

Australian Government
Department of Health and Ageing

CLOSING THE GAP
tackling Indigenous chronic disease

Sentinel Sites Evaluation

Interim Report

June 2012

menzies school of health research

Closing the Gap.

ABBREVIATIONS

The following abbreviations are used in this document:

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AHS	Aboriginal Health Service
AHW	Aboriginal Health Worker
AIHW	Australian Institute for Health and Welfare
AMS	Aboriginal Medical Service
APCC	Australian Primary Care Collaborative
CC	Care Coordinator
CCSS	Care Coordination & Supplementary Services
CDSM	Chronic Disease Self-Management
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CtG	Closing the Gap
DGP	Division of General Practice
CHAP	Community Health Action Pack
DoHA	Department of Health and Ageing
EHSDI	Expanding Health Services Delivery Initiative
FTE	Full-Time Equivalent
GP	General Practitioner
GPMP	General Practitioner Management Plan
H4L	Healthy for Life
HLW	Healthy Lifestyle Worker
ICDP	Indigenous Chronic Disease Package
IHPO	Indigenous Health Project Officer
IUIH	Institute for Urban Indigenous Health

KWHB	Katherine West Health Board Aboriginal Corporation
MBS	Medicare Benefits Schedule
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
OW	Outreach Worker
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PIRS	Patient Information Recall System
QAIHC	Queensland Aboriginal and Islander Health Council
QUMAX	Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples
RACGP	Royal Australian College of General Practitioners
RTC	Regional Tobacco Coordinator
S100	Section 100 of the National Health Act 1953
SBO	State-Based Organisation
SEIFA	Socio-Economic Index for Areas
SLA	Statistical Local Area
SSE	Sentinel Sites Evaluation
TAW	Tobacco Action Worker
TCA	Team Care Arrangement
USOAP	Urban Specialist Outreach Assistance Program

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DEFINITIONS

For the purposes of this report:

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

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

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

STRUCTURE OF THE REPORT

This report is made up of four sections: the summary, main body of the report, case studies 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 case studies provide a description of how various measures are working together in urban, regional and remote locations.
- The appendices contain more detailed information on the background, evaluation methods and analysis of the data presented in the main report.

1. EXECUTIVE SUMMARY

There has been steady progress with implementation of the Indigenous Chronic Disease Package (ICDP) since the previous reporting period, with evidence of activity at a local level for almost all measures.

Tackling Smoking and Healthy Lifestyle: Recruitment to positions funded under this priority area (Healthy Lifestyle Workers (HLWs), Regional Tobacco Coordinators (RTCs) and Tobacco Action Workers (TAWs) within the Sentinel Sites is largely on track and funding for a substantial number of new positions within the sites has recently been allocated. While recruitment has generally progressed well, the lack of sufficient appropriately skilled applicants and/or high turnover of staff are issues of concern in several sites (including in urban, regional and remote locations). Various approaches to establishing the teams have been developed to overcome recruitment challenges, to support people working in these positions and to suit the local context.

There continues to be limited awareness of the teams amongst DGP staff, private General Practice staff, and clinical staff and to some extent amongst community members. There was a notable lack of recording of smoking status in clinical information systems and this is likely to present a barrier to effective implementation of brief interventions and smoking cessation measures in Health Services.

In this reporting period there appeared to be increased awareness of the national level resources, greater awareness of targeted grant funding availability and some evidence of project level activities related to the targeted grant funding. Access to targeted grant funding was seen to be at least partially dependent on organisational capacity to apply for funding and local stakeholders' perceptions of capacity to effectively utilise funding. It is difficult to gauge the impact of measure A3 related activity as the implementation of activities was at a very early stage in most Sentinel Sites.

PBS Co-payment measure: There is an increasingly high level of awareness of this measure among stakeholders and positive perceptions of the information available to support the measure, especially the role of the Indigenous Health Project Officers (IHPOs) and Outreach Workers (OWs) and Medicare liaison officers. 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, pharmacists, hospital staff and stakeholders in remote sites) continue to be identified by site level stakeholders.

There is increasing evidence that some General Practices with relatively small numbers of Aboriginal and Torres Strait Islander patients are reluctant to participate in the Practice Incentives Program (PIP) Indigenous Health Incentive because they do not see it as time and cost effective to implement the required systems, hence preventing access for their patients to the Pharmaceutical Benefits Scheme (PBS) Co-payment measure.

Patients continue to report difficulty with identifying practices registered for the PIP Indigenous Health Incentive and Health Service staff report difficulties with determining if non-regular patients are registered for the PBS Co-payment measure. There is an ongoing need for a system to allow staff to ascertain if patients are already registered for the PBS Co-payment.

Continuing the trend reflected in the previous report, there is an increasingly widely held perception amongst stakeholders that the PBS Co-payment has made medications more

accessible. Also, the access through removal (or reduction) in cost is translating into improved adherence to prescribed medications and encouraging more regular attendance for health care in general.

There are increasingly strong suggestions from stakeholders that it is timely to increase emphasis on Home Medication Reviews as a way to enhance safe use of medication and adherence to prescribed medication schedules.

There continues to be evidence of a need to raise cultural awareness among some community pharmacists and staff.

Higher utilisation costs for Medicare items: There continues to be an increase in claims for adult health assessments, and follow-up items by practice nurses and Aboriginal Health Workers (AHWs). Claims for follow-up items by Allied Health Professionals have shown a slower increasing trend, but it needs to be recognised that claims for follow-up items by Allied Health Professionals under this measure are not necessarily a good reflection of access by Aboriginal and Torres Strait Islander peoples to allied health services. 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. The increase in the number of private General Practices claiming adult health assessments (while small in absolute numbers in most sites) provides some evidence of impact of the ICDP.

PIP Indigenous Health Incentive: There is a continuing steady increase in private General Practices registering for the PIP Indigenous Health Incentive with substantial scope for further increases. In contrast, the majority of AHSs had signed on prior to this reporting period with relatively little scope for further increases.

There continues to appear to be a strong focus on registering patients, with relatively limited emphasis on completing the requirements to receive a Tier 1 payment. There were exceptionally low rates of Tier 1 payments being triggered nationally. There continues to be little evidence of a shift to a more planned or coordinated approach to care and the poor state of development of clinical information systems (including identification of Aboriginal and Torres Strait Islander patients on these systems).The ability of staff to effectively use available systems continues to be a barrier to high quality chronic illness care.

The understanding of community members of what the PIP registration process is about continues to be very limited. Interviewees continued to indicate that the registration process was administratively burdensome (particularly the re-registration process) and there was ongoing confusion with eligibility criteria. In this reporting period an increasing number of interviewees suggested that payments should be made for delivery of care rather than for registration of patients.

Care Coordination and Supplementary Services: The application process that required demonstration of consultation and planning at local or regional level means this measure has been rolled out in a fundamentally different way to other measures. While there is some evidence of benefits of the planning and consultation, there have been challenges in the effective integration of the care coordination function into existing service systems. Care Coordinators (CCs) describe the role as administratively burdensome, and largely about service navigation rather than managing patients' care and coordination of clinical interventions.

The CC positions have limited population coverage (even in reaching specific vulnerable groups who would stand to benefit most from the program) because of small numbers of positions with responsibility for coverage of large geographic areas or large populations and the consequent need to focus their effort in specific areas. The model of employing a specific person in the CC position is the only approach that has been used in Sentinel Sites, and this may be a constraint on population coverage. Use of alternative models (as outlined in the guidelines for the Care Coordination and Supplementary Services (CCSS) measure) may provide benefits in terms of population coverage and greater integration of care coordination functions into existing primary health care systems.

There is evidence of complementarity between the care coordination roles and other ICDP measures, specifically enhancing self-management capacity. In contrast, stakeholders pointed to potential conflict between the Supplementary Service (SS) funding being used to cover specialist private fees and the USOAP measure that aims to get specialists to work in Aboriginal Health Services (AHSs) at bulk billing rates.

Uptake of the SS funding continues to be limited, partly because of uncertainty about how to use the funding and partly because of the requirement that other potential sources of funding are to be expended before SS funding can be used.

The State-Based Organisations (SBOs) have provided support for CCs (and other ICDP funded workers) and it will be important to ensure there is a mechanism for ongoing support and linking of CCs at the state and territory level.

Increasing access to specialists and multidisciplinary team care: There is evidence of an increase in Urban Specialist Outreach Assistance Program (USOAP) and the Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease (MSOAP-ICD) implementation at the local level since the previous reporting period.

Fundholding is exclusively through the AHSs in the Sentinel Sites. There were some concerns raised about barriers to referral by private General Practice.

In some sites, the identification of specialists has been guided by need, whereas in other sites it appeared to have been determined largely by availability and interest of particular specialists.

Lack of equipment to conduct procedures and investigations in the primary health care facility continues to be identified as a limitation of specialist outreach.

Community members showed some awareness and were in principle supportive of USOAP. The value of not having to pay out of pocket at the point of service was a highly valued element of USOAP.

Underuse of specialist outreach services has emerged as a key concern in many locations. The low use of some specialist services has been attributed to the recent establishment of services, high number of locum General Practitioners (GPs) (who are unaware of referral processes) and GPs being slow to change established referral pathways. The low numbers of patients referred and/or attending these clinics is a threat to the continued participation of specialists and is affecting the motivation of Health Service staff to support specialist outreach.

Workforce Expansion and Support: Progress with recruitment of OWs in both the Divisions of General Practice (DGPs) and AHSs, and of Indigenous Health Project Officers (IHPO) based in

the DGPs is advanced and remains relatively stable. Due to geographical factors, IHPOs and OWs based in DGPs are not active within any of the remote Sentinel Sites.

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, organising access to cultural awareness training and in contributing to improved identification of Aboriginal or Torres Strait Islander status among patients attending General Practices. There is some evidence that the intensity of the ICDP in terms of numbers of ICDP funded workers per population is associated with higher uptake of PIP Indigenous Health Incentive registrations, health assessments and PBS Co-payment.

It appears that the role of the OWs is increasingly becoming more clearly defined and understood within the AHSs, or at least the AHSs are able to define the OW role within their own Health Service more clearly. For OWs in AHSs adequate supervision and support in time-poor environments is a key constraint on the effectiveness of these new positions for some of the sites, particularly in smaller remote health centres. Development of culturally safe team-based approaches, networking, collaboration and organisational support provided by the SBOs are emerging as critical enabling factors for the effectiveness of the IHPO and OWs based in DGPs. With specific exceptions in some sites, there was a lack of evidence of OWs and IHPOs in the two sectors working collaboratively.

