment however, at the time of the evaluation visit it was found that Tamworth had appointed the Care Coordinator commencing in October 2011.

[c] DoHA reported the position as filled but at the evaluation visit it was still being recruited.

[d] Due to the timing of reporting, no allocation data received from DoHA but it was found at the evaluation visit that recruitment had commenced or was planned to commence soon.

[e] Due to the timing of reporting, no allocation data received from DoHA however an SBO interviewee stated the position had been funded in 2010 but they had not been successful in recruiting. They have changed the service delivery model and continue to recruit.

Note: Katherine West and Bairnsdale, both case study sites, had applied for funding but had not heard of the outcome at the evaluation visits.

Full-time Equivalent (FTE).

Position Allocated refers to the FTE allocated by the State Based Organisation. The department does not allocate the number of Care Coordinators, each state has received a flexible pool of funding and allocated positions and recruited Care Coordinators based on local needs assessments.

Source: DoHA, Report on ICDP workforce, 30 June 2011 unless specified by footnotes.

Recruitment- Overall

Fifteen of the twenty-four Sentinel Sites had Care Coordinators allocated; seven urban, seven regional and one remote. Nine of the fifteen sites had recruited to these positions (60%). Three of the urban sites had Aboriginal health organisations as the fundholders (note, one organisation is fundholder for 2 sites). All other sites listed in the table had funds allocated to the DGPs. Five of the sites listed are case study sites. In two of the case study sites (Logan /Woodridge and Brisbane South) the Care Coordinators from the Institute for Urban Indigenous Health, who cover a wide area, had been directed to focus their efforts in other areas as an existing state-based care coordination program covered the Sentinel Sites.

Recruitment - Rurality

Excluding the urban sites of Logan /Woodridge and Brisbane South, another five of the Sentinel Sites were urban and two of those sites had full-time positions recruited.

Seven sites were regional sites, with five of those having positions filled (two had part-time allocations). In the other two sites recruitment had commenced. At the evaluation visit one regional site was found to have applied for a position but had not yet heard if funding had been granted.

One remote Sentinel Site had funding for a Care Coordinator with the position under recruitment. Another remote Sentinel Site was found at the evaluation visits to have applied for a position but had not yet heard if funding had been granted by the fund-holder.

Recruitment - case study sites

Of the five case study sites three sites were urban, and two regional. All Care Coordinator positions were filled but only three sites had relevance for the ICDP for this measure.

In summary, the CCSS implementation is under way with some positions established and others being recruited to. Based on information in the National Evaluation Framework, it appears that recruitment and commencement of service delivery is taking longer than anticipated.

Awareness of the Care Coordinator positions

Half (18/36) of interviewees within the two sites where the care coordination service has been established indicated that they were aware of the Care Coordinator position. Awareness of the position was highest in the Port Augusta site, followed by the Campbelltown site. This is consistent with other information indicating that the Care Coordinator positions covering these areas have active programs. As expected, there is low awareness of Care Coordinator positions in Logan/Woodridge and Brisbane South, as the ICDP funded Care Coordinators, whose work covers the greater Brisbane area, are not working in these two sites.

Geographic coverage

Interviewees did express some concern about the large areas the Care Coordinators are required to cover, and their ability to reach a reasonable proportion of the people in these areas who could benefit from their services. As indicated above, Care Coordinators have been directed to focus their efforts in certain locations. This limits geographic coverage and the locations do not always include the area covered by the Sentinel Sites. Coverage is expected to increase with progressive implementation of this measure over time and with the roll out of increased funding for the program. It will be important to continue to monitor coverage and potential for this measure to provide sufficient coverage to achieve significant population health impact.

Guidelines to assist the development of Care Coordination service and Supplementary Services funding

More than half (9/16) of interviewees strongly or partly agreed with the statement '*The Department of Health and Ageing has clear guidelines available to assist the local care coordination service*.' About one in four interviewees (4/16) partly disagreed. There were mixed views on whether the guidelines developed by DoHA have assisted the development of the CCSS program locally. Some interviewees felt that they were not specific enough. One SBO indicated that they were developing additional, more specific guidelines to supplement the national guidelines at a local DGP level. The state level guidelines are intended to avoid every DGP developing guidelines in addition to the DoHA ones.

> '*While the Commonwealth guidelines for the CCSS program provide an overview of the program requirements, they have been limited in their ability to answer key operation questions. [name SBO] has worked continuously over the past 12 months with the SBO CCSS network to discuss and share knowledge around implementation issues and to determine what is 'in and out' of the program. The program is very complex and requires more specific guidelines, which is why [name of SBO] has developed specific operational guidelines to help Divisions [of General Practice] navigate the program. The SBO network has continued to take key questions back to DoHA and highlights common issues. Without the sharing of this network, each*

> *Division would be left to navigate the program individually and there would be increased duplication of effort and limited consistency nationally.'* (Interview, SBO)

Adequacy of training for the Care Coordinators

Owing to the early stage of implementation of this measure, with only two Care Coordinators recruited in case study sites (and one only recently commenced), the discussion around the adequacy of training provided for Care Coordinators was limited.

The SBOs have been running training for Care Coordinators. One of the two Care Coordinators has accessed the training, and strongly agreed that the training has assisted in equipping them with the skills to fulfil their role. The Care Coordinator had participated in two different training sessions. Firstly, a two day orientation workshop for all Care Coordinators in the state, which allowed for networking and a better understanding of the role. Secondly, through the SBO, Care Coordinators in the state were able to access a two day Self-Management training course [measure B4] offered by Flinders University.

> *'The self-management training was really, really good. It is a little time consuming to put it into place when I am seeing the patients, there are a lot of tools. To get my certificate I had to pick two of our patients to do the care plan with them. The patients found it quite good, one of the patients (a lady) said 'I wish my doctor could do this more often' – she found it very worthwhile as it is the patient setting their own goals, instead of the Doctor, makes it their own and they are more willing to look after their own health.'* (Interview, Care Coordinator)

Feedback from the SBO on the training delivered to the Care Coordinators through Flinders University was positive:

> *'The facilitators were excellent, it made the penny drop for a lot of Care Coordinators about the patient centred approach to practice. This will become another part of the toolkit for them to be able to assist patients. [The facilitators] worked with the Care Coordinators to be able to develop realistic care plans which were patient driven. It was well delivered and the presenters were founded in practice themselves; a physiotherapist, community nurse and a practice nurse background. Very credible presenters.'* (Interview, SBO)

Referrals to the Care Coordination program

This program was in early stages of implementation in the case study sites where positions had been filled. Both of the Care Coordinators interviewed indicated that uptake has been slow and that most GPs in their area were not referring to the service. The program data at a state level supplied to DoHA by the SBOs also shows that referrals from GPs are, at this stage, low (see Table 20). In both sites where there were Care Coordinators working, referrals are only being accepted from a PIP Indigenous Health Incentive accredited practice, with patients known to have an established chronic disease and a GP Management Plan (GPMP)and /or Team Care Arrangement (TCA). One Care Coordinator indicated that she is spending significant amounts of time following up with practices that have referred patients, to ensure the patients have GPMPs and/or TCAs and in order to determine what services are required.

Three of the eight clinicians who were asked about the care coordination service, in sites that had a Care Coordinator, said that they were referring to the service.

A number of interviewees indicated that a barrier to access of the CCSS program for Aboriginal and Torres Strait Islander community was the requirement to only have access to the CCSS if referred by a PIP Indigenous Health Incentive practice and with a GPMP and a TCA.

Interviewees indicated that there will need to be a strong prioritisation of patients who are able to access the care coordination service *'Will this be the best spend for this patient and, importantly, is this patient ready for change?'* In one site they have developed their own subset of eligibility criteria. It includes additional criteria to try to establish whether a patient is ready for change. '*[We] don't want to have patients who are so far down the disease spectrum they will not really benefit. This requires a lot of work …to ensure only appropriate referrals [are made] and not just any Aboriginal patient.'* (Interviewee)

One AHS indicated that they do not need to access the services of the care coordination or supplementary services funding. The Care Coordinator had been in contact to offer services.

> *'We do not really require to access the ICDP funded care coordination services. [AHS service name] has got existing resources.'* (Interview, GP, AHS)

Vignette – Working with GPs

A Care Coordinator in an urban DGP is working collaboratively with a range of providers and services to improve referral mechanisms for patients. The service has been established to work with, rather than duplicate, existing state funded care coordination service, a neighbouring commonwealth funded brokerage service and practice support teams based with the DGP.

The Care Coordinator 's initial focus was informing GPs, working in partnership with the Practice Support Officers at the DGP to visit practices and educate doctors about the program. Resource packs were distributed with information about the ICDP initiative and resources to help identify patients. *'It was very challenging … trying to educate [GPs about] what CtG is, particularly when … [many were] not understanding Aboriginal Health… it has been hard for them to refer patients to me, as … it is all very new to them.'*

In the past few months referrals have been increasing, but often without a completed care plan (an essential criterion). *'Most of the time I am ringing doctors trying to get patients' care plans.'*

Nevertheless, GPs are completing more care plans. The Care Coordinator position has provided a resource person to work within practices to assist with care plan development.

Care coordination work has been particularly successful in enabling more patients in the area to access specialist services; this was previously a problem due to specialists not bulk-billing. *'Having the funding is … getting this program moving. That is the [main] reason why [GPs] are referring patients on to me – there is funding there to help their patients get to services, make it more accessible for them … through a private service, they won't wait as long.'*

The program manager at the SBO attributed one aspect of the success to the Care Coordinator being a former practice nurse with 'excellent understanding of the practice environment' – able to engage with practice staff, to implement a program embedded in regular practice and gain the confidence of existing practice nurses who are key contact people for a care coordination service. These factors, he said, are in addition to a funding framework that allows the extra time needed with patients, and integration of the program with the existing funded program within the DGP.

Awareness of Supplementary Services funding

When clinicians were asked if they are aware of the supplementary services funding pool, only clinicians based in the Campbelltown site responded positively (five out of six clinicians interviewed in this site). In no other sites did clinicians express any awareness of this funding to support patients.

Use of Supplementary Services funding

In response to the statement '*Supplementary Service funding has enabled patients to access services required through the private sector'* most respondents [73% (16/22)] indicated that they 'don't know/can't say'. The reason given for this response was that they were not accessing the funding.

It was highlighted that each site needed to develop and implement localised decision processes for allocation of the Supplementary Services funding, particularly about who gets priority access. It is expected that these processes will take some time to be determined as the care coordination function becomes established. In the one site where the Care Coordinator had been in the position for a number of months they were still not clear on how to use the Supplementary Services funds. The managers in this site wanted to ensure strong guidelines were in place before using the Supplementary Services funding and were concerned about managing community expectations.

> *'There has been concern over how … you manage community expectation when some get something and others don't. This is where these local decision support guidelines are essential. It's a challenge as it is a new pocket of money in the DGP and some are having some challenges prioritising pools. Some DGPs are saying it is just too hard and will only use in very certain circumstances. The guidelines say it has to be not accessible through normal channels. It is a capped amount of funding. Focus has to be 'is this assisting the patient to better self-manage their chronic disease?' Some patients may be further down the track in disease progression and [we] need to make a call where better to spend the money.'* (Interview, SBO)

In one site the Care Coordinator indicated that they were currently using the funding primarily to pay for patient access to private specialists to avoid long waiting times. This patient access to private specialists was seen to be the reason GPs were referring (albeit infrequently) to the care coordination service.

> *'That is the [main] reason why doctors are referring patients on to me – there is funding there to help their patients get to services, make it more accessible for them, especially with the public sector, there is always a longer wait. If you go through a private service, they won't wait as long – patients can see a specialist that is more timely.'* (Interview, Care Coordinator)

The AHS in this site indicated that they had been encouraged to make use of the funding under supplementary services, but they felt that the funding was a small amount and that they had in-house capabilities as they have visiting allied health professionals and specialists.

> *'There was not really enough funding available under the ICDP care coordination - can be consumed very easily by only about 20 patients. The funding available through the care coordination was not adequate - probably enough for some allied health service, but [AHS service name] already have in-house allied health services there, [so] it was not required to access Care Coordination or Supplementary Service.'* (Interview, AHS)

Linkages with other ICDP funded positions

Within the work plans/funding submissions that DGPs are required to submit to the SBOs as the fundholders, DGPs are required to document how they will be working with the other ICDP funded positions in the area. It is seen to be essential that they describe how they plan to establish linkages with the existing and proposed ICDP workforce.

It appears that there may be some changes to the role of Outreach Workers as the Care Coordinators become established in their roles. One SBO has been seeking applications from DGPs which demonstrate linkages between the ICDP funded programs, with a view to refining roles based on how positions work together.

> *'We are actively encouraging funding applications to demonstrate how you will be actively integrating into existing CTG team. The Care Coordinators need a support team and OWs well placed for this. Currently the OWs are predominately community development type workers and they will need to become more clinical, in some respects, if they are going to be able to support the Care Coordinator. The role will hopefully see them assisting Care Coordinators to get patients to specialist appointments, to get medications and to allied health appointments for example. During this time spent with the patient there is a real opportunity [for OWs] to be able to reinforce key messages and in fact to identify issues. This will often require more training.'* (Interview, SBO)

The original intention was that the Outreach Workers were to be entry level workers. There has been concern among DGPs about entry level people being able to provide accurate health messages and potentially giving wrong advice to clients, and about the legal and social ramifications of this. The DGPs want people with established skills and are interested in employing people with clinical skills in the future, thus shifting the OW role from a community development role to a more clinical role as the Care Coordinators join the teams.

As SBOs have workshops with all ICDP workers (IHPO, OW and CCSS), discussions about the role of OWs in supporting the Care Coordinators are creating some expectations that the OW workers in DGPs will be able to broaden their role to support Care Coordinators. To meet this expectation, many existing OWs will require significant up skilling.

In one case study site the care coordination service had yet to be implemented because the SBO had concerns about how the DGP was using the ICDP workers already deployed in this site. There was concern that the IHPO was focusing too much on community engagement and not doing enough work with mainstream General Practices.

> *'It is about the Division [of General Practice] understanding the program guidelines and what they have to actually do and not using the staff to do other things. There are also concerns about what the IHPO does and this then has filtered down to concerns about the care coordination service. The care coordination service relies on the platform that the IHPO and OW do in terms of signing up General Practice and the letting the Aboriginal community know about the PIP.'* (Interview, SBO)

The SBO has been working with the DGP to address these concerns and the CCSS funding is expected to be released shortly.

Partnerships and linkages with existing programs

Interviewees in one urban site drew attention to an existing Aboriginal and Torres Strait Islander care coordination service based in a neighbouring suburb, to which patients can be

referred. This service was described as providing a brokerage service that assists patients to access allied health services, including assistance with organising finances to access specialist care. It will be important for new care coordination services to complement, rather than duplicate, existing services.

Almost half (6/14) of the respondents either strongly or partly agreed with the statement, 'partnership and linkages have been developed with local Health Services to improve client access to services required to manage their condition.'

In one site the care coordination service has spent significant time integrating into existing state and commonwealth funded programs to avoid duplication. The SBO in one state has required applicants to indicate how they will work with existing state health funded programs. The Care Coordinator in this site felt well supported coming into an existing care coordination program, as the service delivery model was somewhat established and peer support was available.

Community perceptions of Care Coordination

Despite the commencement of a care coordination service in two sites, the community focus groups did not note any awareness of the new position. There was generally minimal awareness of what care coordination is.

Administration duplication and confusion

The eligibility guidelines state that other avenues need to be exhausted before utilising Supplementary Services funds. This has caused confusion as to what other avenues may be available, and concern about the long waiting times in some existing avenues. An interviewee in one SBO raised concern about the variety of funding sources, including the Supplementary Services funding, and suggested:

> ' … one big funding pool for all of this for the whole state and people just tap into this as need be. At the moment there are separate pockets of money everywhere; a bit in the Division [of General Practice], a bit in Aboriginal Health Services and some with state Health. …every one of these bodies, too, has a whole administering fund and system. Apply to one big funding pool [in the] state and just acquit to a central body.' (Interview, SBO)

Supplementary Service funding and MSOAP-ICD /USOAP interaction

In one state the SBO and the workforce agency expressed concern that the supplementary service and USOAP/MSOAP-ICD measure are two ICDP measures working in competition, with potential to have a negative impact on each other.

The SBO sees the potential to 'top up some of the funding from Supplementary Services to MSOAP-ICD or USOAP service, to maybe attract someone, if … a location is having difficulty recruiting to the specialist position.' The workforce agency is concerned that this situation would create a 'bidding war' for specialists.

The SBO feels that the USOAP / MSOAP-ICD model may not be the best model, and believes that Supplementary Services funding to top up gap payments for local specialist services is a better model.

> 'The limited access to bulkbilling 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.'*

The workforce agency felt strongly that the Care Coordination and Supplementary Services funding was having a negative impact on the USOAP and MSOAP-ICD program. It viewed the CCSS funding as competing with the aims of the specialist / multidisciplinary outreach measure.

> *'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.'*

> *'The bucket of allocation of Supplementary Services funding to Divisions [of General Practice] seems to be a lot.'*

> *'This SS 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.'*

The workforce agency and SBO have been trying to work on this issue together, but both agencies feel that the problem stems from programs being run out of different parts of DoHA.

Summary

There is some evidence of progress with implementation in a limited number of sites. There is also evidence of efforts to ensure that the Care Coordinator positions are complementing, and coordinated with, positions with similar roles funded through other sources.

There is some evidence that the Care Coordinator positions will have limited population coverage. Within Sentinel Sites, the Care Coordinator positions are generally based within DGPs and are expected to cover the whole Division region. Care Coordinators are being directed to work in specific locations where need is seen to be greatest. Data provided by SBOs on care coordination activity across the country show that less than 260 patients had received care coordination services up to the end of June 2011, and that about 150 Supplementary Services had been purchased in total.

There is early evidence that the uptake of the Supplementary Services funding is limited, and that confusion exists about how to use the funding and how to dispense it equitably.

Generally, the program roll-out is designed to accept referrals to Care Coordinators only from PIP Indigenous Health Incentive registered patients who have a care plan. In theory, this enables the Care Coordinator to be listed as a provider on the team care arrangement and to provide feedback to the GP through the TCA feedback process. In the one site where the service has been accepting referrals, the Care Coordinator was finding it challenging to have patients referred with the appropriate care planning documents and processes in place. This may be an emerging issue to flag, especially given the exceptionally low rates of Tier 1

payments being issued nationally.[92] There is emerging evidence that Aboriginal and Torres Strait Islander patients are being registered for the incentive but that care plans are not necessarily being completed to trigger a Tier 1 payment. In future evaluation reports, we will explore whether the requirement to have only PIP registered patients referred to Care Coordinators is a barrier to patient access.

It is encouraging to see the synergies across measures, for example, the integration of IHPO and OW roles and the use of the self-management training course, funded under measure B4, to train Care Coordinators. This linkage between the CCSS Program and the B4 measure was not an intentional strategic direction from DoHA, rather a recognition of the possible synergies at the SBO level. However, there are some emerging issues in regard to tensions between the philosophy of the USOAP/MSOAP-ICD and that of Supplementary Services.

The way this measure has been rolled out is fundamentally different to other measures. Organisations are required to apply to SBOs for the funding and to demonstrate how they will integrate the funding into service delivery models. While this has delayed the roll out of measure B3 part B funding at a site level, there is some evidence that it has allowed for extensive planning to be undertaken.