Uptake and effectiveness of OW orientation appears to have generally improved since the previous reporting period, although the extent of uptake of orientation in remote sites remains problematic. Challenges in design and delivery of appropriate orientation training includes wide diversity in OW skills and experience, differing task demands depending on work environment and team composition and changing roles as other aspects of ICDP are progressively implemented and established.

Low overall uptake of funding for individualised training was evident across the sites. Factors contributing to the low uptake included lack of awareness of the funding and confusion over eligibility, lack of capacity in some employing organisations to identify training needs and match these to training opportunities, lack of capacity to complete the administrative requirements for access to training (often for a single individual) and early stage of recruitment of OWs in some areas with needs still being identified.

Whilst GP Registrar and training opportunities for nurses were valued in Sentinel Sites, capacity constraints, primarily related to lack of qualified supervisors and lack of physical infrastructure, constrained their uptake (particularly for GP Registrars). There was little evidence from the Sentinel Sites that the ICDP funded scholarships have created opportunities that were not previously available to support training for nurses.

Organisational capacity and support: Organisational stability, leadership and commitment to improve Aboriginal health, adequate supervision, particularly in sites where workers have to cover large geographic areas and team functioning are emerging as key factors in effective implementation of the ICDP. High turnover of staff, high numbers of locum doctors and nursing staff present particular challenges for effective implementation of many of the measures.

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

Identification of Aboriginal and Torres Strait Islander patients with chronic disease in clinical information systems: The poor state of development of clinical information systems in many primary health care services continues to be the most striking feature of the clinical indicator data that has been made available for the SSE. Poorly developed clinical information systems and lack of staff capability to use clinical information systems to support chronic illness care 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 patients of primary health care services, and those Aboriginal and Torres Strait Islander patients who have a chronic illness, or who have risk factors which predispose them to the development of chronic illness. There is a vital need for systematic approaches to develop Health Service staff capability in the effective use of clinical information systems to support chronic illness care.

Transition to Medicare Locals: Some informants saw the transition as an opportunity for greater focus on Aboriginal health due to the increased focus on planning for population health needs. However, others identified potential disruptions resulting from new appointments and requirements for reapplication for positions. Amongst the seven Sentinel Sites where transitions to Medicare Local arrangements had occurred, there is some evidence of the transition causing temporary disruption to ICDP implementation in some sites, but long-term effects are not yet clear.

2. BACKGROUND AND APPROACH

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

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

The SSE is a three year program of evaluation, scheduled to complete in December 2012. It 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').[2] The 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).

Evaluation findings are presented in relation to each of the ICDP measures and in relation to themes under each measure. The final section of the report provides detailed case studies that aim to identify barriers and facilitators to effective implementation of the ICDP across the various ruralities.

Our intention 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. A final evaluation report will be produced in January 2013.

[1] For more information on the ICDP, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/home-1> (accessed 9 April 2012).
[2] Urbis, ICDP Monitoring and Evaluation Framework, September 2010, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ICDP-monitoring-and-evaluation-framework> (accessed 9 April 2012).

2.2. About the Indigenous Chronic Disease Package

The ICDP is funded over four years from 2009-2013 and represents the Australian Government's contribution of $805.5 million to the National Partnership Agreement on Closing the Gap in Aboriginal and Torres Strait Islander 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 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 has three priority focus areas with a number of specific measures within each priority area (Table 2.1). The program is managed across seven Divisions of the DoHA with the Office of Aboriginal and Torres Strait Islander Health (OATSIH) having responsibility for overall coordination and governance.

Table 2.1: Priority areas, measures and funding under the Indigenous Chronic Disease Package, 2009-2013

Priority area	Key	Measure	Funds allocated 2009-2013 ($million)
Tackle chronic disease risk factors (Priority area - smoking)	A1	National action to reduce Indigenous smoking rates	$100.61
	A2	Helping Indigenous people reduce their risk of chronic disease	$37.53
	A3	Local Indigenous community campaigns to promote better health	$22.70
Primary health care services that deliver: Improved chronic disease management and follow-up care	B1	Subsidising PBS Medicine Co-payments	$88.70
	B2	Higher utilisation costs for MBS and PBS Co-payment	$140.40
	B3	Supporting primary care providers to coordinate chronic disease management	$115.08
	B4	Improving Indigenous participation in health care through chronic disease self-management	$18.56
	B5	Increasing access to specialist and multidisciplinary team care	$70.78
	B6	Monitoring and evaluation	$39.94
Fixing the gaps and improving the patient journey: Workforce expansion and support	C1	Workforce support, education and training	$17.74
	C2	Expanding the outreach and service capacity of Indigenous health organizations	$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, <http://www.health.gov.au/internet/ctg/Publishing.nsf/Content/icdp-monitoring-and-evaluation-framework/$file/ICDP%20evaluation%20framework%20vol%201.pdf> (accessed 5 April 2012).

2.3. Scope and purpose of this report

In order to provide the DoHA with early identification of implementation successes and problems and to guide ongoing refinement of the ICDP, the SSE produces six monthly interim evaluation reports. This report is the fourth interim evaluation report providing a summary of the findings of the SSE up to June 2012. The timeframes for the various data sources varies and are detailed in Section 4.

The broad scope of the ICDP and the primary focus of the SSE on monitoring implementation at the local level in purposively selected sites, mean the SSE will not provide a comprehensive evaluation of the overall program.

In order to be optimally useful to the managers responsible for implementation, findings are presented separately for each of the measures. 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 (Appendix A).

In the previous report (December 2011), we presented case studies of three sites at varying stages of ICDP implementation in order to provide an additional perspective on factors that may explain variation in uptake of various ICDP measures between sites. Building on these case studies and on additional data collected in this reporting period, in this evaluation report, we provide cross-case comparisons based on rurality in order to illustrate how the different measures of the ICDP have been implemented in specific contexts and geographic settings.

In order for the design and implementation of the measures to be refined in a way that maximises the potential for them to work in a complementary and synergistic way in the range of settings across Australia, it is important that people with the responsibility of managing specific measures understand how the range of measures are playing out on the ground and the extent to which synergies are being achieved in practical terms at the local level. We therefore encourage measure managers to read not only the sections of the report that refer to their specific area of responsibility, but also the sections on other measures that have the potential to play a complementary role. The final report, which will be developed at the end of the SSE, will draw together information and lessons learned throughout the period of implementation of the project.

The large number of indicators in the National Framework and the qualitative nature of many of the indicators result in a lengthy document. We have endeavored to make the report as concise as possible while at the same time dealing with a wide range of important issues in sufficient detail to provide clear justification for our findings.

The report needs to be interpreted in the light of the overall aim of the SSE being to 'provide place-based monitoring and formative evaluation of the ICDP'. The specific objectives of the SSE, which are reflected and addressed throughout this and the other interim evaluation reports, are to:

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

2.4. Other issues

ETHICAL OVERSIGHT

The Department established an Evaluation Ethics Advisory Group to provide advice on the ethical conduct of the ICDP evaluation including the SSE. The Evaluation Ethics Advisory Group endorsed the application for the SSE project on 29 October 2010. As a result of constraints on the ability of key members of the Departmental Evaluation Ethics Advisory Group to have ongoing involvement in ethical oversight of the SSE, Menzies subsequently submitted an application to the Departmental Ethics Committee to provide ongoing ethical oversight for the remainder of the SSE. The Departmental Ethics Committee granted ethical approval for the SSE in April 2012.

GENERALISABILITY

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

- The Sentinel Sites included in SSE all have at least one Aboriginal Health Service (AHS). The presence of an AHS may mean that these sites have a different pattern of utilisation of private General Practices, compared to communities without AHSs.
- Site selection was to some extent based on where ICDP investment was occurring relatively early and/or was more intense and therefore ICDP measures may be better established in some of these sites than in some other communities.
- Participation in the SSE may have increased understanding and awareness of the ICDP in the community. Feedback from sites, particularly the case study sites where more in-depth data collection occurs, has been that the SSE team has been an important source of information about the ICDP. In addition, site-specific feedback of data provides early opportunities for locally-initiated system improvements. These factors may have influenced how ICDP measures were taken up in the Sentinel Sites compared to other communities. The provision of site-specific feedback to local stakeholder organisations is consistent with Aboriginal and Torres Strait Islander research values and therefore considered a core part of the evaluation.

EVOLUTION OF UNDERSTANDING AND DATA INTEGRITY

Each interim evaluation report builds on the previous interim evaluation reports. As the evaluation progresses, the development of relationships and trust with key stakeholders and informants in each site helps to develop in-depth understanding of the issues addressed in the evaluation and enhances the integrity of the data being collected.

EVOLUTION OF METHODS AND APPROACHES

Evaluation methods and approach to analysis are being refined throughout the SSE 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 differences and similarities between sites 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 following section outlines the Sentinel Sites and implications for interpretation of findings from the SSE.

3. OVERVIEW OF SENTINEL SITES

3.1. Location and stage of site establishment

The SSE has established a total of twenty-four Sentinel Sites for the purposes of the evaluation. These include urban, regional and remote sites located across the States/Territories (Figure 3.1). As indicated in the figure, there are three different types of sites: tracking, enhanced tracking and case study sites, distinguished by the depth of data collection at each site. The differences between these types of sites and implications are described further in Section 4.

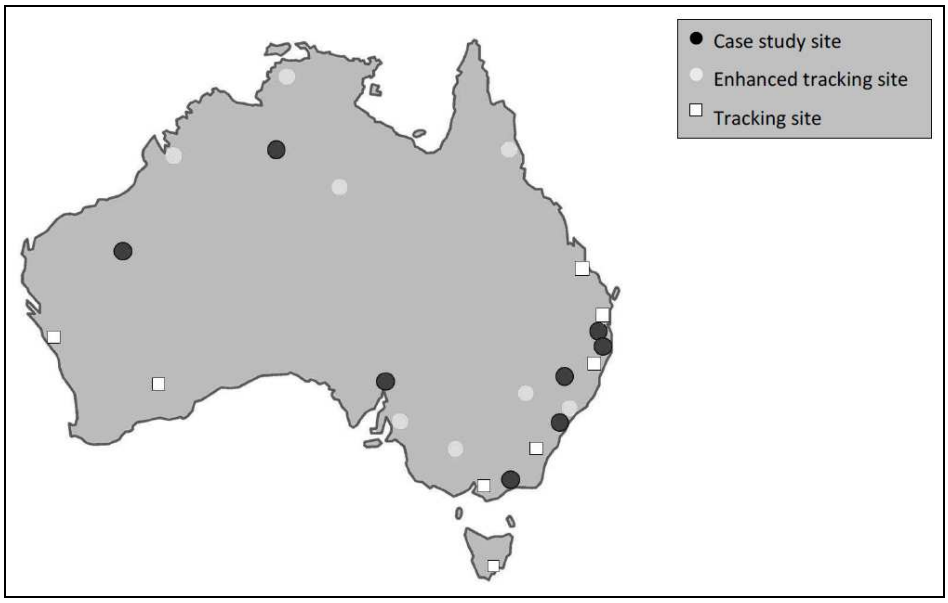


Figure 3.1: Location of Sentinel Sites

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

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. 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 mid-2011. Developments in all twenty-four sites were first presented in the *Sentinel Sites Evaluation Interim Report: December 2011* and in this fourth interim evaluation report.