The SBOs provide a support structure and function for Care Coordinators at a state level. Interviews suggest that this has been beneficial in linking not only Care Coordinators, but also other ICDP funded workers. There is a possibility that the establishment of Medicare Locals will result in the abolition of SBOs. Should this be the case, it will be important to ensure there is a mechanism for ongoing support and linking of Care Coordinators at the state and territory level.

The SSE will continue to monitor experiences with implementation of the measure within the Sentinel Sites.

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[92] DoHA reporting - In 2010, 31 000 patients were registered for the PIP Indigenous Health Incentive and of those, 1 382 (4%) triggered a Tier 1 payment and 24 796 (80%) triggered a Tier 2 payment.

15. Helping Indigenous People Self-Manage Their Risk of Chronic Disease (*Measure B4*)

It was agreed with DoHA that due to limited implementation within Sentinel Sites this measure would not be evaluated during this reporting period.

15.1. Description of measure

Accredited chronic disease self-management training is to be provided to up to 400 health professionals. Health professionals who receive the training are expected to be existing employees, such as Aboriginal Health Workers and practice nurses at Aboriginal Health Services and Divisions of General Practice.[93]

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[93] DoHA, Improving Indigenous participation in health care through chronic disease self-management – Fact sheet [website], (accessed 29 November 2011).

16. Increasing Access to Specialists and Multidisciplinary Team Care (*Measure B5 part A*)

16.1. Description of measure

This measure provides for the introduction of an Urban Specialist Outreach Assistance Program (USOAP) that will support outreach services focusing on chronic disease management in major cities and inner regional areas.[94]

It is to be implemented in a staged approach with the program to be initiated in a small number of sites in the first two years (2009-2011) and progressively established more widely in the following years 2011-2013.[95]

16.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure B5 Part A, and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- Effective fund holding arrangements in place

- Potential host organisations informed

- Medical specialists identified

- Specialists demonstrate cultural awareness

- Increased specialist services available

Expected early results for years 2-4:

- Indigenous Australians utilise and value services

- Increased number of specialists

Expected medium term results for years 4+:

- Access to a wider range of on-going specialist care

- Care coordination is improved

16.3. State of implementation

The following information was provided by DoHA in September 2011 on the state of implementation of measure B5 part A at a national level (relevant to the SSE):[96]

- USOAP services are currently in operation in NSW, Vic, WA and Qld. Implementation of USOAP services in NSW, Qld and Vic occurred according to timeframes contained in the program plans. Implementation of services in WA were delayed due to recruitment,

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[94] As identified by the Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA) 1 and 2
[95] USOAP Program Funding Guidelines [website], (accessed 19 November 2011).
[96] DoHA, B5A report, 6 September 2011.

training and orientation processes taking longer than anticipated, and the competing priorities with the transition to Medicare Locals.

- There has been some variation from the specialties and/or service sites identified in the implementation plans due to workforce availability.

- Stakeholders on the Program Advisory Committee in each state include representatives from Aboriginal and Torres Strait Islander health representative bodies such as the NACCHO Affiliates, state/territory health departments, and medical specialist, General Practice and consumer organisations. The Program Advisory Committee is required to liaise closely with the Indigenous Health Partnership Forums in each state, providing further opportunities for communication with stakeholders. Updates on USOAP progress are also provided via the regular ICDP Newsletters.

16.4. Findings from Sentinel Sites

Notes on collection and analysis of data

Interviewees were asked about the USOAP measure in the three urban case study sites of Brisbane South, Campbelltown and Logan/Woodridge. There are no USOAP services being funded specifically within the boundaries of the Brisbane South Sentinel Site, however there are funded USOAP services in neighbouring suburbs. Due to the early stages of implementation there has, to date, been limited activity at the local site level, and there was consequently minimal information provided by interviewees at the local site level. Fundholder organisations in Qld and NSW were interviewed during this reporting period.

Focus group discussions covered perceptions of access to medical specialists, the cultural appropriateness of specialist care and perceptions of change since the previous reporting period. Given that this measure is focused on urban areas, the findings reported here are based on six community focus groups held in three urban case study sites. The generalisability of the findings presented is therefore limited. It should also be noted that comments reflect a situation where implementation of USOAP is in early stages.

USOAP services in Sentinel Sites

Table 21 shows USOAP activity in seven of the thirteen eligible Sentinel Sites. Three of the sites are case study sites. Data were sourced from DoHA reporting and through interviews.

The data received from DoHA was for Newcastle, Dandenong and Grafton. Grafton was the only service with service activity statistics, as this was the only site in which the outreach services had commenced prior to the submission of the first progress report (the period to 28 February 2011).[97] Interestingly, Grafton receives USOAP and MSOAP-ICD funding for different health professionals.

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[97] DoHA, B5A report, 6 September 2011.

Table 21: USOAP activity by Sentinel Site

Site type	Site	Host Organisation	Specialty	Number of services/ visits	Number of patients	Changes since the June 2011 report and as found at evaluation visits
Case study sites	Logan/ Woodridge	Aboriginal and Torres Strait Islander Community Health Services	Dermatologist	2 per month	na	Dermatologist provided two services already will be visiting monthly [a]
			Cardiologist	na	0	Cardiologist booked to do service orientation September 2011. [a]
			Ophthalmo-logist	na	0	Ophthalmologist booked to do service orientation September 2011. [a]
			Endocrinologist	na	0	Endocrinologist, orientated and ready to start monthly visits in November 2011 [a,b]
	Brisbane South	Aboriginal and Torres Strait Islander Community Health Services, Woolloongabba [c]	Dermatologist	nr	nr	Dermatologist commenced and will do monthly service. [a]
			Respiratory physician	nr	nr	Respiratory physician commenced and will do monthly service. [a]
			Cardiologist	nr	nr	Cardiologist was undertaking orientation in September 2011. [a]
	Campbelltown	Tharawal Aboriginal Medical Service	Orthopaedics	nr	nr	Five different services identified and funding available. Only one of these five services is operating. [b]
Enhanced tracking sites	Newcastle	Awabakal Newcastle Aboriginal Cooperative Ltd	Physician – Geriatrics	nr	nr	na
			Physician – General	nr	nr	na
Tracking sites	Dandenong	Dandenong and District Aboriginal Cooperative	Psychiatry	nr	nr	na
	Gladstone	nr	Ophthalmo-logist	na	na	Orientation was scheduled in September 2011, commencing monthly visits [a]
	Grafton	Bulgarr Ngaru Medical Aboriginal Corporation	Physician - Cardiology	nr	nr	na
			Physician – Endocrinology	4	28	na

[a] General Practice Queensland, personal communication, 5 September 2011.

[b] Evaluation visit update.

[c] Services will be provided outside the boundary but in a nearby suburb. Brisbane South residents may be attending those clinics.

Note:

nr– Not reported, not established in time for DoHA progress report.

na-not applicable.

Source: DoHA, B5A report, 6 September 2011 unless otherwise indicated in footnotes.

Awareness of USOAP specialists

Half (10/20) of the relevant interviewees in the urban case study sites indicated awareness of USOAP services.

Referrals to specialist services

Fundholders in both NSW and Qld indicated that generally the feedback they receive is that there are good referral processes being established between the GPs and the USOAP specialists. They indicated that there were a number of challenges emerging, particularly in changing the established referral practices of GPs in urban areas and despite some potential advantages of the new arrangements under USOAP. One clinician indicated that substantial work had been put into building relationships with specialists and establishing referral processes, and that he did not anticipate changing current arrangements as a result of the USOAP coming on stream.

Fundholders reported a perception among some stakeholders that there is no shortage of specialists in urban areas, and that the focus should be on getting patients to specialists in existing facilities.

> *'One of the challenges with this program is dealing with the general established model of referral out rather than referral in. GPs generally have a fixed mindset on what specialist they will use. In urban areas there is no shortage of people to refer to. There are established pathways already and now we are asking GPs to think about different ways. There is no supply issue rather it should be about improving access to existing specialists.'* (Interview, Workforce Agency)

Fundholders indicated that time has been spent by Health Services promoting the specialist services, and that it is up to the host organisation to encourage doctors to refer patients to the new specialist service.

Care coordination

Fundholders highlighted the fact that it is not enough to have referrals being made, and that there is also a requirement for systems to ensure patients attend specialist appointments. It was pointed out that having the specialist located in the Aboriginal Health Service does not necessarily guarantee attendance.

> *'Recall and reminders are needed and if the Health Service is not doing this, the specialist can sit there with minimal patients. There needs to be a good model where patient referred, patient booked in and reminded of the appointment.'* (Interview, Workforce Agency)

One clinician at a Sentinel Site indicated that patient attendance was a challenge. Lack of attendance at appointments may be due to lack of care coordination.

> *'Another challenge is clients not turning up. The specialist was here but no one came. The receptionist phoned the clients the day before and no one answered, it was pension day. It's hard to get them to come in on pension day.'* (Interview, GP, AHS)

In order to achieve good coordination of care, it is viewed as important by the fundholders for USOAP funded Health Services to have strong links with the other ICDP funded positions. One fundholder indicated that they are actively looking for applications from Health Services that demonstrate linkages with existing ICDP workers in the DGP, such as Outreach Workers and Care Coordinators. It was recognised that the requirement may present challenges, because Outreach Workers and the Care Coordinators are generally based in the DGPs, while the USOAP specialist services are generally based in Aboriginal Health Services.

> *'Everyone not necessarily communicating - need to ensure strong links to the Care Coordination and Outreach Workers but they are based in the Division of GP and may not necessarily be working with Aboriginal Health Service. In order to make this work, need a team approach. Can't see the specialist service in isolation … not just a specialist … think about the team.'* (Interview, Workforce Agency)

Cultural awareness training

The funding guidelines specify that the USOAP specialist must undertake cultural awareness training and demonstrate cultural competency, and that the fund holder is responsible for organising or providing access to, and verifying completion of this training.

One fundholder indicated they had established good networks and providers to deliver cultural awareness training and were offering the training as group sessions, or as one on one sessions, as required. Other strategies being employed were:

- Orientation visits, where the specialists meet the staff at Aboriginal Health Services, and both parties have opportunities to establish expectations. The visits are also used as an opportunity to assess the 'cultural appropriateness of the provider' and enable the requirements for booking of patients and equipment to be discussed.

- Another strategy used is 'word of mouth' when recruiting specialists, targeting those specialists who are known to behave and communicate in culturally appropriate ways.

The demonstration of cultural competency was viewed by one fundholder *as '…the way they communicate, engage, often known to community as using existing providers [with] excellent interpersonal skills, how receptive they are to working in the way the service works.'* (Interview, Workforce Agency)

One fundholder indicated that it was able to provide the generic cultural awareness training required, but would like the training to include an introduction to the local situation. The fundholder indicated that it had been engaging with both the AHSs and DGPs to provide localised input to cultural awareness training and that the support provided was not always satisfactory. The DGPs don't often view it as their role to provide locally relevant cultural awareness training and the AHSs are, at times, perceived to be delivering sessions that are inadequately planned and lack useful content.

> *'Some services, including Aboriginal Health Services are just ticking the box and saying 'yes' we have done cultural awareness and in reality they have just had a cup of tea. It needs to be systematic and planned. We have discovered that you can't assume it has been done thoroughly or at all for that matter when they just have to tick a box. May tick the box and say 'yes done' a cuppa tea with DGP doesn't cut it.*

> *Get much more systematic and not assume anything on the part of DGP that they will do that.'* (Interview, Workforce Agency)

The fundholder suggested there was need for a program that covered issues such as how to work in an AHS, and that *'the whole issue of Aboriginal people not being compliant with taking medications needs to be discussed with specialists. This is not like a normal clinic where people come in and do as they are required for their health.'*

Fundholders also pointed to the need to establish clear expectations of cultural awareness training from the specialist and host organisation from the outset.

Consultative service only viewed as a limitation

A number of interviewees from fundholders, and also from a state/territory NACCHO affiliate, expressed concern that the funding for the USOAP was for a bulk-billed consultative service only, and was therefore 'funding only one part of the pie' because it is not necessary for the provider to bulk-bill surgical procedures that may be required as a follow-up to the consultation. This issue was raised more strongly for USOAP services than for MSOAP-ICD, possibly because the specialties covered under USOAP (such as Ear Nose and Throat, and Ophthalmology) often require follow-up surgical intervention. There was no indication of any one type of specialty being of more concern than others. Interviewees indicated that patients and specialists were frustrated by this. Most people are already on public waiting lists for surgery, which are often perceived to be long.

> *'[It's] not enough to just have the service in a Health Service where [people] feel comfortable. These people [attending the specialist] are generally … a long way down the track with a chronic disease and a high proportion need treatment and intervention. This expectation is from both the specialist and the patient that they will get treatment. Specialists are frustrated by this funding model of one piece of the pie. Some have said it is half baked.'* (Interview, Workforce Agency)

> *'The funding assumes specialists will bulk-bill for the consultation but not for the surgery often required. The public wait lists are beyond imaginable. We are using private specialists and to try and get private specialist to bulk-bill surgery too, not just consult, is not working. This has been a clear gap in the scoping of this service. Need a service that provides more than just consultation. Most people are already on all the wait lists for public [surgery] and this service ends up just providing more consultation but not surgery. Funding has only been provided for one piece of the service. People need follow-up not just consultation.'* (Interview, Workforce Agency)

An interviewee from a NACCHO affiliate described how a specialist might refer [a patient] to an allied health provider, who may indicate that the patient requires products or equipment, such as orthotics or a glucometer. It was reported that no funding was available under the program for this type of equipment. The affiliate interviewee expressed frustration that they were repeatedly being told that Supplementary Service funding would provide access to these resources, but access was proving to be problematic. *'This keeps getting told to us as the solution but again there are a number of challenges to this.'* The identified challenges included a) the need to be in a site where there is a funded Care Coordinator position; b) the Care Coordinator can only see a limited number of patients and the Supplementary Services funding is for clients being seen by the Care Coordinator, and the patients who require the equipment are not necessarily clients of the care coordination service; c) the practice the patient is attending needs to be PIP accredited to access the care coordination service, and not all patients are attending a PIP accredited practice; and d) the guidelines from the Supplementary Service funding indicate that it does not cover co-payment costs for surgery.

Recruitment and management of positions

USOAP fundholders indicated that there was no funding for a dedicated person to recruit specialists and to manage the service when specialists are consulting at host organisations. Having no dedicated person to coordinate the service at a host organisation often means specialists are not recruited, or when they are there is no one on the ground to manage bookings, appointments and follow-up for patients. This was reported to be the case in one Sentinel Site, where the GP was left to recruit specialists to positions. Of the five approved positions only one had been filled at the time of the evaluation visit.

> *'Often it is left up to the GP to recruit and they are already very time poor.'*
> (Interview, Workforce Agency)

> *'it is not that they don't need services but [there is] limited coordination already and asking people to recruit and coordinate for services without necessarily supplying them with resources means it drops off the list of things to do.'* (Interview, Workforce Agency)

Challenges recruiting specialists in urban locations

Fundholders indicated that there had been some difficulties recruiting specialists to the USOAP. *'It has been real pick and shovel work to recruit to the USOAP positions.'*

It has emerged as being quite difficult in urban areas for a variety of reasons, including close proximity to specialist rooms or hospitals with specialists, and specialists being reluctant to travel the short distance to provide a service in the AHS when there is a higher risk of AHS patients not attending appointments.

> *'… from a specialist perspective, regardless of remuneration, the through-put at the AMS will be less than [at] the principle place of practice which is possibly again only [a bit further] down the road. It is difficult to make the argument that the service is needed in the location.'* (Interview, Workforce Agency)

A further challenge has been that specialists do not perceive urban work as outreach work.

> *'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.'* (Interview, Workforce Agency)

One workforce agency indicated that, in the process of negotiating with a specialist to work in the USOAP, they agreed instead to take patients to the specialist's rooms, only a few kilometres up the road, where they would be bulk-billed. This was agreed to be a mutually satisfactory arrangement and was a more workable alternative for the specialist than conducting an outreach clinic at the Aboriginal health Service. Arrangements such is this are not reported as they are not arranged under the USOAP. However, they are a direct and positive 'by-product' of the USOAP.

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 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.

Summary

There is evidence of USOAP activity in seven of the thirteen eligible Sentinel Sites, with three of these sites being case study sites. Implementation has progressed since the last evaluation cycle, but is nevertheless still at an early stage.

A number of issues are emerging from the early experience of implementation, including:

- challenges of shifting established behaviours in relation to referral to specialists (some of which were seen to be working well)

- perceptions by some stakeholders that the focus should be on improving access to specialists in their usual facilities rather than getting specialists to see patients in primary care facilities

- ongoing difficulties in ensuring patients turn up for scheduled appointments

- the need to orient specialist to the primary health care service environment, and to ensure they feel comfortable working in this environment, in addition to promoting access to, and use of, appropriate cultural awareness training

- as for MSOAP-ICD, the lack of support through USOAP of follow-up investigations, procedures, aids or equipment, and ongoing barriers of long waiting lists in public facilities and high costs in private facilities

- lack of clear synergies between USOAP and the Care Coordination and Supplementary Services, with supplementary services apparently only being available to the limited number of clients prioritised for care coordination, and many patients who require supplementary services not requiring care coordination and therefore not being eligible for support under this measure

- lack of support for recruitment of specialists, difficulty with recruitment due to lack of interest of specialists, and consequent lack of progress with implementation.

The SSE will continue to monitor progress with implementation, including seeking to identify innovative solutions to emerging challenges and suggestions for refinement to the emerging models of care being implemented through USOAP.

17. Increasing Access to Specialists and Multidisciplinary Team Care (*Measure B5 part B*)

17.1. Description of measure

The aim of the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD) is to enable Aboriginal and Torres Strait Islander people who live in regional and remote communities to have better access to health care services provided by specialists, general practitioners and allied health professionals. The primary focus is the delivery of services to Aboriginal and Torres Strait Islander people residing in remote and very remote communities, however, inner regional communities are also eligible to be supported under this measure.[98]

The pre-existing MSOAP has been administered on behalf of the Australian Government by nine agencies, which together covered all states and the Northern Territory. The agencies were engaged to plan services and recruit appropriate health professionals to deliver services. To assist with the recommendations about the location of services to Aboriginal and Torres Strait Islander communities, the existing MSOAP advisory forums in all states and the Northern Territory have been expanded.[99]

The composition of MSOAP teams varies depending on the specific health and treatment needs of each community, and may include specialists, general practitioners and allied health professionals.

Funding agreements have been signed with fundholder organisations (two each in NSW and QldQld, and one each in Tas, WA, Vic, SA and the NT) for the period 2009-10 to 2012-13.[100]

Terminology

Terminology used in this chapter of the report is based on the MSOAP-ICD guidelines where:[101]

- 'service' is defined as a health professional (i.e. any individual medical specialist, GP and/or allied health professional) visiting and providing a medical consultation

- 'fundholder' is the state based organisation that auspices the funds on behalf of the Commonwealth. Generally the fundholders are workforce agencies

- 'health professionals' are the personnel that make up the multi-disciplinary teams funded under MSOAP-ICD

- 'host organisation' is the organisation funded to host the outreach service.

17.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure B5 Part B, and relevant to the current stage of implementation, include:

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[98] DoHA, Medical Specialist Outreach Assistance Program Indigenous Chronic Disease 2009-2013 Guidelines. (accessed 29 November 2011).
[99] DoHA, Increasing Specialist and Allied Health Care Follow Up – Fact Sheet, (accessed 29 November 2011).
[100] DoHA, Report ICDP update, March 2012.
[101] DoHA, Medical Specialist Outreach Assistance Program Guidelines [website], (accessed 12 February 2013).

Expected outputs for year 1 and beyond:

- Effective fund holding arrangements in place.

- Indigenous Australians utilise and value services.

- Specialists demonstrate cultural awareness.

Expected early results for years 2-4:

- Increased specialist and allied health services.

Expected medium term results for years 4+:

- Care coordination is improved.

17.3. State of implementation

The following information was provided by DoHA in August 2011 on the state of implementation of measure B5 Part B (relevant to the SSE):[102]

- Compulsory cultural awareness and safety training is provided to all health professionals providing a service under MSOAP-ICD prior to commencing consultative services.

- Orientation visits to host organisations are being made available for new service providers prior to commencement of consultative services.

- Reported strategies to secure the services of health professionals to provide outreach included approaching urban teaching hospitals to source outreach personnel and focusing recruitment efforts at recently qualified or semi-retired specialists with potentially fewer commitments.

- A reported barrier when seeking organisations to host the MSOAP-ICD is the availability of appropriate coordination at the outreach location. Activities to mitigate this issue include risk management strategies via annual project plans to ensure that any potential barriers are dealt with effectively and efficiently.

- The South Australian fundholder requested a change to the reporting timeframes for MSOAP-ICD. This is due to an expansion in several MSOAP programs, generating a larger workload and creating difficulty for service providers to submit the necessary reporting paperwork within the required timeframe.

DoHA reported that recent changes had been made to the guidelines to clarify the meaning of 'local travel' for host organisations.[103]

17.4. Findings from Sentinel Sites

Notes on collection and analysis of data

There are four case study sites that have MSOAP-ICD funding and that recruited health professionals to work in the MSOAP-ICD. Information on implementation of MSOAP-ICD is

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[102] DoHA, B5B Sentinel Sites data report 15 August 2011.
[103] DoHA, B5B update, personal communication, 22 November 2011.

limited by the relatively early state of implementation on the ground and the very recent availability of information on workforce allocations and agencies that are fundholders for the MSOAP-ICD. Most of the information collected to date is from interviews with staff of the workforce agencies who are the fundholders for the MSOAP-ICD. While there were a number of common issues raised by the workforce agencies in different states/territories, state specific issues were also raised. This section firstly reports the issues that were common to a number of states/territories and then, secondly, addresses issues that were state/territory specific.

Community focus group participants discussed awareness and perceptions of access to medical specialists, cultural appropriateness of specialist care and their perceptions of change since the previous reporting period. The findings reported are based on information gathered from nine focus group discussions held in four regional and remote case study sites.

MSOAP-ICD Services in Sentinel Sites

Table 22 shows MSOAP-ICD services delivered and planned for locations in Sentinel Sites. Nine out of the sixteen potentially eligible Sentinel Sites are represented, four of which are case study sites. Many of the sites appear to be in the early stages of MSOAP-ICD service delivery.

Of the Sentinel Sites, Tamworth stands out as having the most established MSOAP-ICD related services. The Derby, Grafton and Dubbo sites, on the other hand, have had a small number of visits with good patient attendances. Two of the locations, Bairnsdale and Swan Hill, have recorded consecutive visits by health professionals without patients being seen. This may be a recording error, as was indicated to the evaluation team in relation to Bairnsdale. Some sites have recorded single health professional visits without patients. This may represent orientation visits but it is not differentiated. Other services have had single visits by health professionals and large numbers of attendances (142 for diabetic/cardiac education in Katherine, for example). This may indicate that participants in group activities were included in the attendance counts as well as individuals attending consultations.

East Pilbara is eligible for MSOAP-ICD and has, at this stage, not submitted an application for the funding. Interviews with key stakeholders during evaluation visits to the East Pilbara site indicated that they were aware of the availability of the funding through the workforce agency. Interviewees indicated that the agency had invited submissions from within the region for the ICD extension of MSOAP. The DGP and the AHS in the East Pilbara site are planning to discuss the development of a submission for MSOAP-ICD funding at upcoming regional forums. The region is currently receiving specialists' services through MSOAP funding.

Data on the name of host organisations for the MSOAP-ICD services were not available from DoHA. From evaluation visits it is evident that, within the Sentinel Sites, the majority of the host organisations are AHSs.

There is a wide range in the number of reported visits and the number of clients seen by different types of visiting providers and in different sites. There appears to be a variety of models of outreach operating, but the reasons for the wide range in the number of clients accessing outreach services is not clear. Future evaluation cycles will include a focus on understanding different models of outreach and reasons for the reported variation in patient numbers.

Table 22: Reported MSOAP-ICD services in Sentinel Sites for 1 July 2010 - 30 June 2011

Site name and type	Location	Type of service	Number of visits	Number of patients	Changes since the June 2011 report and as found at evaluation visits
Bairnsdale – Case study site	Bairnsdale	Aboriginal Health Worker	3	0	na
		Dietitian/Nutritionist	8	0	na
		Diabetes Educator	12	0	na
		Podiatrist	11	6	na
Port Augusta – Case study site	Port Augusta	Occupational Therapist	3	8	Every fortnight [a]
		Endocrinologist	nr	nr	Monthly, commenced September [a]
		Physician -Respiratory	1 [a]	0 [a]	Started October 2011. There were no patients to see the physician at his first visit. Additional SA ICDP funding targeted for respiratory care. [a]
Katherine West – Case study site	Katherine	Physician - Cardiology	1	25	Other services are described in footnotes [b]
		Physician - Rehabilitation	4	38	As above
		Rehabilitation - Top End	2	69	As above
		Diabetic/Cardiac Education	1	142	As above
Tamworth – Case study site	Tamworth	Physician - Endocrinology	11	58	The endocrinologist comes from Sydney. He has been visiting since 2007 under different funding initially. There is a further application for a podiatrist submitted [c]
		Diabetes Educator	24	145	The diabetes educator and is a local service. [c]

Site name and type	Location	Type of service	Number of visits	Number of patients	Changes since the June 2011 report and as found at evaluation visits
		Dietitian/Nutritionist	23	137	The dietitian is a local service. [c]
Derby – Enhanced tracking site	Derby[d]	Psychiatrist	nr	nr	New child and adolescent service (1 visit a year for 14 days) – service hasn't commenced. The psychiatrist is already working with Kimberley Mental health team and this is a new service[e]
		Physician Respiratory	nr	nr	The respiratory team is a newly recruited service. They will visit twice a year for 4 days each time.[e]
		Aboriginal Health Worker – respiratory	nr	nr	As above
		Registered Nurse	1	13	na
		Aboriginal Health Worker	2	16	na
		Orthoptist	1	47	Orthoptist is being funded to link into the existing WA country health diabetes team. Planned 8 visits per year for two days each time[e]
		GP - General Practitioner	1	27	na
	Fitzroy Crossing	Registered Nurse	1	29	na
		Aboriginal Health Worker	1	27	na
		Orthoptist[e]	1	48	na
		General Practitioner	1	28	na
	Fitzroy Crossing Aboriginal Community	Registered Nurse	1	22	na
		Aboriginal Health Worker	1	22	na
		General Practitioner	1	23	na
Dubbo – Enhanced tracking	Dubbo	Physician - Cardiology	6	24	na
	Wellington	Diabetes Educator	3	6	na

Site name and type	Location	Type of service	Number of visits	Number of patients	Changes since the June 2011 report and as found at evaluation visits
site		Asthma Educator	4	7	na
		Dietitian/Nutritionist	3	25	na
		Nurse - Cardiac Rehabilitation	0	0	na
Swan Hill/ Mildura – Enhanced tracking site	Mildura	Physician – Cardiology	1	0	na
		Aboriginal Health Worker	1	0	na
	Robinvale	Physician – Cardiology	1	0	na
		Aboriginal Health Worker	1	0	na
	Swan Hill	Physician – Endocrinology (diabetes)	2	0	na
		Aboriginal Health Worker	3	0	na
		Diabetes Educator	6	0	na
		Dietitian/Nutritionist	4	4	na
Grafton – Tracking site	Grafton	Physician - Respiratory	1	0	na
		Diabetes Educator	3	21	na
		Exercise Physiologist	5	14	na
		Nurse - Mental Health	11	19	na
		Psychologist	0	0	na
		Asthma Educator	9	41	na
		Dietitian/Nutritionist	0	0	na
		Exercise Physiologist	0	0	na

Site name and type	Location	Type of service	Number of visits	Number of patients	Changes since the June 2011 report and as found at evaluation visits
Geraldton – Tracking site	nr	Nephrologists	nr	nr	The renal team is to have two visits a year for three days each time. Pre-existing nurse and AHW team. Had some difficulty finding a Nephrologist. However, advertised widely and managed to find two interested. One will be commencing later in 2011[e]
		Registered Nurse	nr	nr	As above
		Aboriginal Health Worker	nr	nr	As above

[a] Rural Doctors Workforce Agency, personal communication, September 2011.

[b] NT DoHA, private communication, September 2011. There are no MSOAP- ICD funded services in Katherine West that visit Lajamanu directly due to need for equipment, diagnostic capacity and infrastructure. Instead they tend to use the established larger health clinics. They are also getting services from other funding sources. Up until recently Katherine West had other organisations providing funding for allied health services . The NT Department of Health described the MSOAP-ICD services in Katherine as; liver clinic (6 weekly) cardiac rehabilitation. dietitian, podiatry, renal physician, and exercise physiologist.

[c] Evaluation visit update. The endocrinologist was initially funded under the Indigenous Specialist Outreach Assistance Program (ISOAP).

[d] DoHA, B5B Sentinel Sites data report 2 September 2011. The service models for Derby are generally part of the larger services that cover the Kimberly region. Derby township has MSOAP-ICD funded services through WA country Health and Kimberly Aboriginal Medical Service Council (KAMSC). Through KAMSC 2 teams consist of general physician, nurse, and AHW providing three visits per year for three days

[e] DoHA, B5B Sentinel Sites data report 2 September 2011.

Note:

MSOAP-ICD is restricted to rural and remote communities. Urban Sentinel Sites are not eligible. The sites that are eligible but are not represented in the table are East Pilbara, Cairns, Darwin, Hobart, Gladstone, and Kalgoorlie. East Pilbara has existing MSOAP services but has not applied for MSOAP-ICD (DoHA, B5B Sentinel Sites data report 2 September 2011).

Other towns near Sentinel Sites have been reported as having received MSOAP-ICD services by DoHA. It is not clear whether these would be accessible to any of the Sentinel Site population and have not been included in the table. They include Port Hedland, Broome, Coffs Harbour, Casino, Armidale, Gunnedah and Yarrabah.

A service is defined as one health professional attending and providing consultation to an approved location (e.g. a podiatrist, dietitian, and endocrinologist to a specific location is three services).

Each health professional (or service) may visit an outreach location a number of times in a reporting period to deliver care.

nr – Not reported in the DoHA template therefore lacking full information for this table.

na – Not applicable

Source: DoHA, B5B Sentinel Sites data report 15 August 2011 unless otherwise specified in footnotes.

Planning processes and perceptions of whether client needs are being met

In response to the statement '*arrangements for the outreach team under the MSOAP-ICD meet the needs of local Aboriginal and Torres Strait Islanders'*, 50% (12/24) of interviewees strongly or partly agreed with the statement, and most [42% (10/24)] of the rest indicated that they 'don't know/can't say'. The proportion responding 'don't know/can't say is consistent with the

proportion of sites where there has, to date, been no or very limited MSOAP-ICD related activity.

Fundholder organisations indicated that there had been extensive consultative processes when developing proposals for service locations. Fundholder organisations often played a role in bringing together key stakeholders at service locations such as DGPs, AHSs and community health centres to develop proposals suitable to the local service environment and to lever off existing service arrangements. Fundholders often supported organisations through planning and priority development processes.

Whether the services established have been driven by need, rather than available service providers, will be explored in the next reporting period.

Recruitment strategies

As highlighted in guidelines and as evident from interviews, fundholders played a role in recruitment for personnel to the MSOAP-ICD teams. Approaches to recruitment included:

- targeted mail-out to specialists listed on a data base held by the rural workforce agency

- placing advertisements in the e-bulletins of relevant professional groups and hospitals, and in newsletters

- developing marketing strategies that outlined good news stories about remote and outreach work.

One fundholder organisation found that a successful strategy for attracting specialists was to focus the marketing strategy on the outreach location and to have the proposed specialist and /or allied health providers contact the host organisation directly.

Stakeholders in another site worked together to recruit specialists who were providing services to an existing outreach program, negotiating with them to provide additional services when visiting the region.

In the previous reporting periods, stakeholders across all sites indicated that the limited number of available specialists and allied health providers would potentially hinder recruitment to MSOAP-ICD teams. The concern was not raised in this reporting period, which may be an early sign of the success of marketing campaigns and recruitment strategies developed by the fundholder organisations.

> ***Vignette – Collaborative recruitment and management approach***
>
> In one regional centre, discussions between the DGP and AHS led to an expansion of MSOAP. The DGP was already administering MSOAP funding, so when the AHS requested it temporarily administer the ICD component on their behalf, it was straight forward to lever off existing arrangements. Visits by a cardiologist and respiratory physician under the existing MSOAP arrangements were extended to include an additional day working in the AHS and this was funded under the ICD component.
>
> Coordination from one point has been found to be a good specialist recruitment model, providing expectations are made clear and the challenges of working in Aboriginal and Torres Strait Islander health are accepted.
>
> **'***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 a trip.'*

Awareness of the MSOAP-ICD services

Seventy-one per cent (22/31) of interviewees indicated they were aware of the MSOAP-ICD services operating in the four Sentinel Sites.

When asked about their perceptions of the MSOAP-ICD services, the majority of respondents indicated that they 'don't know/ can't say'. This is likely to be mainly due to the relatively early implementation of the services in the Sentinel Sites.

Coordination of service providers and patients

When asked to respond to the statement '*there is good coordination of care for patients between service providers and the MSOAP-ICD outreach team'*, about half of the interviewees [54% (13/24)] indicated that they 'don't know/ can't say'. Of the rest, almost all (10/11) interviewees either strongly or partly agreed with the statement. This suggests that where the program is operating, and where stakeholders feel able to make an assessment of coordination between service providers and the outreach team, the assessment is primarily positive.

However, as previously reported, interviewees expressed concern about the lack of a coordination support for the MSOAP-ICD teams and that this was impacting negatively on the coordination of the MSOAP- ICD services. The lack of coordination was perceived to be having a negative impact on patient attendance, understanding of prescribed medications and adherence and follow-up processes with other team members and with general practitioners. Stakeholder interviewees indicated that these challenges could be addressed through a dedicated coordinator position.

> *'There is no funding, at this stage to provide a dedicated person to provide coordination, this has presented as a real gap.'* (Interview, SBO)

In the Derby site, the AHS was using the ICDP funded OW to coordinate compilation of patient lists and to undertake follow-up. The coordination role of the OW was viewed as vital to the success of the service.

It was also noted that coordination of services from 'both ends' is lacking; that is, coordination to ensure effective operation of the service when providers are on the ground, and also coordination to ensure the outreach teams come together and travel on the same day.

> *'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.'* (Interview, Workforce Agency)

A number of interviewees attributed the problem of patients not turning up to appointments to this lack of coordination. It was viewed as a major contributor to the limited use of the MSOAP-ICD services.

One workforce agency indicated they had commenced discussions with DoHA to develop funding models to support coordination approaches for MSOAP-ICD teams. The agency was proposing that, particularly in a remote context, a potential solution may be to have a tiered model of coordination. The model would involve having a regional coordination position (for example, in a regional service centre), with 'sub-positions' in local communities to support community members to get to appointments. These sub-coordinator positions could be employed on an hourly rate.

> '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.' (Interview, Workforce Agency)

In the remote context the workforce agencies, as the fundholders, have been trying to ensure that not all the service providers attend on the same day. There is a number of existing specialist teams and having them attend a health centre on the same day would overwhelm the capacity of health centre staff and facilities.

> 'One of commitments we gave to clinics was that we would do everything in our power to minimise multiple 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.' (Interview, Workforce Agency)

Another fundholder had established their own coordination unit, rather than negotiate for coordination models to be implemented at a regional level. The coordination unit has a number of functions and works with host organisations to:

- avoid multiple presentations by too many service providers at once, unless this is deemed appropriate

- save costs on charter flights by bringing people in together, balancing this saving with the need to ensure adequate infrastructure & staff to support visiting teams

- coordinate appointment lists centrally from the fundholder organisation; the coordination unit in the organisation sends lists of patients to clinics, and the clinics add patient names to lists as necessary.

Within the guidelines for MSOAP-ICD there is a funding allocation available for session based payments to support coordination for the host organisation. A number of workforce agencies indicated that there were not many host organisations accessing this session based coordination funding. They suggested a number of reasons for this, including:

- lack of staff to provide the service, perceived as additional work for already overstretched staff

- services not invoicing for the coordination service despite being allocated funding, apparently due to limited capacity to invoice. In addition, some host organisations did not feel the funding was adequate to warrant making the effort to invoice.

> *'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.'* (Interview, Workforce Agency)

> *'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 … people already too busy … The sessional rate is well intended but not working and problematic.'* (Interview, Workforce Agency)

Improving access and care

Interviewees indicated that having the multidisciplinary teams visit as outreach services was increasing access for patients to specialists and allied health care. One AHS in a regional site indicated that having the teams visit locally reduced the time Health Service staff previously spent organising travel for patients. The site also spoke of the improvement in communication between health service providers when consults were done within the AHS, providing the opportunity for face-to-face meetings between health professionals to discuss patient care. Another advantage was being able to enter information onto the patient information system immediately. In one site the AHS felt that it was preferable to have more frequent visits from outreach teams because they would maintain patient engagement.

Community focus group participants in two regional case study sites where the MSOAP-ICD services were established were aware of their existence, and had been accessing available services available via referral from the AHS doctors. The services were viewed positively in regard to improving access and there was a perception that services were culturally safe.

Non-attendance of patients

Non-attendance by patients was consistently seen as a particular challenge by fundholders, host organisations and health professionals. A number of reasons for non-attendance were identified by interviewees, including lack of coordination at the host organisation, difficulties with transport, and effectiveness of clinic management.

> *'The service is then responsible for getting the patients to the clinic. It is completely personality driven. If you have a good clinic manager you will get a great turn out. If you have a poor clinic manager your ['do not attend'] level is high.'* (Interview, Workforce Agency)

The lack of attendance at some clinics is evident in the program data above, which shows that for some visits there have been few or no patients attending.

In remote locations there were reports that visiting specialists and allied professionals sometimes drive around looking for patients. Some visiting health professionals have been willing to do home consultations.

> *'Sometimes we have to go to extremes to get people to get their follow-up and it is not uncommon for, say, the O&G [Obstetrics and Gynaecology] service to be literally driving around the community picking up people and finding people. If the specialists / team members don't need equipment they usually leave the clinic to try and find patients [and do home consultations].'* (Interview, Workforce Agency)

Accuracy and meaningfulness of reporting

As expected at this early stage of implementation, comments from staff of fund-holding organisations indicate there is some work to be done in working with host organisations to refine reporting processes, clarifying expectations and requirements for reporting and/or how the reports will be used for monitoring and planning purposes to enhance the effectiveness of this measure.

Staff of some fund holding organisations expressed concern that some DoHA staff don't appear to understand the challenges of service delivery to Aboriginal communities (and not only in the remote context), and that they, as fundholders, were being 'questioned' over small numbers of patients seen, or over the reasons host organisations did not provide reports. This experience was contrasted by some interviewees with the situation in NSW, where the state controlled the funds [under the Indigenous Specialist Outreach Assistance Program (ISOAP)] and the state health department was able to understand host organisations' positions in regard to capacity and reporting.