These twenty-four sites, comprising eight tracking sites, eight enhanced tracking sites and eight case study sites comprise the full complement of sites included in the SSE; no further sites are to be added. Table 3.1 summarises the Sentinel Sites according to key factors including their establishment stage.

Owing to the different times that sites were established and the ways in which the routinely available datasets are constructed, the periods covered by different types of data do not always exactly correspond; the timeframes covered by different data sources and implications of any discrepancies are discussed further in Section 4.

A key component of the Australian Government's National Health Reforms was the establishment of a new nation-wide network of Medicare Locals from 1 July 2011.[3] Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. They are to drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities. The process of transition from Division of General Practices (DGPs) to Medicare Locals is an important development that has occurred during the course of the SSE. It is particularly important for the SSE because DGPs are key stakeholders in the Sentinel Sites. For the purposes of this report we will continue to refer to DGPs, recognising that in some sites the DGP may have already transitioned to a Medicare Local.

3.2. Types of sites and criteria for selection

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. Case study sites are involved in more intensive local data collection processes relative to tracking and enhanced tracking sites in which predominantly routinely collected data are analysed.

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. Establishment of the Sentinel Sites was dependent on the agreement of the key stakeholder organisations (the AHS and the DGP) in each location to participate in the SSE.

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

Sentinel Site boundaries were defined on the basis of:

- 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 DGPs and AHSs), while at the same time recognising the wide diversity of settings in which Aboriginal and Torres Strait Islander peoples live.

[3] DoHA, 'Your Health' [website], <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocals-lp-1> (accessed 30 May 2012).

3.3. Overview of sites and differences between sites

The twenty-four sites taken together provide a rich source of information regarding how the ICDP is implemented in different contexts. As indicated in Table 3.1 below Sentinel Sites differed with respect to key factors including the proportion of people who are Aboriginal and Torres Strait Islander (ranging for example, from less than 1% in one of the urban sites to 76% in a remote site) and workforce allocation (ranging from less than 2 per 10 000 population in a regional site to around 18.2 per 10 000 population in a regional site). The key stakeholder organisations in each site were identified through consultation with DoHA and generally include an AHS and a DGP. In one site there is no active involvement of a DGP and in another two regional sites there are two AHSs. Two urban sites include two DGPs as key stakeholder organisations. Three urban sites also include a regional peak body of AHSs as a key stakeholder organisation. Detailed profiles of each of the Sentinel Sites are provided below.

These contextual factors are important influences that are considered in interpreting data from the sites.

Table 3.1: Sentinel Site characteristics

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
Case study sites								
Katherine West	1	NT	Remote	2 126	2 795	76.1%	9.4	AHS
Port Augusta	1	SA	Regional	2 303	13 874	16.6%	10.9	AHS, DGP
Brisbane South	1	QLD	Urban	4 768	302 382	1.6%	6.8	AHS, DGP
East Pilbara	2	WA	Remote	1 429	6 543	21.80%	7.0	AHS, DGP
Tamworth	2	NSW	Regional	3 710	53 595	6.9%	6.7	AHS, DGP
Bairnsdale	2	VIC	Regional	764	25 368	3.0%	18.2	AHS, DGP
Campbelltown	2	NSW	Urban	3 834	143 076	2.7%	9.9	AHS, DGP
Logan/Woodridge	3	QLD	Urban	4 376	173 269	2.5%	6.6	AHSx2, DGP
Enhanced tracking sites								
Cairns	1	QLD	Regional	9 558	122 234	7.8%	1.2	AHS, DGP
Newcastle	1	NSW	Urban	12 285	493 466	2.5%	3.8	AHS, DGP
Dubbo	1	NSW	Regional	5 147	45 964	11.2%	3.9	AHSx2, DGP
Derby	1	WA	Remote	4 031	6 507	61.9%	2.8	AHS, DGP
Swan Hill/Mildura	1	VIC	Regional	2 238	70 452	3.2%	12.7	AHSx2, DGP
Elizabeth	2	SA	Urban	2 777	126 717	2.2%	10.3	AHS, DGP
Barkly	3	NT	Remote	1 770	3 333	53.1%	1.7	AHS, DGP
Darwin	2	NT	Regional	6 233	66 291	9.4%	8.8	AHS, DGP
Tracking sites								
Geraldton	2	WA	Regional	1 836	18 916	9.7%	7.1	AHS, DGP

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
Hobart	2	TAS	Regional	5 413	189 637	2.9%	4.5	AHS, DGP
Grafton	2	NSW	Regional	1 238	22 812	5.4%	7.4	AHS, DGP
Gladstone	3	QLD	Regional	1 481	45 626	3.2%	6.1	AHS, DGP
Kalgoorlie	3	WA	Regional	2 135	28 423	7.5%	5.7	AHS, DGP
North Lakes/Caboolture	3	QLD	Urban	4 682	216 349	2.2%	7.1	AHS, DGPx2
Dandenong	3	VIC	Urban	2 996	581 191	0.5%	11.7	AHS, DGPx2
Canberra	2	ACT	Urban	3 847	323 326	1.2%	10.4	AHS, DGP

[a] See Appendix C for rurality classifications.

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

[c] The population denominator is based on the whole DGP population as this is expected to be the combined reach of the Outreach Workers (OWs), Indigenous Health Project Officers (IHPOs), and Care Coordinators (CCs) funded by the ICDP. The numerator of the workforce allocation data is based on information provided by DoHA for reporting period 4 (these data are for a period up to 31 December 2011). Where applicable other sources of information including personal communication with DGPs and AHSs and evaluation visit updates were also used.

Per 10 000 workforce allocation calculations used the following rules: = (IHPO &/or OW &/or CC @ DGP + OW &/or CC @ AHS)/Aboriginal and Torres Strait Islander population in the DGP coverage x 10 000.

There are exceptions to the population denominator and workforce numerator data used for Katherine West and Darwin site. For Katherine West the site level population data and workforce allocation to the AHS only have been used. Whereas for Darwin, the site level population data and workforce allocation to both AHS and DGP (for Darwin only) have been used.

Source: Australian Bureau of Statistics, Census, 2006.

3.4. Site-specific descriptions

The following section provides a brief description of each of the twenty-four case study sites. The sites that were the subject of detailed case study (case study sites) are denoted with a ●, enhanced tracking sites are denoted with a ● and tracking sites are denoted with a □. Further details of the sites are provided in Appendix B.

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 DGP office is in

[4] Remote Service Delivery [website], <http://cgris.gov.au/Site/rsd.asp> (accessed 5 April 2012).

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 commencing on 1 July 2012.[5]

The KWHB operates seven Health Services in remote communities and small towns within the region. Programs and services for all Health Services are managed from the Health Board office in the town of Katherine. Under existing service arrangements, Specialists Outreach NT provides specialist assistance for site residents. There is a regional hospital in Katherine and a tertiary level hospital in Darwin. Katherine West was classed as a district of workforce shortage at the time of the evaluation visit.[6]

Pharmaceuticals are supplied through the special arrangements to supply Pharmaceutical Benefits Scheme (PBS) medicines to Remote Area Aboriginal Health Services through Section 100[7] of the *National Health Act 1953* (S100) in the KWHB region. KWHB receives funding under the Healthy for Life program.

The site includes the Health Service that serves the community of Lajamanu. This is the focus of community consultation and interviews with local Health Service staff. Lajamanu is approximately 500 kms from the town of Katherine.

One focus group was conducted this reporting round in Lajamanu.

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 of the DGP office is in Karratha. The area covered by the Pilbara Health Network is larger than the East Pilbara site and includes the towns of Karratha, Roebourne, Dampier, Wickham and Port Hedland covering 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. 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.

[5] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[6] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[7] DoHA, Section 100 [website], <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous-faq> (accessed 1 December 2011).

The site includes a regional 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. East Pilbara was classed as a district of workforce shortage at the time of the evaluation visit.[8]

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 kms. The AHS does not provide any clinical services in the town of Newman. The four AHS clinics work live off the same Communicare server located in Newman. This was part of the web-based patient information system Medical Messaging Exchange (MMEx) installed in 2011.[9]

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 this reporting round.

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.

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 funded 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 (Aboriginal and non-Aboriginal) 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 works 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).

[8] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[9] Puntukurnu Aboriginal Medical Service [website], < http://www.puntukurnu.com/service-delivery/joining-up-our-patients-journey/> (accessed 24 April 2012).

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 patients. An online collaborative e-health platform, the Medical Message Exchange (MMEx), has been established to enable communication across AHSs, hospitals and other Health Services.[10]

Pharmaceuticals are supplied under S100 arrangements. The AHS receives Healthy for Life funding.[11]

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 peoples 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 commencing from 1 July 2012.[12]

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.[13] 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.

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

[10] Medical Message Exchange (MMEx) [website], <http://www.mmex.net.au/> (accessed 20 April 2012).
[11] Healthy for Life [website], <http://www.health.gov.au/healthyforlife> (accessed 5 April 2012).
[12] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[13] Royal Flying Doctor Service [website], <http://www.flyingdoctor.org.au/About-Us/Our-Bases/OB-CO/Tennant-Creek/> (accessed 5 April 2012).

surrounding region. The total population of the site is approximately 54 000. Aboriginal and Torres Strait Islander peoples 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, which commences on 1 July 2012.[14]

There is a hospital located in Tamworth. The AHS is auspiced by the DGP and services a region within an approximate 70 km 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. The AHS is currently exploring a new auspice arrangement with Wellington Aboriginal Corporation Health Service.

There are several private General Practices in the site, however, at the time of the evaluation visit Tamworth was classed as a district of GP workforce shortage[15] and most Health Services, including the AHS, have had their books closed to new patients 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.[16]

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) program.[17]

A funding agreement was executed in May 2011 with the North West Slopes DGP for refurbishment of a property for use as a medical facility in Tamworth. The AHS have now moved into this facility located on the same site as the Division of General Practice.