> *'There really is quite a disconnect between the understanding in Canberra[DoHA]of what happens and often the challenge of delivering services. For example, you think you are going to see 30 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 really poor disconnect and 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.'*
> (Interview, Workforce Agency)

This quote, and the issues raised around reporting for MSOAP-ICD services, need to be interpreted in the light of the early state of implementation of this measure and the associated uncertainties regarding appropriate reporting of MSOAP-ICD activity (as reflected in the table above on MSOAP reported activities and the associated comments on reasons for low numbers). The above quote reflects some concern by fund-holding organisations about how the reported data might be interpreted and used. This may reflect a need for further communication and clarification of this issue.

Challenges with reporting as identified by interviewees of fund-holding organisations included the following examples:

- At times host organisations don't have the capacity to report, and that this may lead to incorrect figures being provided, or no figures being provided. In one location, the workforce agency negotiated for the health professional providing the service to be responsible for the reporting, rather than the host organisation. This was a response to the host organisation's diminished capacity, at the time, to meet the necessary reporting requirements.

- In one Sentinel Site a health professional who was involved in delivery of services through MSOAP-ICD indicated, when shown the data that had been reported to DoHA, that the data were under-reporting activity, and that the reported figures were a reflection on the Health Service's lack of capacity to report, rather than lack of patient consultations.

- Uncertainty about how to report 'group sessions'. For example, when an allied health professional facilitates a group consultation.

- A number of workforce agencies indicated that the current form of reporting on number of patients seen by health professionals does 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 1000 people and have absolutely no impact whatsoever, or we could see 50 and change a whole community environment.'* (Interview, Workforce Agency)

One fundholder went as far as suggesting that the focus of reporting should be on clinical outcomes. The fundholder recognised that this would present challenges, but offered a suggestion about using relevant routinely available data (such as transport out of the community for hospitalisation). In one location, the development of a new health information system, which was intended to improve robustness of data on patient movement, was seen to have the potential to provide data relevant to 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 at the moment about patient movement is not great under the current system, it is actually pretty ordinary - 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 6-12 months we are able to increase our ability to report on health outcomes.'* (Interview, Workforce Agency)

DoHA staff have indicated they are aware of a number of the issues raised, that they are willing to hear the concerns of fund holders regarding reporting requirements and to find ways to address these concerns.

Complex system for invoicing

One fundholder indicated that there had been invoicing challenges as a result of health professionals having many categories to deal with 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 suggested that there were:

> *'… 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].'* (Interview, Workforce Agency)

Requirement for surgery or other treatment and follow-up

Fundholders for both MSOAP-ICD and USOAP expressed concern that the service provided is consultative only. Several interviewees pointed out that specialist consultations were only part of the services required and there was need for funded follow-on services. See Chapter 16 on USOAP for further detail about this emerging theme.

A fundholder supporting services in a remote context spoke of the limitations of existing manual systems for managing the travel associated with surgery. It was explained that patients needing surgery (following specialist consultations) were placed on a public wait list, with the process managed by the patient travel team at the workforce agency. *'It is a manual system so there is a real risk of losing track of patients, but we are in the process of implementing a fully automated system that will go live in 2012, and hopefully the risk of losing patients in that system will diminish.'*

Lack of physical infrastructure to accommodate specialist or allied health providers

In the remote context in particular, accommodating new specialist teams within existing physical infrastructure was a common concern for stakeholder interviewees, due to lack of available space. The coordination role played by the fundholders was crucial to avoid having a number of outreach teams in one location concurrently when physical infrastructure was limited on site. Having adequate staff to support the service was also viewed as a challenge, not only for team and patient coordination but also to meet reporting requirements and to undertake contract negotiations.

> *'Infrastructure at Health Services can be a challenge. Some are quite small - the clinics and resources are very limited. Not just physical space but also staff to support the service.'* (Interview, Workforce Agency)

Inability for mainstream General Practice to refer under MSOAP-ICD

In two regional case study sites, concern was expressed about the inability of GPs in private practices to refer patients to MSOAP-ICD services being run in Aboriginal Health Services.

> *'These services are based at the AHS and only open to AHS clients.'* (Interview, GP, General Practice)

In one site, the DGP negotiated with the fundholder to have the specialist service under MSOAP-ICD operating part-time at the hospital and part-time at the AHS. Due to administrative challenges to having the specialist service based at the hospital, an agreement was reached for the service to operate from the AHS, but to be available for referrals from all GPs. The fundholder indicated that:

> *'I believe it is open to all GPs to refer to. This was part of the original negotiations with the Endocrinologist [who] was originally going to spend part of his time at the hospital … so people who did not normally access [AHS] could access through the hospital. It just was too complicated to do this through the hospital so [we] funded it through [AHS] but open to all.'*

Despite this, interviewees at the site expressed concerns about not being able to access the new specialist service.

> *'There is a gap in the need of Aboriginal patients who don't go to [AHS] as this is where the positions are based. It is early days though.'* (Interview, GP, General Practice)

Not only was this an issue for the new specialist service, but also for an allied health service being funded under ICDP in the site.

> *'[There are] issues with access to non [AHS name] patients. The [allied health professional name] is going to find out if she can see non [AHS name] patients.'*
> (Interview, GP, General Practice)

Reasons given by the AHS for not opening up the service in both sites was that the MSOAP-ICD services were 'fully subscribed' by their own patients. It is evident in the program data for one regional site that there are large numbers attending the service, however it is not as amplified in the data for the other regional site.

If it is the intent of the program to ensure specialist and allied outreach services are available for referral of eligible patients by all GPs, regardless of the host organisation, further work may be required at the site level to communicate this intent to the host organisation and to other GPs in the region.

Difficulties in billing Medicare

In a remote context, a fundholder indicated that patients not having Medicare cards had presented a barrier to billing Medicare.

> *'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 have a Medicare card may have three or four Medicare cards. They often don't even know their date of birth.'* (Interview, Workforce Agency)

This comment indicates a lack of awareness of the MSOAP-ICD guidelines which provide for additional funding for 'workforce support' for areas where billing Medicare presents a challenge. More explanation of the funding available, and how to access it, may assist not only fundholders but also health professionals.

Complementary programs

The Medical Specialist Outreach Assistance Program

The existing MSOAP funding was consistently viewed as a complementary program that has enabled relatively rapid implementation of MSOAP-ICD. The fundholders had all had previous experience administering the MSOAP, and therefore generally felt the contract negotiations were relatively straightforward with both host organisations and with health professionals.

In one enhanced tracking site MSOAP funded providers used MSOAP-ICD to expand their existing service and to spend additional time offering services 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'. As the fundholder the DGP is well placed as already working with existing specialist outreach such as MSOAP and can lever off these specialists.'*
> (Interview, Workforce Agency)

The Indigenous Specialist Outreach Assistance Program

The Indigenous Specialist Outreach Assistance Program (ISOAP),[104] (an outreach program funded by the Office for Aboriginal and Torres Strait Islander Health to increase medical

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[104] Rural Doctors Network [website], (accessed 12 February 2013).

specialist outreach to rural Aboriginal communities in NSW) was viewed by the fundholder as a program that had complemented the roll out of the MSOAP-ICD. This program had provided experience with contract negotiations and implementation of services in Aboriginal communities. The fundholder viewed it *'as a precursor or forerunner to the ICD work.'*

In NSW, the fundholder felt they had been successful in implementing MSOAP-ICD, and based this perception on having a high number of services engaged and having already recruited to funded positions. They felt success could be attributed to a number of factors that were linked to having existing ISOAP funding:

- The workforce agency had prior experience with such programs under MSOAP and ISOAP.

- Administering the ISOAP program provided valuable experience in working with Aboriginal Health Services and services targeting Aboriginal clients. *'ISOAP made us well placed for the MSOAP-ICD as we had existing relationships with the Aboriginal Health Services and experience in administering this program'.*

- Existing relationships with fundholders provided a foundation for MSOAP-ICD.

- A mapping process had been undertaken before funding became available as part of evaluation of and planning for the MSOAP and ISOAP programs.

  'It has been useful having us involved as we hold a lot of corporate memory of what has happened in the past with the implementation of a service and if there are changes of personnel at the Aboriginal Health Service we can up skill and manage that change process quite easily and quickly.' (Interview, GP, General Practice)

The More Allied Health Services Funding Scheme

The Rural Primary Health Services (RPHS) funding scheme was established in 2001 to increase access to allied health services for General Practices in rural areas. The scheme was noted by a fundholder organisation as being an existing complementary program to the MSOAP-ICD. While the fundholder did not directly administer the program, they felt that it was a starting point for DGPs to become involved in contracting allied health providers and managing these contracts and health professionals. In the negotiations for MSOAP-ICD the fundholder *'tries to lever off existing allied health programs and use those instead of funding [new] programs. For example, use a funded allied health position at the DGP, (there are a lot of allied health providers in DGPs funded under MAHS [More Allied Health Services Program]), or try and leverage off existing allied health services in community health.'* (Interview, Workforce Agency)

Programs which conflict with, or impact negatively on, MSOAP-ICD

The Supplementary Services funding under Measure B3 Part B was highlighted as a program that is having a negative impact on the implementation of the MSOAP-ICD and USOAP. This funding is viewed as competing with the aims of specialist / multidisciplinary outreach. See Chapter 14 for further detail on this issue.

As noted above, concern was raised about the lack of coordination of health professionals under MSOAP-ICD, and lack of coordination for attendance by patients at the host organisation. One fundholder noted that this might lead to DoHA funding coordination positions, and was concerned that such a strategy may complicate service delivery arrangements with existing Care Coordinators in some sites.

Tele-health – opportunities and challenges

The MSOAP-ICD guidelines indicate support for tele-health as a supplement, rather than a substitute, to provision of direct care. In addition, Medicare recently announced new item numbers for tele-health.[105] One fundholder indicated that they were commencing a trial of a tele-Health process for follow-up of surgical procedures, separately to MSOAP or MSOAP-ICD arrangements. However, it was highlighted that specialists and allied health providers in some locations are often in salaried positions, which excludes them from claiming Medicare items.

> *'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.'* (Interview, Workforce Agency)

> *'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.'* (Interview, Workforce Agency)

No fundholders indicated that health professionals under MSOAP-ICD were using case conferencing facilities or claiming these types of Medicare item numbers.

Access to transport, accommodation

The community focus groups continued to report the following barriers to accessing specialist and multidisciplinary care:

- A perception of a lack of transport in regional sites and of the high expense of travel to access care. The AHSs were again noted as providing or arranging free transport to access specialists.

- Desire to be accompanied by a family member when needing to access care in larger centres, and not being able to meet associated transport and accommodation costs.

- Cost and long waiting times to access specialist care, especially follow-up investigations or procedures.

Summary

Most of the information on MSOAP-ICD provided to the SSE has come from State-wide organisations such as Workforce Agencies and Division State Based Organisations, which are the main fundholders for MSOAP-ICD funding. Some additional information was obtained from interviewees in Sentinel Sites where there was MSOAP-ICD activity.

There is increasing evidence of progress with implementation of MSOAP-ICD on the ground in the Sentinel Sites, but implementation was still at an early stage during the period covered by this report, with substantial activity being directed at consultation and planning and recruitment of providers. There is some evidence of progress in recruitment of providers since the previous reporting period. Nine out of sixteen potentially eligible Sentinel Sites appear to have been allocated funding for MSOAP-ICD, including four case study sites. This may be, to some extent, a reflection of the current reach of MSOAP-ICD across the country.

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[105] Medicare Australia [website], (accessed 18 November 2011).

There is a wide range in the numbers of reported visits and the numbers of clients seen by different types of visiting providers and in different sites. There appear to be a variety of models of outreach emerging, but the reasons for the wide range in numbers of clients is not clear. Future evaluation cycles will include a focus on understanding different models of outreach and reasons for the reported variation in numbers.

Coordination on the ground, of outreach services and to ensure patients attend as required, continues to be a focus of attention for providers, with many continuing to feel uncertain about how this will work. However, there is evidence of development of strategies to enhance coordination and of positive views regarding the potential for effective coordination.

The need to develop appropriate and meaningful approaches to reporting on MSOAP-ICD programs emerged as an important theme of discussion, with considerable dissatisfaction expressed about the potential for current reporting requirements to provide a meaningful reflection of the value of these services in the variety of contexts and across the variety of providers and locally specific programs.

Concerns were also expressed about the extent to which MSOAP-ICD provides support for only part of the process of specialist care, with limited potential to enhance access to related follow-up investigations or procedures, many of which require attendance at a regional or specialist referral centre with the required infrastructure. There were also some concerns raised about barriers to referral to MSOAP-ICD by private General Practices, complexity of invoicing requirements for specialists, lack of administrative capacity in relation to billing Medicare, and some patients not being registered with Medicare.

A number of programs were reported to be complementary to, or to have facilitated the implementation of, MSOAP-ICD. These included MSOAP, the Indigenous Outreach Assistance Program, and the More Allied Health Services Funding Scheme.

18. Workforce Support, Education and Training (*Measure C1*)

18.1. Description of measure

This measure aims to increase the capacity of Aboriginal Health Services and mainstream health organisations to provide care for Aboriginal and Torres Strait Islander people with chronic and complex health conditions.

Key elements of this measure include:[106]

- Orientation and training opportunities for Outreach Workers (OWs) employed in Aboriginal Health Services (through measure C2) and Divisions of General Practice (through measure C3).

- Orientation for Outreach Workers during the first six months of employment. Outreach Workers will be mentored and encouraged to undertake further accredited training in the health field, though this is not mandatory.

- Expanded professional development nurse scholarships and undergraduate clinical placement scholarships within Aboriginal Health Services, and additional GP registrar training places to be created in Aboriginal Health Services.

18.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure C1, and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- The measure would be implemented according to the work plan.

Expected early results for years 2-4:

- Participants in C1 activities are effectively oriented, trained (though not mandatory) and supported to provide quality care to Indigenous Australians.

18.3. State of implementation

There are a number of aspects to this measure. The focus for the SSE in relation to the measure is on only one component: orientation and training activities for Outreach Workers.

The following information describes the progress in the development and delivery of orientation to Outreach Workers (relevant to the SSE) nationally as at 30th June 2011: [107]

- NACCHO affiliates were funded to develop and deliver an orientation package throughout the 2010-11 year. NACCHO affiliates reported a number of factors that contributed to a delay in the delivery of orientation packages, including:

  - the need for broad consultation during the development of orientation modules, resulting in delays in the completion of orientation packages and the delivery of training

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[106] DoHA, Workforce, Education and Training – Fact Sheet [website], (accessed 22 November 2011).
[107] DoHA, C1 report, 6 September 2011.

–   the slower recruitment of Outreach Workers, and some turnover in those recruited, was a barrier to bringing together groups for orientation sessions and to having them receive the orientation training by 30 June 2011 as planned.

- The Aboriginal and Torres Strait Islander Outreach Worker National Workshop was held in Sydney on June 21-22 2011. The aim was to have national networking opportunities for OWs, to improve mutual understanding on the roles, to ensure OWs receive clear and consistent information on orientation, training and career pathway options, and to establish a shared understanding of responsibilities and options for addressing OWs support needs.[108] The report from this NACCHO workshop was publicly released in September 2011.[109]

Further updates were provided by DoHA on 23 November 2011:[110]

- Orientation packages are in place in all jurisdictions except Tasmania. Queensland now has the modules in place and will begin rolling out orientation programs.

- Where individuals are being recruited and there are not enough people to form group workshops, the training provider will deliver individualised orientation training (for a small number of OWs).

- Eighty-four of the 107 (79%) Outreach Workers recruited commenced orientation or training programs.[111]

- Twenty-six Outreach Workers have been provided with funding support to undertake nationally-accredited health-related competency based training in the vocational education and training (VET) sector.

- Under measure C2, the next phase of funding allocations for 20 OW positions will occur in November/December 2011. Orientation for the newly recruited positions is planned to occur within 6 months of commencing.

- The individualised competency based training for OWs was promoted by DoHA at the Aboriginal and Torres Strait Islander Outreach Worker National Workshop. An accredited module for Outreach Workers has been developed in WA. This has not occurred in other states at this stage.

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[108] HealthInfoNet, Aboriginal and Torres Strait Islander Outreach Worker National Workshop Reports [website], (accessed 12 February 2013).
[109] DoHA, C1 report, 6 September 2011.
[110] DoHA, C1 personal communication, 23 November 2011.
[111] There are a number of caveats provided by DoHA for these data. There may be some anomalies in the counting of the Outreach Worker orientation data, and b) the data are reported by the NACCHO affiliates at the jurisdictional level however, in order to maintain participant confidentiality, the data can only be provided at the national level for the SSE.

18.4. Findings from Sentinel Sites

In sites where Outreach Worker positions had been filled, interviews with key informants included open ended questions about orientation and individualised training opportunities for Outreach Workers employed in both AHSs and DGPs.

Orientation

Availability of orientation

Interview and program data indicate that there have been delays in the delivery of orientation to OWs. NACCHO affiliates were provided with funding to develop orientation packages for OWs in both the AHS and DGP sectors. The orientation had not been offered in Queensland by the time of the evaluation visit.

Despite the commencement of orientation, of the eight case study sites there were only three sites where stakeholders indicated that the Outreach Workers had attended orientation training. Of these three sites, the OW in one site was not available to be interviewed (because she was on leave). Of the other two OWs who attended orientation and were interviewed, one was based in an AHS and the other in a DGP. The OW in the AHS was from a remote site where they have combined the state and Commonwealth ICDP funding (including HLW and OW funding) to fund several generalist positions, including a part-time receptionist position. The receptionist at this remote site and a worker in one of the generalist positions attended the orientation training. The OW based in the DGP was from a regional site, and this worker was not entirely sure that the workshop attended was the orientation.

Though orientation had been delivered in the majority of states and territories by the time of the evaluation visits, interviews with managers and OWs indicated that the majority of OWs in both sectors (AHS and DGP) had, for a variety of reasons, not attended any orientation training. Reasons for non-attendance at orientation training included:

- being new to the role and finding the orientation training had already been delivered

- not viewing the training as a priority, due to having relevant skills and qualifications

- family commitments and reluctance to travel long distances without family.

Long distance travel, family commitments and reluctance to travel alone to a capital city were particular barriers for OWs in a remote case study site, who chose not to access the orientation training offered interstate.

> *'No orientation has been accessed by the OW workers in [site name] and this has been a real barrier to increasing the skill and capacity of the workforce. The barrier is local community people generally don't want to travel long distance to Canberra or Adelaide for orientation or anything really. They don't want to travel on their own or without family to the city. They have both been off a lot and sick but this issue of training and national workshops being held in capital cities has been raised as an issue for remote context.'* (Interview, NACCHO affiliate)

The majority of interviewees from both sectors indicated frustrations that there had been significant delays in the roll out of the orientation. Some stakeholders felt this delay had compromised the potential of OWs, particularly those OWs who had minimal qualifications or relevant experience (i.e. who were, as the guidelines recommended, in 'entry level positions').

> *'First [training] 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 in saying this we have left them in very vulnerable positions with no training. The roll out of that orientation training is quite delayed and it has impacted in particular on the Outreach Worker positions as they are quite vulnerable positions. These positions are often people employed with no qualifications or minimal [qualifications].'* (Interview, SBO)

> *'They discovered a number of OWs that had been in their role for a year and had not received any orientation. 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.'* (Interview, NACCHO affiliate)

> *'This training 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'.'* (Interview, Manager, AHS)

> *'I have had no training at all in the 16 months I've been in the role.'* (Interview, OW)

A number of interviewees indicated the need to continue to offer orientation, due to staff turnover and also to keep up with changing role expectations of the OWs.

> *'Haven't had any orientation or training because I started later than other OWs.'* (Interview, OW)

Two Outreach Workers indicated that they had attended the OW workshop that NACCHO ran, one aim of which was to facilitate networking for OWs. The workshop was viewed very positively as an opportunity for networking and discussion on roles.

> *'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. Kept on bringing the workers back to the guidelines of the funding, which was helpful.'* (Interview, SBO)

Development of the orientation packages

Program data from DoHA indicated that there has been a delay in the delivery of orientation and this delay was related to extended consultation and development of content for the orientation package. There were a number of SBOs who felt that they had minimal to no opportunities to provide input into the development of the orientation training being developed by NACCHO affiliates.

> *'We were not privy to the content and were not invited to attend. It was meant to be a collaboration putting the orientation together and we attended several meetings and kept getting told when the time comes you will be able to see course content and have input. This time never came.'* (Interview, SBO)

In one state, the orientation had been significantly delayed due to extended consultation. This consultation between the sectors was perceived to be very positive as the SBO felt that they had adequate input into the development of the orientation package. While it extended the time taken for the development process, it was seen as important to ensure the orientation aligns with other relevant activities. Consultation and alignment has been achieved through several strategies:

The SBO meeting with the NACCHO affiliate to develop an appropriate orientation package.

The SBO sending out an online survey to all OWs in the state, in order to identify orientation needs.

The SBO identifying what orientation was required by reviewing position descriptions across the state and consulting with DGPs about the mismatch that has, in some cases, occurred between position descriptions and actual roles being carried out.

One OW based in a DGP indicated that they had attended a workshop in June 2011 about the development of the orientation. This was consistent with the information provided by the SBO.

Orientation effectiveness

When asked if orientation or training had provided them with the skills to fulfil their roles, more than half (5/8) of the OWs interviewed strongly disagreed and two others indicated that they 'don't know/can't say'. This was predominately due to the OWs not yet accessing the orientation, or not accessing additional training. One respondent partly agreed, on the basis of attending the NACCHO workshop.

The interviewed OW based in the AHS in a remote site, who did attend the orientation, viewed it positively:

> 'The orientation program helped me to understand the structure and expectation of the work of an Outreach Worker in the community. However, aspects of an outreach worker's work are almost similar of what the health promotion workers are doing anyway.' (Interview, OW)

The OW based in the DGP within a regional site indicated that the orientation did not give her the skills to fulfil the role. However, she felt that the support offered by the IHPO and the guidelines and job description had assisted.

Differing perspectives between different sectors

Overwhelmingly, the DGP sector viewed the orientation as inappropriate. This is reflected in responses from interviewees in all SBOs, managers within the DGP and a number of OWs. The perception was that the orientation did not assist in providing skills for the role for OWs based in the DGP, as it was focused on work within the AHS sector. These quotes highlight the need for the orientation to give more attention to the role of the OWs in the General Practice sector.

> 'Despite this, we heard the OWs enjoyed it which is different from gaining skills to carry out their role. The focus was on OH&S and safe work practices and a bit more clinical than actually working in DGP.' (Interview, SBO)

> '…very Aboriginal Health Service focussed. Working in General Practices is very different to working in Aboriginal Medical Services. [NACCHO affiliate name] need to work with people from the Division [of General Practice] so they know the GP culture.' (Interview, Manager, DGP)

> '[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. [NACCHO affiliate name] ran three sessions with very small numbers and there was more DGP staff than AHS staff.' (Interview, SBO)

> *'Orientation to happen for them took ages. The orientation was outsourced to the ACCHO sector. [NACCHO affiliate name] ran a two day orientation recently. At the orientation they had 3 OW from AHSs and 8 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.'* (Interview, SBO)

There were also perceptions of the need for a different kind of orientation for OWs based in AHSs, for example:

> *'We needed another kind of orientation to what the role they were doing as outreach workers in DGPs.'* (Interview, SBO)

In contrast to the views of interviewees in the DGPs and SBOs, as reflected above, the perceptions of some of the NACCHO affiliates who had been funded to provide the orientation were more positive, for example:

> *'I would like to highlight the implementation of the orientation package as a major success. All feedback from this training was significantly positive. There is also a comprehensive report that is available upon request. Another success was the motivational interviewing training. Outreach workers developed the skills to motivate behaviour change in an individual. Outreach workers also indicated the significance of these skills and further promoted the training within their respective organisations.'* (Interview, NACCHO affiliate)

Others pointed to the lack of evaluation of the extent to which the orientation had assisted OWs in their role. The timing of the orientation, in relation to when OWs commenced in their roles, was identified as an important factor in determining the effectiveness of the program, as illustrated by the following quote:

> *'The orientation itself has been evaluated but it has not been evaluated on how it has assisted them in their role. DoHA funded us to provide orientation in [state name] for OWs and they went through the process of developing an orientation manual and facilitated 2 days of orientation. They discovered a number of OWs that had been in their role for a year and had not received any orientation. 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 been on board a long time and find detailed information from Medicare and other parts of the package.'* (Interview, NACCHO affiliate)

The lack of orientation (or at least the delays in availability and in the process for determining funding allocations for orientation) was seen to contribute to the uncertainty among stakeholders about the role of the OWs, and therefore of their effectiveness. Even when orientation had been accessed, some appeared unclear of their roles, for example:

> *'There was training and an orientation pack to outline what the role involves for the ICDP workers, though OWs weren't provided with orientation training. NACCHO affiliates had to fight for money for training. [Name state health department] are starting their own training later in the year. It's hard when ICDP workers don't know what their role is.'* (Interview, NACCHO affiliate)

> *'A lot of people have been to the orientation training, but feedback has been that a lot are still unclear of their role.'* (Interview, NACCHO affiliate)

The need for different types of orientation to meet the needs of different groups

As reported in the previous reporting period, the diversity of skills and experience of the recruited OWs presents challenges for the development of orientation packages. In this reporting period stakeholders also highlighted the diversity in roles the OWs play between organisations.

> *'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 …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.'* (Interview, SBO)

The issue of role diversity for the OWs is further complicated by the potential for the roles to change as other ICDP funded positions and programs become established and expectations change. In Chapter 14 there is a discussion about how the establishment of Care Coordinators may influence OW roles, as people in the respective positions work together to support patient care plans and access to services.

> *'As SBOs have workshops with all the ICDP workforce (IHPO, OW and CCSS) this discussion about a role of the OW is emerging in supporting the Care Coordinator 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. I thought one of the ideas was to have a more skilled workforce in health.'* (Interview, SBO)

Entry level positions and OWs with qualifications and experience

The OW positions were originally intended to be 'entry level' positions with regard to a workplace pathway. The intention was for the positions to be drawn from the local community and particular qualifications were not included in the selection criteria. Consistent with this recruitment approach, there is a significant allocation of ICDP funding for individualised training plans to be developed and supported.

Similar to the previous reporting period, stakeholders indicated that the OWs are bringing a wide range and variety of skills and qualifications to the role, from entry level with minimal education backgrounds to highly qualified and experienced professionals. Some OWs would be considered well above 'entry level', for example one OW is a registered nurse and another is a qualified AHW.

> *'Previously she has completed a 'Cert' IV in Aboriginal Health and a certificate in reception operations.'* (Interview, Manager, DGP)

Others, particularly in remote locations, are community people with no formal qualifications.

Generally there has been 'a mixed bag of people coming into the roles as Outreach Workers'. Many have brought qualification levels that are quite high, 'not coming from an entry level as envisaged.'

Training

Individualised training and local availability of training

From what we could ascertain at the time of the evaluation visit, only one OW within the case study sites was, at that time, enrolled in additional training. The OW accessing training was placed in the DGP and was enrolled in a Certificate IV Aboriginal Health Worker training course that was available in a nearby location. This additional training was viewed by colleagues/managers as vital, because the OW had come from an administration, rather than health, background.

One AHS (in an enhanced tracking site) produced a detailed training plan for the OW and indicated that the OW had completed a Certificate IV in Project Management and had commenced this course immediately on employment. No other sites mentioned individualised training plans.

An interviewee in one remote site referred to the challenges of accessing both orientation and individualised training, as staff at the site are often unwilling to travel to cities due to distance and to 'not feeling comfortable to travel alone'. The remote site stakeholders indicated that online training manuals or distance education are not necessarily good solutions to this challenge, because of limited literacy levels and English skills:

> *'training that is online or distance is too challenging for limited literacy levels and English is a second or third language.'* (Interview, NACCHO affiliate)

The implication of this finding is that a high investment of in-community education support is needed for remote community-based adult students who have limited experience of study and English literacy.

In this reporting period there were a small number of interviewees within DGPs starting to question the commencement of OWs on individualised training programs when, at this stage, contracts for the OWs employed in the DGPs end in June 2013. Concern was raised that the training is often done in blocks, which means employees are away from workplaces for significant amounts of time. The perception is that DGPs may not benefit from the investment of time and support for worker training, because the funding and positions will end in eighteen months. Another issue raised was that training courses undertaken may extend beyond the contract period and there would need to be a plan in place to manage this scenario.

> *'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.'* (Interview, DGP)

> *'There are some tensions as the funding is only to June 2013 and this will come quickly. By the time we train this person they will have the funded position come to an end and we may not see directly the investment in time we have committed back to the organisation.'* (Interview, SBO)

Complexity of OW role and implications for training

The diversity of OW roles and of the need for individualised training is also relevant to the potential complexity of the OW role, as identified by one interviewee:

> *'We are learning that the Outreach Worker roles are a lot more complex than what guidelines state.'* (Interview, Manager, DGP)

> *'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.'* (Interview, SBO)

This interviewee also raised the issue that the performance indicators of the Outreach Worker role, such as how many times the worker provides transport and how many times he or she has assisted patients with getting medications, do not reflect the complexities inherent in these roles.

Summary

Orientation had been conducted in the majority of states and territories in the period covered by this report. The majority of interviewees from both sectors expressed frustration that there had been significant delays in the roll out of the orientation. The small number of OWs in the Sentinel Sites who had attended the orientation provides some reflection of perceptions of the value of the orientation in relation to the effort required to access the orientation, and the timing of the available orientation workshops.

The majority of SBOs expressed concerns that they had not been adequately, or in some cases not at all, consulted about the development of the orientation package. Overwhelmingly, the DGP sector viewed the orientation as inappropriate. This is reflected in responses from interviewees in all SBOs, managers within the DGPs in Sentinel Sites and a number of OWs based in the Sentinel Sites. The perception was that the orientation did not assist in providing skills for the role for OWs based in the DGP, as it was focused on work within the AHS sector.

The diversity of skills and experience of the recruited OWs presented challenges for the development of orientation packages. The issue of role diversity for the OWs is further complicated by the potential for the roles to change as other ICDP funded positions and programs become established and expectations change.

There has not been strong uptake of the individualised training. In this reporting period, an emerging issue was concern from some DGPs about commencing OWs on individualised training programs when, at this stage, contracts for the OWs employed in the DGPs may cease before finishing training.

There is a need to further encourage the development by employing organisations of individualised training plans for OWs. Further investigation is required as to why OWs are not undertaking the individualised training, and this will be addressed in future evaluation cycles.

The outputs for year one in the evaluation framework program are vague, and refer simply to 'the measure is implemented according to the work plan'. On the basis of information available to the evaluation team, the extent to which this output has been achieved is not clear.

Processes to deliver the expected early result (year 2-4) that participants in C1 activities are effectively oriented, trained and supported to provide quality care to Indigenous Australians appear to be well under way. However, the extent to which the orientation has contributed to this appears limited, and there has been significant concern expressed about the orientation not being suitable for OWs placed in DGPs. There has also been minimal uptake of the individualised training to date.

19. Expanding the outreach and service capacity of Indigenous Health Services (*Measure C2*)

19.1. Description of measure

This measure provides funding for local Aboriginal and Torres Strait Islander people to work as Outreach Workers (OWs) in Aboriginal Health Services. Outreach Workers will encourage and support Aboriginal and Torres Strait Islander people to access primary health care services and to ensure follow-up treatment is accessed. This may include assisting people to travel to and from appointments.

Outreach Workers will be drawn from the local community and are not expected to have existing qualifications. The Outreach Workers will be supported, mentored and supervised by practice managers and Aboriginal Health Workers (AHW) based in Aboriginal Health Services. Training and orientation for Outreach Workers will be available through measure C1. Funding is also available for practice managers and other health professionals to expand the workforce in regional and remote Aboriginal Health Services, and for additional housing and clinic upgrades to support this workforce.[112,113]

19.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure C2, and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond:

- The measure is implemented according to the work plan.

Expected early result for years 2-4:

- Stronger links are forged between ACCHSs and other health service providers to improve the continuity of care for Indigenous Australians with or at risk of chronic disease.

- Indigenous Australians in contact with participating primary health care providers utilise and value the enhanced services.

19.3. State of implementation

The following information was provided by DoHA on the state of implementation of measure C2 at a national level as at 30th June 2011 (relevant to the SSE).

- Implementation of this measure is considered to be on schedule by DoHA, with staff having been recruited to the majority of funded positions. The national ICDP allocation table for 30 June 2011 shows that:

    – funding allocated for 41.5 FTE Outreach Workers; 37.5 FTE recruited

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[112] DoHA, Expanding the Outreach and Service Capacity of Indigenous Health Services – Fact Sheet [website], (accessed 22 November 2011).
[113] Urbis, ICDP Monitoring and Evaluation Framework, September 2010 [website], (accessed 12 February 2013).

      – funding allocated for 20.10 FTE Practice Managers; 19.5 FTE recruited

      – funding allocated for 12.8 FTE additional health staff; 12.8 FTE recruited.[114]

- The workforce expansion will continue with an additional 22 OWs, 11 practice managers and 9 additional health staff to be funded in 2011-2012, and a further 23 OWs, 12 practice managers and 10 health professionals to be funded in 2012 - 2013. Funding for the 2012 - 2013 positions was announced in October 2011.[115] The next round of allocations will affect the Sentinel Sites of Barkly, Canberra and Dubbo.[116]

- Retention data for the OWs are not provided by DoHA, however the issue of recruitment and retention of OWs in both sectors (AHSs and DGPs) has been raised by the National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates as an issue during the orientation training process. The turnover of OWs has affected the efficient organisation of orientation workshops.[117]

- In response to comments made at the recent Aboriginal and Torres Strait Islander Outreach Workers National Workshop[118] about a lack of clarity surrounding job role and expectations for the OW positions based in AHSs, the DoHA felt that it was important to engage State and Territory Offices to work directly with funded organisations to ensure that there is consistency in the types of activities and the roles performed by Outreach Workers, and that these requirements be reflected in each funded organisation's 2011 - 2012 action plans. In November 2011 State and Territory Offices commenced this process. They will actively monitor progress during the annual review of each organisation's action plan.

- It is expected that OWs will undertake a range of tasks such as: community liaison; facilitating client access to services providing practical assistance and other client support; advocating, networking and collaborating to meet client needs; performing relevant administration tasks and; providing feedback to Health Services regarding access problems.
  Activities for OWs could involve (but are not limited to):

      – distributing information and resources to local Aboriginal and Torres Strait Islander communities about available services and encouraging them to contact primary health care services in their regions (either Aboriginal and Torres Strait Islander specific or private General Practices)

      – encouraging and helping Aboriginal and Torres Strait Islander people to attend initial appointments, return for follow-up appointments with their GP and/or practice nurse, return for relevant diagnostic tests and/or referrals to other primary health care providers (including allied health), attend referred specialised services and care coordination meetings as necessary, and collect prescribed medications from pharmacists.[119]

- Measure C2 also manages and reports on the Indigenous Health Project Officers (IHPO) positions in NACCHO and State/Territory affiliates (excluding ACT). DoHA reports that funding

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[114] DoHA, report National ICDP workforce 30 June 2011
[115] DoHA C2 report, 12 September 2011
[116] The Hon Warren Snowdon MP, media release [website], (accessed 12 February 2013)
[117] DoHA, C1 report, 6 September 2011
[118] NACCHO, Aboriginal and Torres Strait Islander Outreach Workers National Workshop Report, June 21-2nd 2011
[119] DoHA, C2 report, 17 November 2011

was offered to continue employment for these eight IHPO positions in September 2011.[120,121] DoHA also reported that the IHPOs based in the NACCHO affiliates take an active role in providing support and state-wide coordination to assist member organisations in implementing the range of ICDP measures relevant to the community controlled health sector, and to encourage increased cooperation and partnership between the community controlled health sector and the DGP network. [122]

- There are two funded capital works projects within Sentinel Sites reported by DoHA. As at 30 June 2011, funding agreements had been executed for the following: [123]

    – Grafton Sentinel Site - Bulgarr Ngaru Aboriginal Corporation, for a health administration facility

    – Tamworth Sentinel Site - North West Slopes Division of General Practice, for refurbishment of a property for use as a medical centre facility in Tamworth. The refurbishment has commenced.

19.4. Findings from Sentinel Sites

In case study sites where Outreach Worker positions based in AHSs had been filled, stakeholders were interviewed about their awareness and perceptions of the additional workforce capacity. Four case study sites had recruited six OWs based within the AHSs. Of the six OWs in AHSs, only one was available for interview during this reporting period. (Others were unavailable for various reasons, including a recent death in the community and training commitments. They were also not available for follow interviews, at least partly due to unwillingness to do interviews over the phone). Two enhanced tracking sites had OWs recruited to positions in AHSs and were able to provide feedback on the OW roles.

Focus group discussions covered perceptions of access to Health Services (both General Practices and AHSs), participants' awareness of the new Outreach Workers based in AHSs and perceptions of the contribution this expanded workforce had on the quality of care they receive. The findings reported here are based on discussions held in all seventeen community focus groups in the eight case study sites, and include data from some case study sites where an OW had not yet been recruited to the site. Progress with recruitment of OWs has been taken into consideration in the interpretation of the data from each site.

Progress with recruitment of Outreach Workers

Table 23 presents the allocation and recruitment findings from two sources; the DoHA reported allocation and recruitment as at 30 June 2011 and the findings at evaluation visits that occurred between August -October 2011. There are some disparities between the two data sources. In some sites the DoHA report shows a position as filled while the evaluation visit found it to be vacant. This information is detailed in the table and footnotes below. Data on the number (and %) of positions filled, as reported in the text below, are based on the findings at the evaluation visit.