Three community focus groups were held in Tamworth this reporting round.

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 peoples 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 commencing from 1 July 2012.[18]

[14] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[15] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[16] DoHA, North West Slopes DGP Annual Report 2009-2010, <http://www.phcris.org.au/dios/displayReport0910.php?pageDst=viewReport&curPage=pro&curVal=35694&reportid=1194> (accessed 5 April 2012).
[17] QUMAX [website], <http://www.qcpp.com/sites/5CPA/Initiatives/ATSI_Programs/QUMAX.page> (accessed 5 April 2012).
[18] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).

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 classed to be a district of workplace shortage for GPs at the time of the evaluation visit.[19]

The AHS has QUMAX funding and is part of an established regional consortium for the state-based Aboriginal health promotion and chronic care program[20] and for Healthy for Life.

Two community focus groups were held in Bairnsdale this reporting period.

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 peoples 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 commencing on 1 July 2012.[21]

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 and there is a history of partnerships between the AHS and the DGP for program delivery.[22] The town hospital has an existing visiting specialist service. Port Augusta was not classed to be a district of workplace shortage for GPs at the time of the evaluation visit.[23]

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

Two community focus groups were held in Port Augusta in this round.

[19] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[20] Aboriginal Health Promotion and Chronic Care, <http://www.health.nsw.gov.au/cdm/severe_chronic_disease_management_program.asp/> (accessed 5 April 2012).
[21] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[22] Flinders and Far North Division of General Practice [website], <http://dev.flindiv.com.au/services-to-general-practice/aboriginal-health/> (accessed 5 April 2012).
[23] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).

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 in excess of 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 peoples 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 commencing from 1 July 2012.[24]

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 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 peoples make up about 11% of the total site population.

Two AHSs (Dubbo 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 commencing from 1 January 2012.[25]

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 patients.[26]

Until recently, Dubbo was classed as a district of GP workforce shortage. Wellington is currently a district of workforce shortage.[27] 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.

[24] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[25] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[26] Bawrunga [website], <http://bawrunga.org.au/> (accessed 9 April 2012).
[27] DoHA, Doctor Connect , <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/locator> (accessed 5 April 2012).

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 peoples 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 Swan Hill) will be covered by the Loddon-Mallee-Murray Medicare Local. Both of the Medicare Locals were commencing from 1 January 2012.[28]

There are a number of private General Practices. Privately operated GP super clinics opened within the last two years 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 peoples 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 commencing from 1 January 2012.[29] 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.

[28] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[29] Ibid.

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 thirty SLAs. The site does not include the city of Palmerston (which lies about twenty 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 organizations in the site. The Darwin site will be included in the area covered by the single Northern Territory Medicare Local commencing from 1 July 2012.[30]

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. Tasmania now has a single Medicare Local which commenced 1 July 2011[31] and the DGP is referred to as Tasmanian Medicare Local (South).

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 at Clarence attached to the community health centre. Three hospitals including a major public hospital are located in the site.

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

[30] Ibid.
[31] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).

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 peoples 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 commencing 1 January 2012.[32]

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 commencing from 1 July 2012.[33]

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

[32] Ibid.
[33] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).

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 peoples 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 commencing 1 January 2012.[34]

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 peoples make up about 1.6% of the total population of the site.

The DGP (currently operating as Accoras formerly known as 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 Greater Metro South Brisbane and the West-Moreton Oxley Medicare Locals, which commenced 1 July 2011.

The AHS is a major Health Service provider to Aboriginal and Torres Strait Islander people within the site. The Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) operate a part time GP clinic from an independent Aboriginal school in Acacia Ridge.[35] 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 in the site 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 majority of the

[34] Ibid.
[35] ATSICHS [website], < http://www.atsichsbrisbane.org.au/medical-services/acacia-ridge/> (accessed 9 April 2012).

SLAs within Brisbane South site (33/45) was not classed as district of workforce shortage at the time of the evaluation visit.[36]

The AHS participates in the Healthy for Life program.

Three community focus groups were held in the suburb of Inala this reporting round.

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 commencing on 1 July 2012.[37]

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.[38] The DGP employs a large team including dietitians and exercise physiologists.

A large care coordination team, funded through NSW Health[39], is based at the DGP. There are two hospitals within the site. Campbelltown had been classed as a district of workforce shortage at the time of the evaluation visit.[40]

The AHS participates in the QUMAX program.

Two community focus groups were held in Campbelltown in this evaluation period.

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 peoples make up about 2.5% of the site population.

The DGP (GP Access previously know 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

[36] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[37] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[38] Marumali, <http://www.marumalihealth.com.au/aboutmarumali.html> (accessed 5 April 2012).
[39] NSW Health, Connecting Care [website], <http://www.health.nsw.gov.au/cdm/severe_chronic_disease_management_program.asp> (accessed 5 April 2012).
[40] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).

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 commenced 1 July 2011.[41]

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 which are Aboriginal or Torres Strait Islander peoples. Adelaide itself is a city of 1.2 million people, with about 1.2% being Aboriginal or Torres Strait Islander.

Both the DGP (Adelaide Northern Division of General Practice) and the AHS (Nunkuwarrin Yunti of South Australia Inc) are key stakeholder organisations. The site will be covered by the Northern Adelaide Medicare Local commencing 1 January 2012.[42]

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 peoples make up about 2.5% of the total site population.

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. Some of the SLAs within the site (9/17) had been classed as districts of workforce shortage at the time of the evaluation visit.[43]

The DGP is based within the site. The area covered by the DGP will become part of the Greater Metro South Brisbane Medicare Local, which commenced 1 July 2011.[44]

[41] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[42] Ibid.
[43] DoHA, Doctor Connect [website], <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator> (accessed 26 April 2012).
[44] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).

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

Four community focus groups were held in Woodridge in this evaluation period.

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 which commenced 1 July 2011.[45]

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. In addition there is a not-for-profit, Aboriginal owned and operated bulk billing medical centre situated in the site.[46]

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 with farmland and tourism, but it also covers an area of urban growth. The total population of the site is approximately 580 000, 0.5% of which 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. Both of the Medicare Locals are commencing 1 January 2012.[47]

Greater Dandenong is the most culturally diverse municipality in Victoria[48], however, this cultural variation is not present throughout the site.

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 in Berwick, another private super clinic, five private hospitals and many private General Practices within the site boundary.

[45] Ibid.
[46] Murri Teileah [website], <http://www.murrimedical.com.au/index.html> (accessed 10 April 2012).
[47] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).
[48] City of Greater Dandenong website, <http://www.greaterdandenong.com/Resources/SiteDocuments/doc21735.doc> (accessed 11 April 2012).

The AHS participates in the QUMAX program.

Canberra □

The Canberra site covers the Australian Capital Territory including eight Statistical Sub-divisions (114 SLAs) and has a total population of about 320 000. Aboriginal and Torres Strait islander peoples 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 peoples 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. The ACT Medicare Local which commenced 1 July 2011 covers the same area.[49] 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.

[49] DoHA, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocprofiles> (accessed 24 April 2012).

4. DATA SOURCES AND ANALYSIS

4.1. Overview

The SSE includes collection and analysis data derived from a range of sources as illustrated in Figure 4.1 below. From the tracking sites, data sources include administrative data and program data, and from the enhanced tracking sites and case study sites, additional data sources include key informant interviews, clinical indicators and community focus groups.

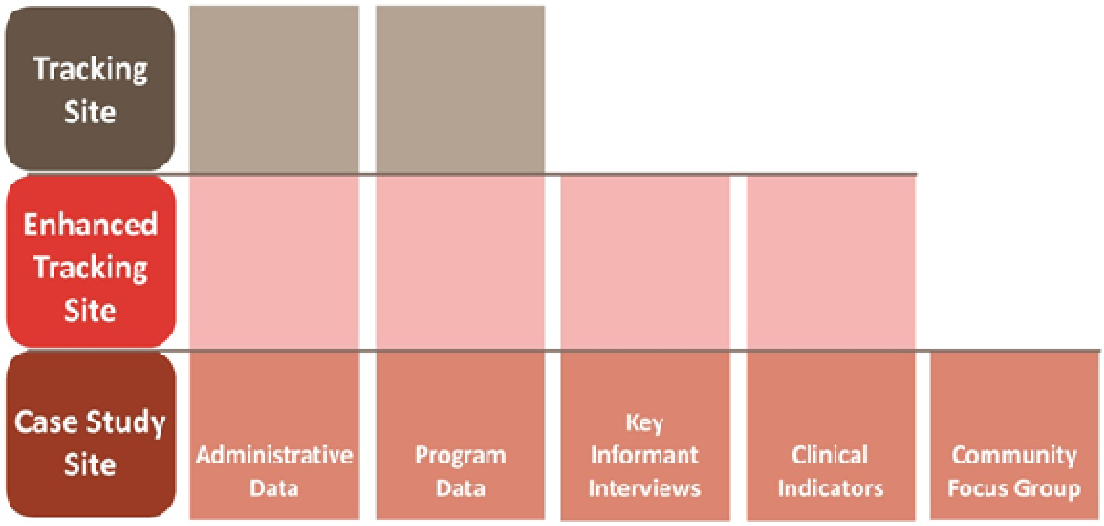


Figure 4.1: Sentinel Sites evaluation processes

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

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.

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

4.2. 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.[50]

PHARMACEUTICAL BENEFIT SCHEME CO-PAYMENT MEASURE

The Pharmaceutical Benefit Scheme (PBS) Co-payment measure was introduced in July 2010 to provide reduced or subsidised medications to Aboriginal and Torres Strait Islander people with the aim of reducing the financial barrier to access to medications. In this report the PBS data are presented from the first full quarter after implementation (September 2010 - November 2011).

The analysis of these data included:

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

Sentinel Site boundaries in most cases are determined by Statistical Local Areas. PBS Co-payment data are extracted based on postcodes that in some cases lead to a slight mismatch between PBS data and Sentinel Site boundaries. In addition, PBS data are updated as new claims are processed, so that there will be variation in data depending on the date of extraction. This variation is small for extractions that occur three months or more after the date of the service. Appendix G Table G1 lists the dates that the PBS data used in this report were extracted.

While the ICDP program is a new initiative it is preceded by and coexists with other initiatives to improve access to medicines among Aboriginal and Torres Strait Islander people including QUMAX Program[51] in urban and rural areas and the supply of medicines to patients of remote area Aboriginal and Torres Strait Islander Health Services through Section 100 of the National Health Act (S100).

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 and therefore these are included in the SSE. In this report, MBS data are presented for the period March 2009 - November 2011. For the purposes of the SSE, March 2009 - February 2010 is defined as a 'baseline' period.

[50] Australian Bureau of Statistics. Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, Canberra: Australian Bureau of Statistics; 2009.
[51] 5th Community Pharmacy agreement, Program Specific Guidelines. <http://www.5cpa.com.au/iwov-resources/documents/5CPA/Initiatives/ATSI_Programs/QUMAX%20Program%20Specific%20Guidelines%20v3.pdf>, (accessed 29 May 2012).

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

- trends in uptake of health assessments (MBS 715)
- trends in uptake of follow-up services provided by a practice nurse or registered Aboriginal Health Worker (MBS 10987)
- trends in uptake of follow-up allied health services (MBS 81300 – 81360)
- trends of number of GPs who claim health assessments
- trends in average number of health assessments billed by GPs.

PRACTICE INCENTIVES PROGRAM INDIGENOUS HEALTH INCENTIVE

The Practice Incentives Program (PIP) Indigenous Health Incentive was introduced in March 2010. It provides incentives to Health Services to increase levels of care provided to Aboriginal and Torres Strait Islander patients. Incentives take the form of a range of monetary payments to Health Services for practice registration with PIP Indigenous Health Incentive, for registration of individual Aboriginal and Torres Strait Islander patients and for provision of certain services to patients as recorded on MBS billing (Tier 1 and Tier 2 payments). In this report, data are presented for the period March 2010 - November 2011. As this is a new program, the analysis of these data only tracks trends over time in the uptake of this measure in the post-implementation period. The analysis of the PIP Indigenous Health Incentive data focuses on:

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

For this report the extraction of data by sector identified some data discrepancies related to attribution of services to 'branch offices' and misclassification of AHSs in some sites. These issues could not be resolved in time to enable analysis by sector for inclusion in this report. DoHA has advised that the issues are being resolved and we expect to present analyses by sector in the next report.

4.3. 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 fund holders.

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.

4.4. Stakeholder interviews

Stakeholder interviews were conducted in the eight case study sites and two enhanced tracking sites during the months of February - April 2012. In addition, stakeholder groups in three of the tracking sites provided perspectives on the reasons underlying change in their administrative/program data during feedback sessions. 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.

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.

A total of 145 interviews were conducted in eight case study sites (Table 4.1). Sixty-six interviews were done in urban sites, 53 in regional sites and 26 in remote sites. In this reporting period interviews were predominately conducted face to face [61% (89/145)] or over the telephone [39% (56/145)]. None were self-completed. A greater percentage of interviews were conducted over the telephone for this reporting period compared to previous reporting periods due to travel restrictions caused by extreme weather conditions in remote sites together with reduced SSE team capacity for face-to-face interviews on one site visit due to illness within the SSE team.

Table 4.1: Number of interviews held in case study sites, by reporting period and geographic setting

	Report 1	Report 2	Report 3	Report 4
Overall	46	102	146	145
Urban	17	35	65	66
Regional	18	49	50	53
Remote	11	18	31	26

Note: For SSE Interim Report 1 there were three case study sites; SSE Interim Report 2, seven case study sites; SSE Interim Report 3 and 4, eight case study sites. Fewer interviews were able to be conducted in remote sites for Report 4 due to interviewee unavailability caused by poor weather conditions during the data collection period.

ENHANCED TRACKING AND TRACKING SITES

During this reporting period, we visited two of the enhanced tracking sites and three of the tracking sites. The purpose of the visits was to provide the local stakeholders with feedback on their program administration data collected for the SSE. During the feedback sessions, some of the stakeholders volunteered their perspectives and understanding of reasons underlying the patterns observed in their data. Where this information was found to be useful in developing understanding of emerging themes, it is referred to in the relevant sections.

4.5. Community focus groups

Nineteen community focus groups were held in eight case study sites during the months of February-May 2012. The purpose of the focus groups was to explore community perceptions of change and, where possible, the extent to which this may have been due to implementation of the ICDP. The issues explored included access to health care, tackling smoking, life style modification, chronic disease self-management, patient registration, access to medications, access to specialists and care coordination services.

A total of 211 individuals participated in the groups, compared to 161 in the previous reporting period (Table 4.2). The number of participants per group ranged from seven to forty-three, with an average of eleven per group.

Table 4.2: Trend in number of attendees at community focus groups held in case study site, by rurality

	Report 1	Report 2	Report 3	Report 4
Overall	66	83	161	211
Urban	11	21	66	86
Regional	20	36	67	90
Remote	35	26	28	35

Note: For SSE Interim Report 1 there were three case study sites; SSE Interim Report 2, seven case study sites; SSE Interim Report 3 and 4, eight case study sites.

Characteristics of focus groups participants varied within and between sites. Analysis and interpretation of the data provided included consideration of potential biases of different participant groups. Appendix E provides an overview of focus group profiles and participant numbers.

4.6. Clinical indicators

In this reporting period, 45 Health Services were requested to provide clinical indicator data for the purpose of the SSE. Of these, 32 Health Services provided data, including 22 private General Practices and ten AHSs. As shown in Table 4.3 there has been an increase in the number of General Practices providing clinical indicators for each reporting period across service types. In this and the previous reporting period, additional emphasis was placed on working with the DGPs practice support teams to assist in data collection from private General Practices. Not as many AHSs were requested to provide clinical indicator data as there were a number of AHSs which indicated previously that they did not wish to provide clinical indicators and so they were not approached again.

Table 4.3: Number of Health Services that were requested and provided clinical indicator data, by reporting period, and sector

	Report 1		Report 2		Report 3		Report 4	
	Requested	**Provided**	**Requested**	**Provided**	**Requested**	**Provided**	**Requested**	**Provided**
Overall	12	4	28	13	53	29	45	32
General Practice	3	0	13	5	32	17	30	22
Aboriginal Health Service	9	4	15	8	21	12	15	10

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

4.7. Data integration and analysis

Analysis of the data gathered during the evaluation period aims to address the SSE objectives, including describing ICDP implementation, identifying and tracking change and identifying the barriers and enablers impacting on effective implementation of the ICDP at local level. Data management and analysis takes into account the large number of data sources including data collected during previous evaluation rounds and the main themes identified during previous rounds.

The analysis processes for the SSE is iterative and dynamic. It is conducted over two main 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 (see Figure 4.2).

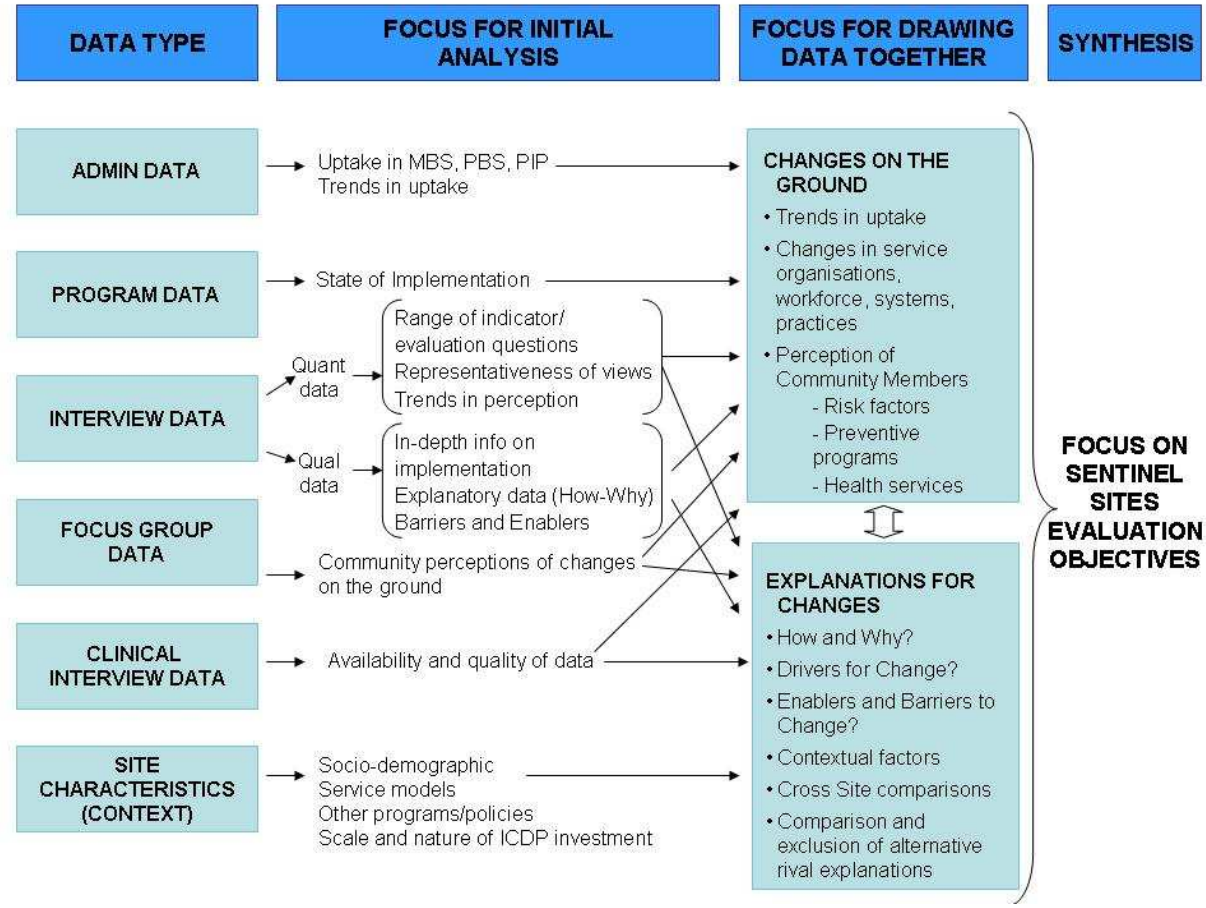


Figure 4.2: Framework for data collection and analysis

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.