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[120] DoHA C2 report, 12 September 2011
[121] Funding and reporting is provided through measure C3, however measure C2 manages this component of the program.
[122] DoHA C2 report, 12 September 2011
[123] DoHA, C2 report, 19 August 2011

Table 23: Recruitment and retention data for measure C2 workforce by Sentinel Site

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
Case study sites	Katherine West	remote	Katherine West Health Board	2 x OW	2	Positions filled. A part-time male and female recruited[a]
				1.6 x additional health staff	1.6	Position filled since previous report
				0.8 x practice manager	0.8	Position filled since previous report
	Port Augusta	regional	Pika Wiya Health Service Aboriginal Corporation	1 x OW	0	Position not yet filled, recruitment underway
	Campbelltown	urban	Tharawal Aboriginal Medical Service	1 x OW	1	Position filled
	East Pilbara	remote	Puntukurnu Aboriginal Medical Service	1 x OW	1	Position filled[b]
	Bairnsdale	regional	Gippsland and East Gippsland Aboriginal Cooperative	1 x OW	0	Position not yet filled, recruitment underway
				0.8 x additional health staff	0.8	Position filled
	Logan/Woodridge	urban	Aboriginal and Torres Strait Islander Community Health Services	2 x OWs	2	Positions filled[c]
			The Institute for Urban Indigenous Health	1 x practice manager	1	Position filled

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
Enhanced tracking sites	Derby	remote	Derby Aboriginal Health Service	1 x OW	1	Position filled
				1 x additional health staff	1	Position filled
	Swan Hill/ Mildura	regional	Mildura Aboriginal Corporation Inc	1 x OW	0	Position filled until recently, recruitment under way[d]
			Murray Valley Aboriginal Corporation	0.7x practice manager	0.7	Position filled[e]
	Cairns	regional	Wuchopperen Health Service Ltd	1 x OW	1	Position filled
				1 x practice manager	1	Position filled
	Newcastle	urban	Awabakal Newcastle Aboriginal Cooperative Ltd	1 x OW	0	Position filled until recently, recruitment under way[d]
	Darwin	regional	Danila Dilba Health Service	2 x OW	2	Positions filled
				1.6 x additional health staff	1.6	Position filled since previous report
				0.8 x practice manager	0.8	Position filled
	Elizabeth	urban	Nunkuwarrin Yunti Inc.	1 x OW	1	Position filled
Tracking sites	Canberra	urban	Winnunga Nimmityjah Aboriginal Health Service	1 x OW	1	Position filled

Site type	Site name	Rurality	Fundholder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the June 2011 SSE report and as found at evaluation visits
	Geraldton	regional	Geraldton Regional Aboriginal Medical Service	1 x OW	1	Position filled
	Grafton	regional	Bulgarr Ngaru Medical Aboriginal Corporation	1 x OW	1	Position filled
				1 x practice manager	1	Position filled
	Hobart	regional	Tasmanian Aboriginal Centre Inc	1 x OW	0.5	New allocation since previous report Position filled[f, g]
	Dandenong	urban	Dandenong and District Aboriginal Cooperative	1 x OW	1	Position filled
	Gladstone	regional	Nhulundu Wooribah Indigenous Health Organisation	1 x OW	1	Position filled
				1x practice manager	1	Position filled
	Kalgoorlie	regional	Bega Garnbirringu Health Services Aboriginal Corporation	1 x practice manager	1	Position filled
				1 x additional health staff	1	Position filled

[a] Evaluation visit update.

[b] 'Outreach Worker' allocated to East Pilbara has been recruited as one of the generalist positions.

[c] There are 4 OWs allocated to the organisation; 2 OWs with responsibility for Logan/Woodridge area as confirmed at evaluation visit.

[d] DoHA report stated position filled. On evaluation visit it was identified as a recently vacant position with recruitment underway.

[e] DoHA, report National ICDP workforce 30 June 2011. Other stakeholder organisation within the site boundary with measure C2 workforce allocation.

[f] DoHA, C2 report update, 26 March 2012. TAC only has 0.5 OW in Hobart and 0.5 OW in Burnie (which is outside the Sentinel Site boundary).

[g] Evaluation visit February 2012 – DoHA report that practice manager allocated and recruited to TAC however position is based at TAC clinic in Launceston, outside of Sentinel Site boundary and not included in this table.

Note: Excluded from this data are Brisbane South, Dubbo, Tamworth, Barkly, and North Lakes/Caboolture sites which currently do not have C2 allocations.

Full-time Equivalents (FTE).
Source: DoHA, report on ICDP workforce 30 June 2011, unless otherwise indicated.

Recruitment overall

Table 23 shows that 18 of the 24 Sentinel Sites have funding to support OW positions within AHSs (3 remote, 9 regional, and 6 urban). Recruitment to the Outreach Worker positions in the AHSs has progressed well with 17 of the 21 (81 %) positions filled at the time of the evaluation visits. Of the four vacancies, two had resulted from a loss of staff since the March - May 2011 quarter, and two had never been filled. There has been one new OW position allocated for a regional site in this reporting period and the position has been filled.

Most sites have 1.0 FTE allocated to the role, however three sites each have 2.0 FTE OW positions allocated. These three sites represent the three geographic categories; urban, regional and remote. The remote site was allocated two positions because a male and a female worker were required for the role.

Recruitment by rurality

The breakdown of recruitment by rurality shows:

- the remote sites have all OW positions filled (4/4)

- the regional sites have the majority of positions filled (7/10)

- urban sites have almost full recruitment (6/7).

Recruitment by case study site

Six of the sites are case study sites; 2 urban, 2 regional and 2 remote. Four of the six sites have OW positions currently recruited (6 positions)

Awareness of the Outreach Workers based in Aboriginal Health Services

As for the previous reporting period, less than half [42% (35/84)] of interviewees indicated they were aware of an OW based in the AHS in the Sentinel Site. This may be an overestimate of the level of awareness of these positions, as it is evident that a number of interviewees reported they were aware of an OW based in the AHS, when there is no OW position filled in the AHS in their site. This occurred quite frequently in the previous reporting period in the regional sites [30% (12/40)], but less frequently in this reporting period [19% (6/31)], which may indicate increased understanding of the ICDP workforce and who they are.

Clinicians based in the AHS tended to be less aware of the OW based in the AHS than practice managers (8/14 clinicians compared to 6/8 practice managers indicated they were aware of the position). This was consistent with interview data, which showed that the practice manager is often the contact point with the OW, rather than a GP.

Development of the roles of Outreach Workers based in the AHS

Two remote case study sites that have funding for the OW based in the AHS have amended the role to be more locally specific. For example, in one remote site the AHS has pooled all the state and commonwealth ICDP funding for HLWs and OW and made several generalist positions, including partial funding for a reception position.

Perceptions of extent to which OWs are providing a new service

The majority [70% (55/79)] of interviewees agreed with the statement 'The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander community that was not previously available'. The proportion that held this view was similar for interviewees in the AHS sector and the GP sector (Table 24). However, there was a difference between practice managers/clinicians based in AHSs compared to those based in DGPs, with the proportion agreeing to this statement being 72% (13/18) and 39% (7/18) respectively (Table 25). These data indicate that practice managers and clinicians based in the General Practice sector were less positive about the additional capacity that the OWs brought to primary health care services. This is likely to be because in AHSs the OWs are based within the service and have more direct and regular engagement with frontline staff, while for General Practices the OWs are based in the DGP and their role is spread across a number of practices. The overall figures on responses to the statements in the table below appear to have been influenced by the positive responses from managers, some of whom would have been responsible for these positions.

Table 24: Perceptions of the role and contributions of Outreach Workers (% who responded 'strongly agree' or 'partly agree'), overall and by sector

Interview Statement	Overall	Aboriginal Health Sector	General Practice Sector
The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander community that was not previously available. MS, CS, PM[a]	70% (n=79)	66% (n=35)	73% (n=44)
The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander community that were not there previously. MS, CS, PM, OW[a]	67% (n=70)	56% (n=32)	76% (n=38)
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]	46% (n=78)	40% (n=35)	51% (n=43)
The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islanders. CS, PM, OW[a]	44% (n=36)	50% (n=14)	41% (n=22)

[a] Type of interview respondent, see Appendix D 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: Aboriginal Health Services, NACCHO State and Territory Affiliates.
General Practice Sector includes: General Practice, Divisions of General Practice and Division State Based Organisations.

Table 25: Clinicians' and Practice Managers' perceptions of the role and contributions of Outreach Workers (% who responded 'strongly agree' or 'partly agree'), overall and by sector

Interview Statement	Overall	Aboriginal Health Service	General Practice
The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander community that was not previously available. CS, PM[a]	56% (n=36)	72% (n=18)	39% (n=18)

Interview Statement	Overall	Aboriginal Health Service	General Practice
The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander community that were not there previously. CS, PM[a]	49% (n=35)	44% (n=18)	53 % (n=17)
Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker. CS, PM[a]	29% (n=35)	44% (n=18)	12% (n=17)
The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islanders. CS, PM[a]	40% (n=30)	54% (n=13)	29% (n=17)

[a] Type of interview respondent, see Appendix D 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'.

Role of the Outreach Worker

The OWs undertook a variety of roles within the AHSs including engaging community, increasing awareness of the ICDP, assisting with follow-up of clients, identifying community members who would benefit from health services such as a health check, providing transport, increasing cultural awareness of clinicians and, to a lesser extent assisting with home medication reviews, assisting with interpretation and explanation in the clinicians' rooms and in pharmacies, coordination of specialist clinics and development of culturally appropriate resources.

Interviewees often viewed these roles as alleviating pressure on clinic staff, leaving them more able to concentrate on clinical work while the OW focused on community engagement and increasing access to services through their work linking community members with services.

> *'The outreach workers are definitely an addition. Previously there were only clinical health workers who were doing outreach work and community work. Now the focus can be specific [for clinical staff and for outreach]. Outreach workers can attend events outside the service that are important to the community.'* (Interview, GP, AHS)

A number of OWs based in the AHSs were being used to fill gaps in clinic operations. Despite this, and in contrast to the previous reporting period, there were no comments about confusion between the roles of OWs and AHWs within AHSs in the current evaluation cycle.

> *'Because we are multi-skilled we have to fill in gaps at the clinic for staff absenteeism, and staff shortages.'* (Interview, OW, AHS)

> *'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.'* (Interview, Manager, AHS)

The data presented in this section provide a general indication that the role of the OWs is becoming more clearly defined and understood within AHS teams.

Community engagement and outreach

The primary focus of the OW roles based within the AHS appears to have been on increasing community awareness and therefore community engagement with ICDP funded services, in particular the PIP Indigenous Health Incentive and the PBS Co-payment measure. The strategies to achieve greater awareness generally included community visits, networking with organisations and attending and organising community events.

The majority [67% (47/70)] of interviewees agreed with the statement *'The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander community that were not there previously'.* However, this perception tended to be held more commonly by interviewees in the General Practice sector than in the AHS sector - 76% (29/38) compared to 56% (18/32) (Table 24). Practice managers and clinicians in both the AHS and General Practice sectors were less likely to hold this perception than interviewees in general [49% (17/35)], and this difference was most noticeable among the practice managers and clinicians in the AHS sector [where 44% (8/18) agreed with this statement] (Table 25).

These data indicate that the particular role of developing links with the local Aboriginal and Torres Strait Islander community is valued by some stakeholders in both sectors, but appears to be more important in the General Practice sector, possibly because the AHSs already have established links with the community.

Interviewees in one case study site spoke about the role the OW plays in providing a 'community service'. In this particular case, the OW assisted with non-clinical work such as organizing 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.

Stakeholder interviewees commonly referred to the role that OWs based within the AHSs play in providing follow–up care in the community. OWs are often utilised to follow-up clients for appointments and to ensure ongoing care.

Assistance with specialist clinics

In one remote enhanced tracking site, the OW based in the AHS was working closely with the visiting MSOAP-ICD teams and other visiting specialist teams. The role in this context involved 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 MSOAP-ICD team visits) was documented.

Provision of transport

The extent to which OWs provided transport varied between sites. In the remote sites, it appeared that the OWs were not involved in the provision of transport services. In one regional site, the OW was providing transport, and this was seen as vital to the role because other transport options were not available to patients. In the urban sites, OWs were providing transport in some instances, but their role in assisting with transport was more commonly through linking clients to the existing transport services. A clinician in one AHS commented on the value of the transport service being offered by the OW due to the previous transport service being over stretched. The perception was that the OW role had increased access.

> *'We have a patient having 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.'* (Interview, GP, AHS)

Culturally appropriate care and resources

About half of interviewees [44% (16/36)] agreed with the statement *'The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islanders'*. This perception was similar for interviewees in the AHS sector and the GP sector. However, practice managers and clinicians in the GP sector were less likely to agree with this statement [29% (5/17)] in comparison with interviewees in general, and particularly in comparison with practice managers and clinicians in the AHS sector [54% (7/13)]. While about a third (36%) of interviewees responded 'don't know/can't say' to this statement, this appeared to be mainly because they were unsure of the influence that OWs might be having on cultural appropriateness of care, and in some cases were unsure of what the OWs were doing in their day to day work.

In one site, interviewees indicated that the OW had assisted by providing advice and support to clinicians about how to provide more culturally appropriate care, and that the OW had been involved in the development of Aboriginal specific material.

> *'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.'* (Interview, GP, AHS)

Vignette – a clearly defined OW role

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 (HMR) pharmacist as a 'cultural broker' when the pharmacist does home visits. The OW is being up-skilled in 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 back 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).

Increased regular attendance at Health Service

About half of interviewees [44% (16/36)] agreed with 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'.* This perception was similar for interviewees in the AHS sector and the GP sector. However, practice managers and clinicians in the GP sector were less likely to agree with this statement [12% (2/17)] in comparison with interviewees in general, and particularly in comparison with practice managers and clinicians in the AHS sector [44% (8/18)]. The role of the OW in encouraging regular attendance of clients in the AHS sector is also reflected in other data presented above, and appears to be valued by a range of stakeholders in the AHS sector.

Support to Outreach Workers

It is important that the OWs are embedded into a support structure within the AHS. The extent to which this was happening varied between case study sites. In two urban case study sites the OWs felt well supported. Both sites had two OWs based in the AHS and this created the potential for peer support. In addition, one OW 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 an established member of the service team. This OW brought significant experience, clinical understanding and skills to the position.

In both remote case study sites the support structure for the OWs was perceived by stakeholders to be inadequate. In one site the OW commented on the lack of support, as a result of being based in a location that was a long distance from the central administration centre. In the other remote site, interviewees from a number of organisations perceived that the local work environment did not provide adequate support for the OW because it was a busy clinic focused on acute care.

Vignette – challenges of OW roles and support

In one remote site the resources of a busy clinic, run by the AHS, tend to be focused on providing acute care, including emergency medical evacuations. The clinic coordinator, who manages the OWs, has neither the capacity nor the management structure to provide effective support. The coordinator's role in supporting other AHS clinics in the region takes her away from the community for periods of time, leaving the OWs, who have limited education backgrounds, with minimal day-to-day support and direction, in an acute care environment where their roles are not always clear. Both OWs have needed to take considerable time off work due to family business and personal illness.

Staff at the NACCHO affiliate office have limited capacity to provide support because they are so far away, and telephone support is difficult due to lack of a common first language.

'I have been unable to support the outreach workers in [Site A] – my role is to support them [but] …. The support is only as good as they want it to be. I have tried calling lots and offered to come out but the workers also are [often] off sick and I think the clinic are worried about me coming all that way and they are not there. I can't engage with right people - it needs to be face-to-face, distance is a challenge.'

Despite these challenges, staff in the AHS and in other organisations recognise the initiative and innovation shown by the two OWs in developing their own roles and work direction. The male OW is working hard with his own initiatives and ideas – *'with right kind of support and right kind of training he would be a 'brilliant' Outreach Worker'*. The female OW combines her outreach role with administrative work in the AHS.

It is generally felt that a more effective support structure and better planning of the OWs roles in the Health Service are needed. A locally suggested solution is for the part-time Chronic Diseases Coordinator, a nurse position, to be based in the community in order to increase the clinic's focus on chronic disease prevention and management, and to help guide, support, and develop the skills of the OWs.

Community members' perceptions of the Outreach Worker role

Similar to the previous reporting period, community focus group participants did not make any references to the new OWs based in AHSs. The OWs were present in a number of group sessions in Campbelltown, because they had been involved in the organisation of the community focus groups. It is possible that community members do not distinguish these roles from that of Aboriginal Health Workers.

As in the previous reporting period, community focus group participants identified a number of barriers and enablers to accessing Aboriginal Health Services that were relevant to the roles of the OWs.

Links between the Outreach Worker based in the Division of General Practice and the Aboriginal Health Service

There is variability in the links between the OWs based at DGPs and OWs based in the AHSs. In both urban case study sites the positions work together:

- In one of the urban sites, the OW funded through the DGP is based in the AHS, together with the OW funded at the AHS. The arrangement has enabled the OWs to support each other in their roles.

- In another urban site, the OW based in the AHS works closely with the IHPO and the OW based in the local DGP. There was a pre-existing relationship between the IHPO at the DGP and the OW based in the AHS. The OW noted that the relationship had been helpful in carrying out her role.

The OWs provided examples of ways they were working together, which included having a shared work plan, and networking across organisations by attending and organizing events together (including community meetings). One OW felt that this *'strategy of working together has led to increased the number of Aboriginal Health Checks in [site name].'* (Interview, ICDP Worker)

In the remote case study sites, (and in one enhanced tracking site), there was no contact between the OW in the AHS and the OW in the DGP due to geographical distances. In one regional enhanced tracking site, the OW was not working with the OW based in the DGP, due to tensions between these organisations.

Summary

Progress with recruitment to OW positions is now well advanced, with over 80% of positions filled. However, there continues to be relatively low awareness of these positions among service staff and community members.

For those who are aware of the positions, the contributions of the OWs are perceived positively. Perceptions of the contribution are more positive in AHSs than in General Practice, probably because of the more direct involvement of OWs in AHSs.

The OWs appear to be taking on diverse roles, depending on the local needs. Different aspects of the role are valued to varying extents by different stakeholders, and the strengthening of links between the services and the community appears to be especially valued by service staff and managers.

The inadequacy of, and the need for, effective support structures was highlighted by interviewees. Where OWs have had opportunities for peer support this appears to have been beneficial. Strengthening of peer support arrangements is therefore a potential strategy for enhancing support for OWs.

It is still too early to assess the extent to which the OWs will be effective in contributing to stronger links being forged between AHSs and other health service providers. However, a number of the roles that OWs are engaged in should improve the continuity of care for Indigenous Australians with, or at risk of, chronic disease.

With regard to the expected early result that 'Indigenous Australians in contact with participating primary health care providers utilize and value the enhanced services', there is still no clear indication that members of the community in Sentinel Sites have a sense of enhanced services as a result of the SSE, and even if they felt there was an improvement in services, the extent to which it would be possible to link this to the C2 Measures is also not clear.

20. Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care (*Measure C3*)

20.1. Description of measure

To improve the accessibility and quality of General Practice for Aboriginal and Torres Strait Islander people, Outreach Workers (OW) and Indigenous Health Project Officers (IHPO) are to be employed within the Divisions of General Practice network (DGP). It is expected that the Outreach Workers will be drawn from the local Aboriginal and Torres Strait Islander community and may not have existing qualifications. Required orientation and optional training will be provided through measure C1.[124] Outreach Workers will encourage and support Aboriginal and Torres Strait Islander people to access primary health care services and to ensure follow-up treatment is accessed. This may include assisting people to travel to and from appointments. The IHPOs will support the OWs.

IHPO positions are being funded to provide leadership in Aboriginal and Torres Strait Islander health issues within Divisions of General Practice, including increasing awareness and understanding of the various ICDP initiatives relevant to mainstream primary care.

Specifically, IHPOs will work in DGPs to improve the capacity of mainstream primary care providers to deliver culturally sensitive services to Aboriginal and Torres Strait Islander people (including through supporting cultural awareness training, quality improvement, health promotion and education, and Indigenous liaison); to help community members access mainstream primary care providers and to work together with AHSs to improve health outcomes for Aboriginal and Torres Strait Islander people; and to support Outreach Workers.