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

5.1. 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. It is intended that the workforce will implement a range of community-based smoking prevention and cessation support activities tailored to local Aboriginal and Torres Strait Islander communities. Also under this Measure, around 1000 existing workers such as nurses and AHWs will be trained in brief interventions. To support these initiatives, the Quitline smoking cessation services will be enhanced for greater accessibility and appropriateness for Aboriginal and Torres Strait Islander people and national social marketing campaigns will be developed. [52]

Through measure A2, Healthy Lifestyle Worker (HLW) positions are being established around Australia. These non-clinical positions aim 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.[53]

Redesign of the workforce element of these measures resulted in the workforce being deployed in teams to create a more concentrated effort in each region (herein referred to as 'Regional Tackling Smoking and Healthy Lifestyle teams').[54] The team members will

[52] DoHA, National Action to Reduce Smoking Rates Factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/national-action-to-reduce-indigenous-smoking-rate/$file/DHA6136%20A1%20Factsheet.pdf> (accessed 5 April 2012).
[53] DoHA, Helping Indigenous Australians to Reduce Their Risk of Chronic Disease – Factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/helping-indigenous-australians-to-reduce-their-risk-of-chronic-disease/$file/DHA6136%20A2%20Factsheet.pdf> (accessed 5 April 2012).
[54] DoHA, Annual Progress Report on the Australian Government's Contribution to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2010, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/publications/$file/ICDP-Yearly-Report-0910.pdf> (accessed 5 April 2012).

undertake programs of learning and development.[55] The program provides funding for teams to undertake community development activities as approved by DoHA.[56]

Twenty-one Regional Tackling Smoking and Healthy Lifestyle teams were funded in the first roll-out 2010-2011, with a further nineteen teams funded in 2011-2012 and seventeen in 2012-2013.[57] Whilst teams can be hosted in any organisation, including DGP, State Government or Non-Government Organisations, teams are commonly hosted in AHSs. Regardless of where the teams are based, it is intended that the services provided by the teams would be accessible to all Health Services within the geographical region.[58]

5.2. 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:

- RTCs and TAWs are recruited.
- Training is well received and well regarded.
- Design and delivery of enhanced or new smoking cessation services and programs.

Expected early results for years 2-4:

- Better access to smoking cessation resources, services and materials for health professionals.
- 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, of resources available to help them quit or cut back and more inclined to seek assistance as part of quit attempts.

[55] TAW and HLW aiming for Certificate II (initially as entry level), III or higher, and RTC leading to Certificate IV. DoHA, HLWs, TAWs and RTC Job Descriptions.
[56] DOHA, A1/A2 update, personal communication, 12 August, 2011.
[57] The Hon. Warren Snowdon MP, media release <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws057.htm> (accessed 15 January 2012).
[58] DoHA, A1 A2 update, personal communication, 12 August 2012.

5.3. 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:

- HLW positions are filled.
- HLW are equipped for roles through training.
- Participation in A2 activities is high.

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.

5.4. State of implementation – national context

The following information was provided by DoHA on the state of implementation of measure A1 and A2 at a national level as at 12 January 2012 (relevant to the SSE):[59]

- OATSIH held an information sharing workshop in December 2011 for Regional Tackling Smoking and Healthy Lifestyle teams. Attendance was high including organisations that are about to receive funding and other stakeholders, such as some of the affiliates and Quitline workers.
- A toolkit, 'Healthy Deadly Strong', was launched in December 2011 and distributed to all teams.
- A guide for Nicotine Replacement Therapy (NRT) 'The Medicines to Help You Stop Smoking' was developed. The guide covers best practice use of all forms of NRT with an emphasis on the nicotine patch which is listed on the PBS for Aboriginal and Torres Strait Islanders and can be obtained free under the Closing the Gap scheme.[60] Resources include the guide for health workers and a pamphlet for communities and individuals. A small number of these resources have been printed and a revised simplified version is to be printed.

[59] DOHA, A1/A2/A3 update, personal communication, 12 January 2012.
[60] The Hon. Warren Snowdon MP, media release, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws057.htm> (accessed 15 January 2012).

- The Community Health Action Pack (CHAP) for HLWs and TAWs was distributed in December 2011 and the booklets are available for download electronically.

Contractual activity reports from organisations funded with Regional Tackling Smoking and Healthy Lifestyle teams were received by DoHA for the July 2011 - December 2011 period. Of the sixteen organisations in Sentinel Sites with funding allocations, thirteen submitted reports to DoHA for this reporting period. [61]

- Across the workforce positions there was evidence of a high uptake of various training courses with a range of training being undertaken, from training specific to smoking cessation and healthy lifestyle choices, through to more general AHW training and other public health related training.

- Brief intervention training for other health professionals including clinic staff and community educators was reported by two of the thirteen organisations. Brief intervention training and smoking cessation training had been conducted for clinic staff and community educators.

- The Regional Tackling Smoking and Healthy Lifestyle Teams in most sites have had access to or have registered to attend a range of training. In some cases the whole team participated. Three organisations did not supply any data on training for these workers. Some organisations did not provide data for training for each of the different workers relevant to this section.

  - Training for RTCs: of the nine organisations that reported on RTC training, three of the RTCs were undertaking one or more courses; Certificate IV Frontline Management, Certificate IV Trainer and Assessor, Diploma of Population Health, Certificate III Social and Emotional Wellbeing, Certificate III Alcohol and Other Drugs. Five RTCs had participated in other training that included attending chronic disease, tobacco and ICDP conferences, tobacco cessation, physical activity and nutrition training. Some were also undertaking training related to first aid, 4WD and motivational interviewing.
  - Training for TAWs: of the ten organisations that addressed the TAW training, all TAWs (six out of six) were undertaking further study; Diploma of Population Health, Certificate IV Aboriginal Health Worker and Certificate III Aboriginal and Torres Strait Islander Primary Health Care. Other training included tobacco cessation training; Quit Educator training, Smoke Check brief intervention, Nicotine addiction and smoking cessation course, Smokelyzer and tobacco cessation related conferences. Other training included physical activity and nutrition training, motivation interviewing and first aid.
  - Training for HLWs: Of the ten organisations that provided data on the HLW training, most HLWs (ten out of eleven) were undertaking further study: Masters of Applied Science in Nutrition and Dietetics, Certificate III & IV in Fitness, Diploma of Fitness, Diploma of Population Health, Certificate II and IV Aboriginal Health Worker, Diploma of Population Health and Certificate III and IV Aboriginal and Torres Strait Islander Primary Health Care. Other

[61] DoHA, A1 A2 site reports, 31 December 2011.

training included nutrition training: 'Good Quick Tucker', principles of nutrition and diet, healthy eating and dental care, physical activity training; sport and fitness forums, 'Traditional Indigenous Games', tobacco cessation training and first aid and others such as motivational interviewing.

- Ten of the thirteen organisations reported on locally created smoking cessation and healthy lifestyle campaign materials. These included distribution of promotional materials (t-shirts, hats, water bottles, back packs, banners, a marquee, calendars, bags, car stickers), educational materials (quit smoking and nutrition pamphlets, posters, quit smoking advertisements for local newspapers, billboards, buses, websites, a wallet sized fold-out resource 'I Quit Because' campaign, quit smoking in the workplace campaign PowerPoint and survey and resources, a recipe book, food diaries, an exercise DVD). The 'Deadly Choices' social marketing TV commercial was also noted.

- All thirteen reports received outlined the types of local tobacco cessation and healthy lifestyle sessions being delivered. These included:

  - Family fun days, Healthy Community Days, Close the Gap days, health checks at large community events, sporting carnivals, a theatre production 'Lost in Smoke', 'the biggest loser' events and health expos.
  - Smoking cessation and healthy lifestyle programs run over several weeks included; gym memberships, twelve week nutrition, physical education, diabetes management sessions, swim gym and a children's bike riding program.
  - Targeted group activities (men, women, Elders, youth, mums and bubs, pre-school children and parents, chronic disease, cardiac rehabilitation, workers, quit smoking support groups) and events or sessions at various locations such as primary and high schools, workplaces, a detention centre, shopping centres and sporting venues.
  - Cooking groups, healthy food demonstrations, community BBQs, walking groups and barefoot bowls. These can be combined together such as in the weekly 'Koori Kitchen'.

- Brief interventions sessions were mentioned in four sites with one remote site reporting participation by 200 people.

5.5. Findings from Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from evaluation visit interviews and, in case study sites, community focus groups. These data were complemented by workforce and program activity data provided by the DoHA. 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 some enhanced tracking sites provided additional information on implementation of this measure.

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

PROGRESS WITH RECRUITMENT

Eighteen of the twenty-four Sentinel Sites have Measure A1 and A2 workforce investment. These sites include a spread of rurality with four remote, seven regional and seven urban sites (noting that three of the urban sites are in an area covered by the same organisation and A1 and A2 workforce).

To date, the funding approach has been to allocate a complement of four staff to a Regional Tackling Smoking and Healthy Lifestyle team: one RTC, one TAW and two HLWs (Canberra excepted) to work in particular locations. This reporting period there has been further investment into Sentinel Sites with ten existing teams receiving funding for an additional TAW position, one site receiving funding for an additional RTC and one new team allocated to a site. There are now teams of five staff in these regions.

Table 5.1 presents the allocation and recruitment findings from two sources - the DoHA reported allocation and recruitment as at 31 December 2011 and the findings at evaluation visits that occurred between February 2012 and April 2012. 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 and vice versa. Data on the number (and %) of positions filled, as reported in the text below, are based on the findings at the evaluation visit. The positions for the Institute for Urban Indigenous Health (IUIH) are separately listed in Table 5.1 but only counted once for three sites (Brisbane South, Logan/Woodridge, and North Lakes/Caboolture).

Recruitment to positions has increased since the last evaluation period, with around three in four allocated positions filled at the time of the evaluation visits. Of the 74 positions allocated to organisations in the regions in which the Sentinel Sites are located, 55 (74%) positions were filled (Table 5.1). Seventeen people had been recruited to previously vacant or newly created positions since the previous report. Of the fifteen newly allocated positions since the previous reporting period, ten have been filled.

Of the nineteen vacancies, five positions are newly allocated and had not yet been recruited to, and nine previously existing positions had never been filled (six out of nine are HLWs). Five vacant positions have previously been filled, but have become vacant (all prior to the current reporting period).

Recruitment was relatively higher for HLW positions and relatively lower for TAW positions compared to RTC positions (with 12/16 (75%) of RTC positions, 19/27 (70%) of TAW positions and 24/31 (77%) of HLWs positions filled). The relatively lower recruitment to TAW positions is expected because there have been a greater number of newly allocated TAW positions and some have yet to be filled.

Recruitment was fairly similar across rurality. Four of the seven urban sites have full recruitment (noting that three sites are covered by one team). The remaining three sites have mostly complete teams. Of the seven regional sites that had been allocated positions,

four have full recruitment, one has always had all positions vacant, one is gradually gaining staff and the other has until recently had a full team. Of the four remote sites two have full or nearly full teams, although neither has been established for long and two have most positions vacant (with only one of each position type currently recruited).

Table 5.1: Recruitment and retention data for measure A1 and A2 workforce by Sentinel Site

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
Case study sites					
Katherine West	Remote	Katherine West Health Board	1.0 TAW	0	Recruitment commenced, Not yet filled [a]
			1.0 RTC	1.0	Position remains filled since August 2011
			2.0 HLW	0	Recruitment commenced, Not yet filled
Port Augusta	Regional	Pika Wiya Health Service Aboriginal Corporation	1.0 TAW	0	Recruitment commenced, Not yet filled
			1.0 RTC	0	Recruitment commenced, Not yet filled
			2.0 HLW	0[a]	Positions not yet filled, recruitment commenced[b]
Campbell-town	Urban	Tharawal Aboriginal Medical Service	2.0 TAW	1.0	One position filled since previous report and one new allocation, not yet filled
			1.0 RTC	1.0	Position filled since previous report. Previously filled until October 2011[c]
			2.0 HLW	2.0	One position remains filled, one position filled since previous report
Tamworth	Regional	Tamworth Aboriginal Medical Service	2.0 TAW	1.0	One position filled since previous report, one new allocation not yet filled
			1.0 RTC	1.0	Position remains filled since August 2011
			2.0 HLW	1.0	One position filled since previous report, one position not yet filled
East Pilbara	Remote	Puntukurnu Aboriginal Medical Service	2.0 TAW	2.0	One position remains filled. One new allocation and recruitment since previous report. One worker based in Port Hedland does not cover the Sentinel Site.[d]

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
			1.0 RTC	1.0	Position filled since previous report [d]
			2.0 HLW	2.0	Positions filled. One filled since previous report (Jigalong) [d]
Brisbane South	Urban	The Institute for Urban Indigenous Health [e]	2.0 TAW [e]	2.0 [e]	One position remains filled. One position new allocation and filled since previous report
			1.0 RTC [e]	1.0 [e]	Position remains filled
			2.0 HLW [e]	2.0 [e]	Positions remain filled
Logan/ Woodridge	Urban	The Institute for Urban Indigenous Health [e]	2.0 TAW [e]	2.0 [e]	One position remains filled. One position new allocation and filled since previous report
			1.0 RTC [e]	1.0 [e]	Position remains filled
			2.0 HLW [e]	2.0 [e]	Positions remain filled
Enhanced tracking sites					
Derby	Remote	Kimberley Aboriginal Medical Services (West) [f]	1.0 TAW	0	Previously filled, position remains vacant since previous report
			1.0 RTC	0	Position previously filled now vacant since previous report
			2.0 HLW	1.0	One position remains filled, and one vacant since previous report
Swan Hill/ Mildura	Regional	Mildura Aboriginal Corporation	2.0 TAW	2.0	One position remains filled. One new position allocated and recruited to since previous report
			1.0 RTC	1.0	Position remains filled
			2.0 HLW	2.0	Positions remain filled
Cairns	Regional	Wuchopperen Health Service	2.0 TAW	2.0	One position remains filled. One new position allocated and recruited to since previous report
			1.0 RTC	1.0	Position remains filled
			2 .0 HLW	2.0	Positions remain filled
Newcastle	Urban	Awabakal Newcastle Aboriginal	2.0 TAW	1.0	One position remains filled. One new position allocated and not yet filled

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
		Cooperative	1.0 RTC	1.0	Position remains filled
			2.0 HLW	1.0	One position remains filled, one position not yet filled
Barkly	Remote	Anyinginyi Congress Aboriginal Medical Service	2.0 TAW[g]	1.0[g]	One position filled, one yet to be filled. Both new allocations since previous report[g]
			1.0 RTC[g]	1.0[g]	Position filled. New allocation and recruitment since previous report[g]
			2.0 HLW[g]	2.0[g]	Positions filled. New allocations and recruitment since previous report[f]
Darwin	Regional	Danila Dilba Health Service	1.0 TAW	1.0	Position remains filled
			2.0 RTC	2.0	One position remains filled and one new position allocated and recruited to since previous report
			2.0 HLW	2.0	Positions remain filled
Tracking sites					
North Lakes/ Caboolture	Urban	The Institute for Urban Indigenous Health[e]	2.0 TAW[e]	2.0[e]	One position remains filled. One position new allocation and filled since previous report
			1.0 RTC[e]	1.0[e]	Position remains filled
			2.0 HLW[e]	2.0[e]	Positions remain filled
Kalgoorlie	Regional	Bega Garnbirringu Health Services Aboriginal Corporation	2.0 TAW	2.0	One position remains filled and one new position allocated and recruited to since previous report
			1 .0 RTC	0[h]	Position filled until late December 2011[h]
			2.0 HLW	2.0	Positions remain filled
Dandenong	Urban	Dandenong & District Aboriginal Cooperative	2.0 TAW	1.0	One position remains filled and one new allocation not yet filled since previous report
			1 .0 RTC	0	Position filled until November 2011 currently under recruitment. Having difficulty finding the right person[i]
			2.0 HLW	2.0	Positions remain filled
Gladstone	Regional	Nhulundu Wooribah	2.0 TAW	2.0	One position remains filled and one new allocation and

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
		Indigenous Health Organisation			recruitment since previous report
			1.0 RTC	1.0	Position remains filled
			2.0 HLW	2.0	Positions remain filled
Canberra	Urban	Winnunga Nimmityjah Aboriginal Health Service	1.0 TAW	1.0	Position remains filled
			1.0 HLW	1.0	Position remains filled

[a] DoHA, A1 A2 site reports, 31 December 2011. Fund holder report to DoHA states a TAW will be employed temporarily from January to July 2012. On evaluation visit 19 March 2012, this position was not able to be identified and the position will be considered not filled for this report.

[b] DoHA reported 1.0 FTE HLW position recruited. On evaluation visit 9 April, 2012, and further follow up the HLW could not be identified and the position will be considered not filled for this report. This is the same situation as the August 2011 - October 2011 evaluation period.

[c] Evaluation visit update 27 February 2012.

[d] Evaluation visit update, 19 March, 2012. RTC is based in Newman (in site). Has contact with worker in community but not leading the site team. Linked to Port Hedland team member, one TAW and two HLWs positions in the site have been designed to service the remote communities of Jigalong, Punmu, Cotton Creek, Kuawantji and Newman. The Jigalong and Punmu based roles have a HLW/TAW function and the Newman based role has a health promotion/OW function.

[e] IUIH personal communication, 31 January 2012. The IUIH have a team that covers all of SE QLD. The same workers are attributed for three Sentinel Sites around Brisbane.

[f] DoHA, report National ICDP workforce 31 December 2011. Positions allocated to the Kimberley Aboriginal Medical Services Council (KAMSC) (West).

[g] Evaluation visit update, March 2012.

[h] DoHA, A1 A2 site reports, 31 December 2011. Report by fund holder to DoHA stated RTC resigned late December 2011.

[I] Evaluation visit update, 21 February 2012.

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

The workers may also 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.

Table excludes seven sites: Dubbo, Bairnsdale, Geraldton, Elizabeth, Grafton, and Hobart, as there are currently no measure A1 and A2 positions funded in these areas. Bairnsdale has a state-funded tobacco team and TAS has had a new team allocated to Flinders Island (out of the site). Adelaide funding is focussed to the south of Adelaide, out of Elizabeth site. DOHA, A1/A2/A3 update, personal communication, 12 January 2012

Full-Time Equivalent (FTE).

Source: DoHA, Report on ICDP workforce, 31 December 2011, unless specified by footnotes.

Recruitment by case study site

Seven case study sites have been allocated Regional Tackling Smoking and Healthy Lifestyle teams. These include two remote, two regional and three urban sites (one organisation covering two of the urban sites). Positions recruited in the case study sites included: five RTCs, six TAWs and seven HLWs. There are noticeably more TAWS recruited in case study sites this reporting period compared to the December 2011 SSE report.

- Three sites had the full team recruited (Brisbane South, Logan/Woodridge and East Pilbara).

- Two sites had more than half of their allocated positions recruited (Tamworth and Campbelltown).
- Two sites had significant gaps in recruitment; Port Augusta has not yet recruited to any positions and Katherine West had only recruited to one position.

Barriers to recruitment

Despite considerable progress in recruitment in all sites, some specific challenges were noted. Where recruitment difficulties were raised in relation to measure A1 and A2 workforce positions, the most commonly reported reason for delays or difficulty was the small pool of suitably skilled people to draw on and the availability of people with skills in delivery of smoking cessation programs. This was particularly evident in the remote and regional sites. Training needs for new recruits was highlighted as an issue, with informants valuing the resources available for training under this measure. This is discussed further below in training.

One of the three urban case study sites (Campbelltown) continues to report recruitment and retention challenges for the A1 and A2 workforce. Limited availability of qualified and experienced personnel together with a general '*lack of interest in the positions*' were identified as challenges to recruitment in this site. The HLW noted

> *'We are struggling with the staff; there's not much interest in a way, for people actually applying for the job. There's a lot of turnover on the job as well. Staffing issues have been a big concern for our team.'* (Interviewee, AHS)

The requirement to work outside normal working hours, in order to deliver community-based programs and events, was perceived as a possible reason for the perceived lack of attractiveness of these positions.

> *'For me personally it's hard work, it's hours outside 9-5 and the awards are much lower than what they would be in the health sector but I do it for the community and I find my job rewarding. Maybe for others that's not enough.'* (Interviewee, AHS)

Of the two regional case study sites with workforce allocation, one site (Tamworth) has had positions filled but notes ongoing difficulties retaining staff, with evident high staff turnover. Staff retention does not appear to be related specifically to IDCP funded positions, as other positions, such as GPs also experienced high turnover. The other regional site (Port Augusta) has also experienced high staff turnover in general, for example, the AHS in this site has had five CEOs in the past two years. This general staffing instability was perceived as contributing to the delays in recruitment of Regional Tackling Smoking and Healthy Lifestyle teams and the ICDP workforce more broadly in this site.

A further challenge identified by one of the remote sites in recruiting TAWs was finding people who were non-smokers. Although this is not a specific requirement from DoHA's perspective, at least one of the sites felt that it was important and had adopted this in their selection criteria. In other sites, non-smoking status was not considered to be an essential selection criterion, as this was perceived to be unrealistic given the high smoking rates amongst the local population.