Funding is also provided for IHPO positions in State Based Organisations (SBOs) and the Australian General Practice Network (AGPN) to lead and coordinate Indigenous health activities at the state and national levels.[125] In addition, IHPOs have been funded in National Aboriginal Community Controlled Health Organisation (NACCHO) and its affiliates to provide a similar leadership and coordination role within the community controlled sector, and to encourage cooperation between the two sectors (reported under measure C2).[126]

20.2. Program logic

As specified in the National Framework the following outputs and early results in relation to measure C3, and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond:

- The measure is implemented according to work plan.

- Indigenous Australians in contact with participating primary health care providers value the enhanced services.

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[124] Training will become available for Certificate II level in Aboriginal and/or Torres Strait Islander Primary Health Care. DoHA, Closing the Gap Improving Indigenous Access to Mainstream Health Primary Care Indigenous Health Project Officers and Aboriginal and Torres Strait Islander Outreach Workers Program Guidelines [website], (accessed 12 February 2013).
[125] DoHA, Engaging Divisions of General Practice to improve Indigenous access to mainstream primary care – Factsheet [website], (accessed 12 February 2013).
[126] DoHA, ICDP Annual Progress Report, November 2010.

Program Logic expected early results for years 2-4:

- Stronger links are forged between primary health care services to assist Indigenous people.

- General practices have a greater understanding of the health needs of Indigenous people and improved capacity to provide quality care.

20.3. State of implementation

The following information was provided by DoHA on the state of implementation of measure C3 at a national level as at 30 June 2011 (relevant to the SSE).

The workforce allocation for C3 has now been completed and is in the maintenance phase.

A six month project (April 2011-September 2011) was undertaken 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.[127]

More recently, the C3 OW workforce role definitions have been raised as an issue due to variations in practice compared with what is described in the funding agreements and guidelines. Complexity particularly results from people in the same roles having differing levels of experience and qualifications, and from the expectation that their work is partly determined by local needs. However, DoHA has reaffirmed that the OW's role is non-clinical, regardless of the qualifications of the person employed.[128]

20.4. Findings from the Sentinel Sites

Interviewees were asked about their awareness and perceptions of the IHPO and OW positions based within DGPs. See Chapter 19 and Tables 24 and 25, for more information on the way stakeholders responded to statements, in regard to OWs based in both the AHS and DGP and differing perceptions of the OW role.

Focus group discussions covered community members' perceptions of access to Health Services (both mainstream and Aboriginal Health Services) and awareness of new Outreach Worker positions based in DGPs to assist with access. The findings reported here are based on discussions held in all seventeen community focus groups in the eight case study sites. See Appendix E for further information on focus group profiles.

Progress with recruitment

Table 26 presents the allocation and recruitment findings from two sources; the DoHA reported allocation and recruitment data as at 30 June 2011, and the findings at evaluation visits that occurred between August -October 2011. There are some disparities between the two data sources. In some sites, the DoHA report shows a position as filled that, at the evaluation visit, was found to be vacant. Data on the number (and %) of positions filled, reported in the text below, are based on the findings at the evaluation visit.

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[127] AGPN website [website],(accessed 22 November 2011).
[128] DoHA, C3 personal communication, 23 November 2011.

Table 26: Division of General Practice ICDP allocation and recruitment data for Sentinel Sites

Site type	Sentinel Site	Rurality	Fundholder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention changes since the June 2011 SSE report and found at evaluation visit
Case study sites	Port Augusta	regional	Flinders & Far North Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled since previous report
	Brisbane South	urban	Brisbane South Division of General Practice	1 x IHPO	1.0	Position filled-staff changed since previous report[a]
				1 x OW	1.0	Position filled- change of model and staff since program commenced[b]
	Campbell-town	urban	Sydney South West GP Link (formerly Macarthur Division of General Practice Ltd	1 x IHPO	1.0	Position filled[c]
				2 x OW	2.0	One position filled since previous report[d]
	Tamworth	regional	North West Slopes Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
	Bairnsdale	regional	East Gippsland Primary Health Alliance	0.75 x IHPO	0.75	Position filled
				1 x OW	1.0	Position filled
	East Pilbara	remote	Pilbara Health Network	1 x IHPO	1.0	Position filled
				1 x OW	0	Position filled until recently, recruitment under way[e]
	Logan/ Woodridge	urban	South East Primary Health Care Network	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
Enhanced tracking sites	Derby	remote	Boab Health Services (formerly Kimberley Division of General Practice)	1 x IHPO	1.0	Position filled
				1 x OW	0	Position filled until recently, recruitment under way[f]

Site type	Sentinel Site	Rurality	Fundholder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention changes since the June 2011 SSE report and found at evaluation visit
	Newcastle	urban	GP Access	1 x IHPO	1.0	Position filled– change of staff since program commenced[a]
				1 x OW	1.0	Position filled– change of staff since program commenced[a]
	Cairns	regional	Far North Queensland Rural Division of General Practice	1 x IHPO	1.0	Position filled
				2 x OWs	2.0	One position filled since previous report
	Swan Hill/ Mildura	regional	Mallee Health Care Network (formerly Mallee Division of General practice)	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
	Darwin	regional	General Practice Network NT	1x IHPO	1.0	Position filled[g]
				1.5 x OWs	1.0	One position filled, one position not yet filled[g]
	Elizabeth	urban	Adelaide Northern Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	2.0	Positions filled[h]
	Dubbo	regional	Dubbo Plains Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
	Barkly	remote	General Practice Network NT	2 x IHPO	2.0	Positions filled, one OW position not yet filled[i]
				3 x OW	2.0	Positions filled, one OW position not yet filled[i]
Tracking sites	Canberra	urban	ACT Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled since previous report
	Geraldton	regional	Mid West General Practice Network	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled

Site type	Sentinel Site	Rurality	Fundholder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention changes since the June 2011 SSE report and found at evaluation visit
	Grafton	regional	Mid North Coast (NSW) Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
	Hobart	regional	General Practice South	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled since previous report
	Dandenong	urban	Dandenong Casey General Practice Association	0.75 x IHPO	0.75	Position filled
			Peninsula GP Network	0.75 x IHPO	0.75	Position filled – change of staff since program commenced[a]
				1 x OW	1.0	Positions filled – change of staff and model since program commenced[j]
	Gladstone	regional	Capricornia Division of General Practice	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled since previous report
	Kalgoorlie	regional	Goldfields Esperance GP network	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
	North Lakes/ Caboolture	urban	GP Partners	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled
			Moreton Bay General Practice Network	1 x IHPO	1.0	Position filled
				1 x OW	1.0	Position filled

[a] Update found at evaluation visits and website review.

[b] Brisbane South Division had funded 2 part-time Outreach Worker positions within the funding package provided. This period it was one full-time OW.

[c] One full-time IHPO position split into two part-time positions to cover Campbelltown and Fairfield/Liverpool regions.

[d] One OW is based at Tharawal and covers Campbelltown region. Second OW is based at Marumali and covers Fairfield-Liverpool region.

[e] DoHA reported position filled, found to be recently vacant on evaluation visit. Organisation states they have difficulty with recruitment due to competition with the mining industry.

[f] DoHA reported position filled, found to be recently vacant on evaluation visit. Also to note the Derby C3 roles do not work in the Derby site boundary but focus on Broome.

[g] DoHA, Report on ICDP measure C3, 14 June 2011. General Practice Network NT is funded for IHPOs and Outreach Workers for Darwin and Alice Springs. There is one IHPO recruited for Darwin and one for Alice Springs. The second IHPO commenced employment after February 2011.The General Practice Network NT progress reports 1 July 2010-31 December 2010 state that two full-time female Aboriginal OWs are recruited for Darwin and Alice Springs respectively. One male Aboriginal OW is to work part-time in Darwin and part-time in Alice Springs

[h] Adelaide Northern Division of General Practice, personal communication, 10 October 2011. DoHA reports 1 allocation funded but 2 positions filled. The organisation stated that they have used other funding to top up to 2 FTE as they felt it important to have one male and one female OW.

[i] The General Practice Network NT cover the whole of NT. The ICDP roles have been allocated to certain regions according to the 6 month DGP reporting to the DoHA. At this stage it is unclear whether Barkly region has coverage by these workers. This will be identifiable in the next reporting round. For this table the workforce have been listed but will not be included in the following text.

[j] Had been 2 part-time OWs now 1 full-time person.

Note: This table excludes Katherine West as there are no ICDP workers allocated to the DGP with coverage of the site. While the allocated IHPO and OW positions may include responsibility for the Sentinel Site, they generally cover an area which extends beyond the Sentinel Site boundaries.

Full-time Equivalent (FTE), Indigenous Health Project Officer (IHPO), Outreach Worker (OW).

Source: DoHA, report on ICDP workforce 30 June 2011

Recruitment Overall

Table 26 lists the IHPO and OW position allocation and recruitment for measure C3 in Sentinel Sites. Twenty-two of the twenty four Sentinel Sites have funding for IHPO and OW positions: eight urban, twelve regional and two remote. Note that two urban sites have two DGPs as key stakeholders and each of those DGPs have C3 workforce allocation. The Barkly site has been excluded from this count as it is unclear whether the workers will cover the region. They are positioned in Darwin and Alice Springs at this stage.

There have been 50 positions allocated to organisations in the Sentinel Sites. Ninety-six percent (48/50) of positions were filled at the time of the evaluation visits (note, one organisation had funding for one worker but created a second position and this is included in the count). Recruitment was under way for the vacant positions. Seven of the positions had been recruited to since the March -May 2011 quarter (six were filled for the first time and one was a replacement position). Sixty-four per cent (32/50) of positions had been filled by the same workers for at least six months. Six other positions have had a change of staff since the initial recruitment, but when this change occurred is not known to the SSE.

Recruitment - Indigenous Health Project Officer

The data show that all sites have an IHPO recruited, with only three sites having had a change of IHPO staff at some stage since commencement. The majority of IHPOs were full-time, however three IHPO positions in Sentinel Sites had 0.75 FTE allocation and another position was split into two positions, with each IHPO covering a distinct geographical area. The implementation of this workforce has been achieved, with all positions allocated and recruited. The IHPO strategy had achieved a maintenance phase.

Recruitment - Outreach Workers

Ninety-one per cent (20/22) of Sentinel Sites with a funding allocation for OW positions had at least one position filled. Since the last report (March - May 2011), six more positions were filled. There remained three vacancies (one not filled previously). Three OW positions have had a change in staff since the initial recruitment, but when this occurred is not known to the SSE.

The majority of sites have been allocated 1 FTE OW per organisation, with exceptions in two urban sites with 2 FTE OWs, and two regional sites with 2 FTE and 1.5 FTE positions respectively. The sites in which there were two OW positions reflected the need for both a male and a female worker and/or coverage of large regions. One of the urban sites had been allocated 1 FTE funded OW, but chose to fund a second full-time position in order to have a male and a female worker. Another interesting model change was seen in two other urban sites, in which each full-time OW position had

initially been split into two part-time positions, but with staff changes had resumed the model of 1 FTE OW position.

The eight urban sites had full recruitment, with two positions filled since the previous report. The twelve regional sites had full recruitment in 11/12 sites and one site was still recruiting to its second position. Four of the regional OW positions were filled since the previous report. The two remote sites, however, had recently lost staff and were again recruiting to the OW positions. One remote site commented on the difficulty of recruiting in general, because of competition for staff with the mining industry sector.

In comparison with the IHPO positions in Sentinel Sites, the OW positions have generally been filled later, have taken longer to be established and have had more turnover of staff. At the time of reporting, the implementation phase of the OW workforce allocation was nearing completion, with only one position never filled, and was moving to the maintenance phase.

Awareness of the Workforce

Awareness - Indigenous Health Project Officer

Similar to the previous reporting period, there appeared to be a high level of awareness of the IHPO positions based in the DGPs, with 73% (62/85) of interviewees indicating that they were aware of the positions (see Table 27). The highest awareness of the IHPO in the DGP was in regional sites [94% (30/32)], followed by urban [74% (22/31)] and remote sites [41% (9/22)]. This probably reflected a less active role of DGPs in the remote sites compared with regional and urban sites. The lower level of awareness in the urban sites, relative to the regional sites, possibly reflected the more complex service environment in urban sites. (Urban sites are characterized by a greater variety and larger numbers of health workers and Health Services and consequently, new workers generally have to compete for attention in the primary health care environment and are less likely to be noticed than in less complex service environments.) To be most effective in their role, IHPOs needed to create a high level of awareness among health professionals of their presence and role. Therefore, the level of awareness among health professionals was, to some extent, a measure of the effectiveness of the IHPO. The SSE will continue to monitor awareness of the IHPO positions.

As expected for the IHPOs based in SBOs and NACCHO state/territory affiliates, who were less likely to be directly involved in the Sentinel Sites at a local level, interviewees tended to be less aware of these positions than of those based in the DGPs. (This was expected because of the broader / higher level roles and their responsibility for supporting activities across a whole state/territory rather than a smaller area such as a DGP.) However, as discussed above, awareness at a local Sentinel Site level may, to some extent, reflect the effectiveness of these positions. Thirty–seven percent (32/86) of interviewees indicated they were aware of the IHPO at the NACCHO state/territory affiliate and 37% (32/86) stated that they were aware of the IHPO based at the Division State Based Organisation.

From the limited data available on trends at this stage of the SSE, there is no clear evidence of a shift in levels of awareness of the IHPO positions in these organisations.

Table 27: Awareness of Indigenous Health Project Officer (% who responded 'yes') overall and by rurality

Interview Statement	Rurality	December 2010	June 2011	December 2011
Are you aware of new Indigenous Health Project Officers (IHPO), based in the Division of General Practice? CS, MS, PM[a]	Overall	67% (n=39)	73% (n=81)	73% (n=85)
	Remote	18% (n=11)	44% (n=16)	41% (n=22)
	Regional	87% (n=15)	93% (n=40)	94% (n=32)
	Urban	85% (n=13)	60% (n=25)	74% (n=31)
Are you aware of the new IHPO based at the NACCHO State Affiliate? CS, MS, PM[a]	Overall	46% (n=39)	35% (n=81)	37% (n=86)
	Remote	45% (n=11)	31% (n=16)	32% (n=22)
	Regional	27% (n=15)	35% (n=40)	39% (n=33)
	Urban	69% (n=13)	36% (n=25)	39% (n=31)
Are you aware of the new IHPO based at the Division State Based Organisation? CS, MS, PM[a]	Overall	28% (n=39)	38% (n=81)	37% (n=86)
	Remote	18% (n=11)	31% (n=16)	36% (n=22)
	Regional	13% (n=15)	38% (n=40)	39% (n=33)
	Urban	54% (n=13)	44% (n=25)	35% (n=31)

[a] Type of interview respondent, see Appendix D 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 awareness of the IHPO based in the DGP varied between interviewees from different sectors (Table 28), with those in the GP sector having a higher level of awareness of this position (89% (41/46) compared to 54% (21/39) in the Aboriginal Health sector).

In General Practice, it is interesting to note that the practice managers (10/10) expressed more awareness than clinicians (11/16) of the IHPO based in the DGP. This was supported by interview data, where the IHPO contact would often be with the practice manager in regard to raising awareness of the new measures under the ICDP, rather than directly with clinicians.

When interviewees who indicated an awareness of an IHPO were asked which IHPO they had communicated with, 71% (47/66) nominated the IHPO based at the DGP, 17% (11/66) nominated the IHPO based in the NACCHO state / territory affiliate and 19% (12/66) the IHPO at the Divisions State Based Organisation. The statements represented below are based on the IHPO with whom the person had the most communication. The higher level of communication of stakeholders with the IHPOs based in DGPs is consistent with the larger number of IHPOS in such positions, the smaller areas for which they have responsibility, and their role in working more directly with stakeholders in front line service provider organisations.

Table 28: Awareness of Indigenous Health Project Officer (% who responded 'yes') overall and by sector

Interview Statement	Overall	Aboriginal Health Service	General Practice
Managers', Practice Managers' & Clinicians' awareness of the IHPO based in the Division of General Practice	73% (n=85)	54% (n=39)	89% (n=46)
Practice managers' awareness of the IHPO based in the Division of General Practice	82% (n=17)	57% (n=7)	100% (n=10)
Clinicians' awareness of the IHPO based in the Division of General Practice?	63% (n=30)	57% (n=14)	69% (n=16)

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

Awareness - Outreach Workers

There was an increase in awareness of the Outreach Workers based in the DGP for this reporting period [70% (60/86)] compared to the previous reporting period [57% (46/81)]. The difference in awareness of interviewees by rurality was similar to the previous reporting period: lower awareness for remote sites [32 % (7/22)] than urban sites [71% (22/31)] and regional sites [94% (31/33)]. In regional sites awareness of the OW based in the DGP increased from 60% (24/40) in the previous reporting period to 94% in this reporting period. As reported in the last round and again this round, this finding contrasts with the awareness of the OW in Aboriginal Health Services, where awareness of the position was higher in remote sites (as reported for the C2 measure).

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 consults 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.'*

The practice nurse 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.'*

Perceptions of the Role and Contribution of the IHPOs

Table 29 details responses of stakeholders who strongly or partly agreed to a series of statements on the role and contributions of the IHPO. Agreement with these statements was strong across urban, regional and remote sites, and tended to be slightly higher in urban sites than in regional or remote sites. Interviewees from the General Practice sector had a markedly higher agreement to the statements than the Aboriginal Health sector. The practice managers were generally more positive about the role of the IHPO, though this is linked to them having greater awareness of the role and contribution than the clinicians.

There was a strong perception that the IHPOs were contributing to a raised awareness of the ICDP measures, and a less strong perception of their contribution to improving access, developing stronger links between primary care providers, and improving identification of Aboriginal and Torres Strait Islander people attending General Practices.

Table 29: Perceptions of the role and contributions of the Indigenous Health Project Officer % who strongly or partly agreed

Interview Statements	Managers, Practice Managers & Clinicians	Practice Managers & Clinicians	Practice Managers	Clinicians	Managers
The IHPO has contributed to improved access to Health Services. (n=35) CS, PM[a]	66%(n=65)	57%(n=35)	71%(n=14)	48%(n=21)	77%(n=30)
The IHPO has been helpful in assisting to raise awareness of the new measures being implemented under the ICDP. (n=35) CS, PM[a]	78%(n=65)	74% n=35)	93%(n=14)	62%(n=21)	83%(n=30)
The IHPO has contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practice. (n=35) CS, PM[a]	59%(n=66)	54%(n=35)	71%(n=14)	43%(n=21)	65%(n=31)
The employment of IHPOs has helped to develop stronger links between Primary Health Care services. (n=35) CS, PM[a]	64%(n=66)	48%(n=35)	64%(n=14)	38%(n=21)	81%(n=31)

[a] Type of interview respondent, see Appendix D 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'.

The following section explores the contributions made by both the IHPOs and OWs. The IHPOs and OWs are often deployed as teams in DGPs. The funding allocation was designed for an IHPO to be appointed first, followed by the recruitment of an OW.

Improved access to Health Services

Overall, 65% (43/65) of interviewees strongly or partly agreed that the IHPO had improved access to Health Services. In the General Practice sector, 51% (22/43) of stakeholder interviewees agreed that Aboriginal and Torres Strait Islander people were attending Health Services more regularly as a result of the work of the OW.

Some information presented for measure C2 on perceptions of the impact of the OWs is relevant to the C3 measure as well: about half of interviewees (44% (16/36) agreed with 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'. This perception was similar for interviewees in the AHS sector and the GP sector. However, practice managers and clinicians in the GP sector were less likely to agree with this statement [12% (2/17)], in comparison with interviewees in general and particularly in comparison with practice managers and clinicians in the AHS sector [44% (8/18)].

The way IHPOs and OWs worked towards improving access, and subsequent awareness of ICDP measure by communities and General Practices, varied between sites. This variation was generally in terms of the balance between/emphasis on various approaches, which included:

• working at the community level, raising awareness of measures and encouraging patients to drive change within General Practices

• working directly and only with General Practices to raise awareness and to change practices in ways that encourage access

• working with practice support teams, to assist them to raise awareness of the ICDP measures

• a combination of all of the above.

A number of stakeholders talked about how the work of their IHPOs and OWs targeted both practice and community levels.

Concern was raised by one 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 at the expense of General Practices. Funding for Care Coordination for this DGP was consequently delayed, because of the SBOs concerns.

DoHA provided the SSE team with the latest available DGP reports, which were for the period 1 July 2010 to 31 December 2010[129]. Due to the information contained being out of date by almost one year, it was difficult to apply the information meaningfully to the SSE formative evaluation, which requires triangulation of administrative data and qualitative site evaluation findings every 6 months in order to provide close to 'real time' feedback to the DoHA. Of the twenty-two DGP 6 month reports received, the OW key performance indicators were reported by only twelve sites in which OWs were employed (many of the other positions were still under recruitment). Comments accompanying these data did highlight two areas of concern for the reporting organisations:

• Distance and transport issues can restrict the reach of the OW role.

• The OW role and activities are not adequately captured in the performance indicators. Examples were given of time spent doing other tasks, such as: communicating with community transport agencies, the Aboriginal and broader health sectors and government departments; providing cultural safety and brokerage in relation to each of the indicators; many episodes of supporting clients referred to crisis support; performing medical reception duties; reminding people of their appointments; providing transport; supporting patients at hospital outpatients, pathology and x-ray departments.

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[129] DoHA, Division of General Practice 6 month reports July – December 2010.

Vignette – improving access

One particular practice offers an example of how support roles provided through DGPs are improving Aboriginal and Torres Strait Islander access to General Practice in real and practical ways.

The suburban General Practice provides a seven days a week service in a regional city. It has seven doctors and two practice nurses. 35% of patients are Aboriginal or Torres Strait Islander, routinely identified on a recently revised patient registration form. The practice's commitment to providing culturally appropriate care has been enabled through the role of the local IHPO and OWs in several ways. Following the IHPO visit, [practice x) extended their existing policy of bulk-billing concession card holders and patients under sixteen to include all patients eligible for the PIP Indigenous Health Incentive. The practice has recruited an Aboriginal Health Worker using the PIP Indigenous Health Incentive funds and is in the process of establishing a referral system so that OWs can help with client transport to improve access.

'Aboriginal people like to come to our practice as it has a … personable approach [and] you can … generally be seen quickly. [We] have a combination of drop in and appointment. … We encourage people to come back for test results to allow for further investigation and we [now have resources to] ring and … reschedule if they don't turn up.'

Raise awareness of the new measures being implemented under the ICDP

General Practice approach

Overall, 78% (51/65) of interviewees strongly or partly agreed that the IHPO had been helpful in raising awareness of the new measures available under the ICDP. Interviewees across all sites spoke about the role of the IHPO in raising awareness of the measures and observed that this has been, and will continue to be, a focus of their work. A number of stakeholders within General Practice indicated that the IHPO had assisted greatly by bringing their attention to material provided by DoHA and by explaining the measures and how to implement them. A number of practice staff commented that the information *'would have just sat in the in tray'* if the IHPO had not brought it to their attention.

> *' … assisted us to implement measures through provision of information, especially walking us through criteria for each measure.'* (Interview, GP, General Practice)

> *'[The IHPO] visited and provided a folder. This had information about the CtG program. We found it very helpful to have this information folder and we have referred to it many times. I have also rung when I needed to clarify things.'* (Interview, practice manager, General Practice)

The initial focus of work has been on encouraging identification of patients at practices and on the sign up process for registering both practices and patients. A number of IHPOs indicated that the focus of their work in supporting General Practices had evolved from signing up patients to helping establish systems to undertake follow-up care and receive tiered payments.

Community approach

An important focus of the work of the IHPOs and OWs (particularly the OWs), has been to raise community awareness of the new ICDP measures and to encourage community members to identify at Health Services.

> *'Time has been spent engaging with the Aboriginal community to encourage them to advocate on their own behalf [at] the practice to engage in PIP Indigenous Health Incentive.'* (Interview, IHPO, DGP)

This strategy has been implemented through community education days, development of pamphlets that are culturally appropriate and individual discussions. A number of DGPs have held community events. Generally the feedback from stakeholders was positive about engagement with communities to raise awareness of the ICDP.

> *'The DGP office has done a lot to promote it and I will give you a few examples. We had a big 'close the gap' day which was a big fanfare here. Media were invited and [there were] all sorts of shows to interest and attract people such as dances and sporting activities. In between we interspaced talks on 'close the gap' [PBS and PIP Indigenous Health Incentive] and all of this was quite warmly received by the community and well attended. For example, holding community health days - I actually attended and provided a health information session.'* (Interview, GP, General Practice)

In one site, however, there were contrasting perspectives on a particular 'Close the Gap' day. The SBO and the DGP spoke very positively about the day, but a General Practice manager who attended reported being dismayed to find that he was the only person that attended besides DGP staff.

As reported in Chapters 13 and 11 community focus groups reported an awareness of the PIP Indigenous Health Incentive and PBS Co-payment, though there has been some confusion between the measures from a community perspective.

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 or 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.' (Interview, SBO)

Improvements in Aboriginal and Torres Strait Islander identification at General Practices

Overall, 59% (39/66) of interviewees strongly or partly agreed that the IHPO had contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practices. Practice managers tended to be more likely to agree with this statement (10/14) than clinicians (9/21). Few

interviewees (5/17) from the General Practice sector (practice managers and clinicians) agreed that the OW had assisted the practice with providing more culturally appropriate care. The perception of the relatively limited role of the OWs in relation to providing more culturally appropriate care may be because this role was more likely to be taken up by the IHPO.

There has been a delay in the roll out of the cultural awareness training that is required when a practice signs up to the PIP Indigenous Health Incentive (see Chapter 13). A number of issues with access to cultural awareness training were noted during this evaluation reporting period. With more General Practices accessing the training, it is expected that there may be an increase in practices systematically and routinely identifying Aboriginal or Torres Strait Islander patients in the future.

Improvement in identification at General Practices was consistently noted as being a major focus on the program of work of IHPOs and OWs. This was evident in case study sites and in the enhanced tracking sites. A number of examples of this program of work are provided in vignettes within this section.

Identification work was focused on the following areas:

- Supporting General Practices to create 'Aboriginal friendly environments'

- Emphasising the clinical link between quality of care and ethnicity

- Supporting practices to organise systems to embed routine identification by provision of examples and training of staff (particular reception staff) on how and why to ask about Aboriginal or Torres Strait Islander status

- Encouraging community members to identify at practices (through community awareness raising events and promotional literature)

- Promoting the financial benefits to practices (through access to financial incentives such as the PIP Indigenous Health Incentive and health assessments payments).

As reported in Chapter 7 on clinical indicators, it was found that continued work is required on systems to support identification of Aboriginal and Torres Strait Islander people, not only in General Practice but also in Aboriginal Health Services.

Within General Practices, the number of regular clients identified in the practice information system as Aboriginal and Torres Strait Islander ranged from 18 to 797. Ten of the 17 General Practices had more than 50 clients identified as Aboriginal and Torres Strait Islander, seven had more than 100 and five had more than 200. Most General Practices seemed to be identifying only adults as Aboriginal and Torres Strait Islander. For all except two General Practices, the total reported number of regular clients identified as Aboriginal and Torres Strait Islander was the same as the number reported to be aged 15 years or more.

As a proportion of all regular clients, the range for those identified as Aboriginal and Torres Strait Islander was from 0.3% to 6.8%. For three 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. In other words, for the majority of practices (13/16) Aboriginal and Torres Strait Islander people made up a smaller proportion of regular clients than the proportion of the population who were identified as Aboriginal and Torres Strait Islander in the total population for the Sentinel Site.

In contrast to the GP sector, the challenge for some in the AHS sector has been that some clients may be inappropriately identifying as Aboriginal in order to gain the benefits available through the

ICDP. AHSs, which by definition have a predominantly Aboriginal or Torres Strait Islander clientele, have not generally been focused on recording Aboriginal and/or Torres Strait Islander status. Services that have some non-Indigenous clients have found themselves needing to institute systems to record Indigenous status. Interviewees in at least one site spoke about the challenges the Healthy for Life reporting had presented with the requirement to differentiate between Indigenous and non-Indigenous patients, and the need to establish systems to accurately capture Indigenous status. IHPOs in DGPs did not indicate that they have been supporting AHSs in their efforts to routinely identify patients, and interviewees in AHSs did not indicate that they were looking for this sort of support.

Vignette – improving identification of Indigenous patients

The IHPO and OW at the DGP in a regional city were diligent in visiting General Practices to inform them about the ICDP. *'We had 148 practices on our list and we visited most of them'*. They were concerned that a number of practices were not identifying Indigenous patients, and did not have systems in place for identification.

In one practice, a patient questionnaire was suggested as a useful way of identifying patients. *'We went to [the practice] and they had three identified patients. I live out that way and know that there is heaps more Aboriginal people out there than that so I said to them why don't we do a little questionnaire 1) who is your next of kin 2) what is your latest phone number 3) are you of Aboriginal and/or Islander descent and 4) smoking status. Within a month they rang us and said they had identified 87 clients. The GP from the practice said he always identified by colour [previously], but now he asks every single patient.'* (Interview, IHPO)

Vignette – providing a welcoming environment

A General Practice in a capital city has found that displaying the Aboriginal and Torres Strait Islander flags (provided by the IHPO and OW) has attracted Indigenous patients. Small flags are displayed on the reception desk and the staff wear Aboriginal flag pins. '*We didn't realise the extent it made a difference. Also if we have done the [cultural awareness] we wear a flag on our uniforms to identify that we, as a practice, have actually done the Aboriginal and Torres Strait Islander training.'*

Most of the reception staff and practice nurse have done the cultural awareness training offered through the DGP. Patients have provided positive feedback.

'We actually had one lady who was out of our area who came down to our practice and had been to other surgeries but felt really comfortable here. She was an Aboriginal elder… and was really quite impressed with the fact that we had done the training. …. She actually wrote to our state manager about it … about having all the services here and [people] feeling comfortable coming in and know that they are not going to be treated like they are different. It made her feel welcome.'

Vignette – motivating and supporting identification

Staff in a General Practice in an urban site had differing views about the impact of the OW and IHPO in raising awareness of the need to identify Aboriginal patients. The practice manager identified the Royal Australian College of General Practitioners (RACGP) as the main driver, when the RACGP made the systematic and routine identification of Aboriginal and Torres Strait Islander patients a requirement to meet accreditation standards. '*The IHPO role was to confirm and support us, in that we [also] needed to do this so we could offer PIP and PBS.'*

The IHPO had helped the practice to create a culturally welcoming environment and to encourage access. 'The IHPO provided pamphlets and posters to put in waiting room, and a sign is placed at the front desk on why we ask Aboriginal status.'

The practice manager believes that the way people are asked has avoided challenges in getting people to identify. '*I go to lots of meetings with other practice managers and they all have difficulties getting people to identify or hostility from people who are asked who aren't. I find tone of voice helps and how casually you ask. No one then takes offence. This is what I get staff to do is ask with a gentle tone of voice.'*

Development of stronger links between primary health care services

Overall, 64% (42/66) of interviewees strongly or partly agreed that the employment of the IHPO had helped to develop stronger links between primary health care services. However, there was a lack of clear information on how this was being achieved or examples of benefits derived from these links.

Geographical coverage

Individual IHPOs and OWs need to cover the entire geographical area of a DGP, which in some cases is larger than the Sentinel Sites boundary. In remote sites, the relevant DGPs were focusing their work on areas that are not within the Sentinel Site boundaries. In this reporting period, stakeholders indicated that they were starting to target their efforts towards General Practices that were interested and wanting to engage, rather than expending time on ones that, on the basis of initial visits, did not wish to engage.

Ongoing funding concerns

There were a number of stakeholders in a number of sites and sectors who expressed concern that the IHPO and OW funding was due to cease in June 2012. Concern was raised for a number of reasons:

- The program of work has only recently started to make an impact and it was felt that longer time frames will be required to see a true change.

- Some DGPs were reluctant to invest time and energy into training OWs when the training program timeframes, if commenced at this stage, may exceed the length of OWs contracts. DGPs felt that they may not reap the fruits of their investments.

- There has been staff turnover, and it is difficult to recruit to positions that are only offered for a further six months.

  'This is not going to get the time required to implement the program properly. If this [program] ends in 2012 it would be a disaster. Many people have put so much time into implementing incentives and programs and are only part way down the track and need to keep going. If we continue to collaborate and work together the government needs to work together more to consolidate this. The first 3 years is initial implementation and they need at least another 3 years for implementation and to collect the data that comes out of that. They need a minimum 6 years. Recruitment takes 2-3 months. Then you have to train the staff, and then 6 months down the track the worker might be making an impact.'
  (Interview, NACCHO affiliate)

Sharing of information

The DGP network has established email lists. Twice yearly meetings have been organised by the SBO. These email communications and meetings encourage sharing and collaboration between IHPOs based in the DGPs and avoid duplication of effort in developing resources.

Organisational support

Lack of infrastructure (e.g. office facilities, not only in DGP workplaces but also for placements in General Practices) was not raised as an issue during interviews in this reporting period, despite being raised in the previous two reporting periods.

As in previous reporting periods, concerns were noted about lack of cultural safety for Indigenous staff in the working environment of some DGPs. In the previous reporting period, interviewees in one site spoke about the importance of building Aboriginal health teams to provide peer support. In this reporting period this concept was discussed more broadly by interviewees in State based Organisations and Sentinel Sites, including a number of enhanced tracking sites. The team strategy aimed to reduce the sense of isolation for Aboriginal and Torres Strait Islander staff employed within DGPs and to 'share the load of Aboriginal Health' within organisations. A number of sites, in particular the sites with higher registrations for PIP Indigenous Health Incentive and PBS items, had this team structure in place and felt it had contributed to providing a supportive structure for team members. It was viewed as a challenge when the IHPO and/or the OW needed to advocate with managers for Aboriginal health matters to take higher priority, compared with being part of a strategic management approach and structure that ensured all staff were responsible for supporting Aboriginal health initiatives. In a number of these sites, people also spoke about linking in with the practice support team and using every GP and practice staff education session or program as an opportunity to have an Aboriginal component.

Vignette – supportive work environment

In one regional site, a relatively high proportion of the population are Aboriginal. Therefore, the local DGP is accustomed to working on Indigenous health issues and programs, and has worked closely with the Aboriginal Health Service over many years, investing time and effort into the development and maintenance of joint advisory groups for different programs.

This is a positive working environment for ICDP funded staff. The IHPO and OW have been working collaboratively with the DGP practice support team and the new Care Coordinator to visit General Practices, providing information and encouraging those practices that are not signed up for PIP Indigenous Health Incentive to access incentives and services. Referral forms for care coordination have been developed in consultation with GPs. Time has also been spent raising the awareness of the Aboriginal community to encourage them to advocate on their own behalf for practices to engage in the PIP Indigenous Health Incentive. This community engagement has meant that people *'… actually come and ask to be signed up. They are being very proactive.'*

The role of Divisions of General Practice (and Medicare Locals)

In this and previous reporting periods, the perceived strong and robust relationships between DGPs and General Practices were again noted as being important for enabling roll out of the ICDP measures.

The IHPO and OW played an important role in facilitating links between General Practices and the communities they serve. In this reporting round, an increased number of stakeholders made particular mention of utilising the existing practice support teams within DGPs to assist with the dissemination of material on the ICDP to General Practices and that this had been a useful strategy.

> *'Going out as teams with the practice support team (some have even given funding to practice support team and the practice support team does visits on their behalf).'* (Interview, DGP)

As highlighted in the previous report, it will be important to ensure that as Medicare Locals are rolled out, the contribution made to the implementation of the ICDP to date by DGPs, and the importance of the Medicare Locals in playing a vital ongoing role, is not overlooked.

Summary

The recruitment to IHPO and OW positions has continued to progress well, with almost complete recruitment to IHPO positions in DGPs. There is also ongoing evidence of a high level of awareness of IHPOs, and increasing awareness of the OW positions in DGPs. There are positive perceptions of the contributions being made by the IHPO and the OW, particularly in supporting improved access to primary care services, in raising awareness of the measures amongst providers and community members, and contributing to improved identification of Aboriginal or Torres Strait Islander status among clients attending General Practices.

There is evidence emerging that the new workers are becoming established as teams, and are being integrated with existing teams within DGPs. The impact of these new workers appears to have been more marked where this has occurred. However, concerns were expressed in relation to uncertainty of the potential to extend positions beyond the current employment contracts, and this uncertainty is likely to impact on the effective functioning of these workers. These issues highlight the importance of the role of the DGPs in relation to engagement of GPs in new initiatives, and the concerns identified here are linked to the establishment of the Medicare Locals and the dis-establishment of DGPs.

The extent to which the expected outputs as specified in the evaluation framework are being achieved continues to be unclear. As reflected elsewhere in this report, there is to date limited evidence of enhanced services as a result of the ICDP, and there is no clear evidence that community members are yet experiencing the intended benefits of the ICDP (aside from the PBS Co-payments removing the cost barrier to filling prescriptions and possibly increasing adherence to medication). In the context of discussion regarding the potential to extend the contracts of the new workers, interviewees also highlighted the need to be realistic about the timeframes in which these new workers could be expected to have an impact.

21. Attracting More People to Work in Indigenous Health *(Measure C4)*

This measure is not covered by the scope of the Sentinel Sites Evaluation, however the description and general implementation have been included in this report to reflect its corresponding activity.

21.1. 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. [130]

21.2. State of Implementation

The following information was provided by DoHA on the state of implementation of measure C4 at a national level as at 31 August 2011: [131]

- The advertising campaign 'Health Heroes', which prompts Aboriginal and Torres Strait Islander secondary students to visit the campaign website[132], was launched on 24 July 2011. The campaign, based on extensive research, focuses on real people in a diverse range of careers in the health sector. It is 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 career advisor resource kit (poster, brochures and DVD) will be mailed to approximately 1300 schools.

- A national program of community engagement sessions and school workshops, which are attended by health professionals and aim to encourage careers in health, commenced. In August-November 2011 there were 20 sessions planned in NSW, QldQld, Vic and SA, with further sessions planned for 2012 and 2013.

- The 'Do Something Real' website[133], which targets existing health professionals and health students, was launched by Minister Snowdon on 9 August 2011

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[130] DoHA, C4 report, 31 August 2011.
[131] DoHA, C4 report, 31 August 2011.
[132] DoHA, Health Heroes [website], (accessed 9 December 2011).
[133] DoHA, Do Something Real [website], (accessed 9 December 2011).

22.   Clinical Practice and Decision Support Guidelines (*Measure C5*)

It was agreed with DoHA that due to early stages of implementation and limited impact at this stage within Sentinel Sites this measure would not be evaluated during this reporting period.

22.1. Description of measure

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 is being developed. The resource is intended to bring together, in a single resource, existing tools, guides and other information that promotes 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 to be amended to include information specific to Aboriginal and Torres Strait Islander people.[134]

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[134] DoHA, Clinical Practice and Decision Support Guidelines – Fact Sheet [website], (accessed 29 November 2011).