'We take the position that we can't be too harsh – it's addictive and hard to get off. We don't want to be hypocritical, but don't also want to be too hard on people.' (Interviewee, AHS, HLW).

Vignette – It takes extended time to facilitate successful community based health promotion

The AHS in a remote site prefers to recruit local people to Tobacco Action Worker and Healthy Lifestyle Worker positions. Experience over a number of years indicates that it takes several years for workers from outside the community to effectively engage community groups in determining health promotion priorities and strategies, and to facilitate activities with potential to change health behaviours and lifestyles.

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

WAYS OF WORKING

In this reporting period, we learnt more about sites that had established or restructured the Regional Tackling Smoking and Healthy Lifestyle team to meet local needs. This had been done in some cases to overcome recruitment challenges and in others, to better fit with local context, for example in remote areas, it was seen to be more realistic to have a one-community one-worker model, rather than different positions having to traverse vast geographic distances.

- As described in the previous reporting period, in East Pilbara, the AHS has pooled the state and commonwealth Closing the Gap funding to create generalist positions.
- A similar model to East Pilbara is being established in Darwin, where money is pooled (OW and HLW) and position descriptions changed to reflect their role as 'family support workers' and to overcome perceived limitations of more narrowly focussed positions. These are entry level positions and will support family access to health services. The AHS wanted to create generalist positions from the TAW and RTC funding. However, following discussions with the National Coordinator, the TAW and RTC roles remain focused on tobacco work.
- In Tennant Creek, an existing sport and recreation program lost funding and workers from that program were appointed as HLWs. This has enabled ongoing employment of the workers and consistency in programs delivered in the community.
- The Healthy Lifestyle team in Campbelltown is relatively new due to staff turnover. Originally, the design for HLW positions was to split the roles, one focused on physical activity and the other on nutrition. While this remains the aim, there is more emphasis on sharing and broadening knowledge across the team, including tobacco workers.

- In Katherine West, a TAW has been identified for a six-month period to assist the RTC in her role. However, due to competing clinical demands, the TAW has yet to commence working with the RTC. A suggested recruitment strategy for the region is to run a 'Healthy Lifestyle Summit' where community and health professionals come together and are informed of the healthy lifestyle worker role and healthy lifestyle messages.

- In Tamworth, the RTC and HLW are working together to plan and deliver expos. There is also a plan for the TAW to work within this structure.

- The workforce model at the IUIH remains unchanged since the previous reporting period, although the number of workers has been increased.

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

WORKFORCE APPROPRIATELY SKILLED AND EQUIPPED FOR THEIR ROLE

As outlined in the section on the 'State of Implementation – national context' above, there was a high level of engagement in various training activities by staff recruited to positions under Measure A1 and A2. There has also been considerable activity in development and distribution of toolkits and resources to support the workers in their roles.

In the Sentinel Sites, there was a general consensus about the need for on-the-job training to ensure individual workers are developing the necessary skills and understanding to carry out their roles. One respondent noted the importance of the additional funding made available to support professional development and training once workers were recruited to their positions.

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

Interviewees from the Regional Tackling Smoking and Healthy Lifestyle teams generally felt they were able to access training that provides them with skills to fulfil their roles. Positive comments from workers about training they had attended included: the training received had helped develop confidence and ability to talk with the community, particularly about smoking and physical activity it had been useful and practical in carrying out day to day activities and gave an opportunity to network and hear about what other workers were doing.

> *'Lots of show and tell – really good to learn about how other teams have worked, showing the know-how.'* (Interviewee, AHS)

By contrast, the 'show and tell' workshops were considered less valuable by some and not at the level required of the positions. This interviewee suggested that on the job support and skill development was needed. The extent to which workers were supported in their role

may have varied by position, with some workers in more supportive environments than others.

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

A number of interviewees commented on the importance of taking a team approach to training.

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

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

Other training suggestions provided by interviewees included evaluation, survey writing, report writing and training to identify and use appropriate research evidence in their work.

An issue raised by workers in positions that have been created through a pooling of funds, for example in East Pilbara and Darwin (described above), is the expectation to attend different orientation workshops. Time away from their role and from family was of particular concern for these workers.

Another emerging theme in this round is dual role positions. In three sites, (in different ruralities) it appeared that tackling smoking and healthy lifestyle positions share both a clinical and non-clinical role. It is possible that the reason behind combining these roles was to fit with skills of best available candidates for the roles. However, there is some concern over the ability of workers to carry out both roles effectively. For example, it was evident from information gathered at an interview in a non-remote site that, due to clinical demands, the TAW had been unable to spend time in the non-clinical role. This was also evident at a remote site, where the interview did not take place because the worker had yet to commence in the non-clinical aspect of her role. For these workers, the clinical role seemed to have the potential to 'overshadow' the non-clinical role, perhaps reflecting the priorities of the organisation or staff that may be in supervisory positions within the organisation, or the particular background of the worker, as illustrated below.

By contrast, in one regional site, the HLW appears to be functioning in both roles. However in this case, the worker was relatively new to the position and recognised the need to improve her skills in the non-clinical aspect of her role:

> *'I need to learn about setting up programs because I'm used to clinic work only.'* (Interviewee, AHS)

There was a high level of awareness of the national level toolkits and resources available under the Measures, particularly among workers who had attended the workshop where these tool kits and resources had been promoted. It was difficult to ascertain the extent to which these were being used. In one site, interviewees noted that they did not find the toolkits particularly helpful and '*we are doing our own things*.' Comments were also made by other interviewees about the extent to which the toolkits were appropriate for local use:

> *'The information needs to be simplified for Aboriginal people.'* (Interviewee, AHS)
>
> *'Any educational resources can be used but they need to be culturally suitable.'* (Interviewee, AHS)

Evidence from DoHA program activity data indicated that sites have developed local resources and material. There was no clear information on the extent to which the nationally distributed resources have been used or have assisted in the development of local initiatives during this evaluation period. Whether or not these national resources were meeting an existing need was also unclear. One manager in an AHS commented that the issue is not the lack of resources but locating and accessing the appropriate resources.

> *'There's plenty. People don't realise what's out there. It's about knowing where to look and how to get them.'* (Interviewee, AHS)

AWARENESS OF THE WORKFORCE

In order for the Regional Tackling Smoking and Healthy Lifestyle teams to link effectively with other service providers as envisaged in the program logic, it is important that staff in other organisations and community members are aware of the presence of these workers. Consistent with greater numbers of people being recruited to these positions since the previous reporting period, awareness of this workforce in the current reporting period was generally higher than previously. This is consistent with generally increased knowledge about the ICDP across Sentinel Sites.

Awareness of the Regional Tackling Smoking and Healthy Lifestyle teams was highest in remote sites followed by urban and then regional sites. Lower awareness in the regional sites may have been due to staffing changes in these since the previous reporting round. There were generally similar levels of awareness of the HLW between sectors, but lower awareness of the tobacco-specific workforce (TAW and RTC) in private General Practice compared to AHSs.

Responses to the question *'are you aware of the following positions … [name]?'* are summarised below:

- Seventy-eight percent (42/54) of interviewees said they were aware of the RTC position. There were differences in relation to remoteness of sites with the greatest awareness in remote sites [100% (13/13)] and urban sites [84% (21/25)] compared with only half of interviewees in regional sites [50% (8/16)].

- Fifty-two percent (28/54) were aware of the TAW position. Awareness tended to be higher in the remote sites [77% (10/13)] compared to urban sites [64% (16/25)] and regional sites [13% (2/16)].

- Sixty-four percent (34/53) were aware of the HLW position. Awareness tended to be higher in urban sites [79% (19/24)] and remote sites [69% (9/13)] compared to regional sites [38% (6/16)].

- Interviewees from the Aboriginal health sector were generally more aware of the Tackling Smoking Workforce (RTC and TAW) than interviewees from the General

Practice sector. However, there was no difference in awareness of the HLW across sectors.

Increased awareness across respondent groups is likely to be important for appropriate use of the workforce in assisting with smoking cessation activities organised through services and/or appropriate referrals.

BETTER ACCESS TO SMOKING CESSATION AND HEALTHY LIFESTYLE RESOURCES - PRIVATE GENERAL PRACTICE

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

To date in the Sentinel Sites there is no evidence of Regional Tackling Smoking and Healthy Lifestyle teams having had a role in increasing use of smoking cessation resources or healthy lifestyle resources by private General Practice and their patients. Lack of awareness and/or clear understanding of the roles and services offered by the teams were evident, as were lack of personal communication and collaborative relationships between private GPs and the Tackling Smoking and Healthy Lifestyle Teams.

Although there has been increased awareness of the Regional Tackling Smoking and Healthy Lifestyle teams amongst clinicians where these workers have been deployed, in three of the case study sites, interviews with private GPs indicated that this awareness was insufficient for the development of collaborative working relationships or increased ability on their part to access support from the teams. Clinicians in these sites requested some contact by the teams and possibly small media or other means of communication to enable them to make appropriate referrals.

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

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

Interviews with private GPs in two sites (Tamworth and Campbelltown) were simply not aware of the positions, with a typical response being *'I'm not aware of any of healthy lifestyle workforce positions.'*

This is consistent with information about referral patterns from private GPs to the team, reported by both HLWs and clinicians. Five out of the eight HLWs interviewed indicated that they 'partly or strongly disagreed' when asked to respond to the statement *'local doctors often refer Aboriginal or Torres Strait Islander patients to the HLWs.'* Just over half of the clinicians either 'partly or strongly disagreed' (six out of eleven) 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*.'

Lack of existing relationships between the team and GPs was identified as a barrier to referrals.

> *'There needs to be a process of building relationships between the team and GPs.'* (Interviewee, AHS)

The HLW in one site commented that referrals are not coming from doctors but rather is done from the community.

> *'We refer people to the doctors because we have the contact with the community.'* (Interviewee, AHS)

In one site, interviewees described that social networking media such as Facebook and Twitter has generated some interest and enquiries for GP services within the community. This has also created interest to develop events and programs for particular community groups. Healthy community days were identified as an opportunity to improve links between the healthy lifestyle and clinical teams.

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

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

Two IHPOs made comments that indicated their confusion over the role or responsibility of Divisions in delivering healthy lifestyle and tobacco programs.

> *'We didn't get the resources; they aren't available to us because we don't deliver that.'* (Interviewee, DGP)

> *'Divisions don't feel this to be part of their role.'* (Interviewee, SBO)

Apart from one urban site, where the IHPO described working with the Regional Tackling Smoking and Healthy Lifestyle team on the design and delivery of a local health campaign, there was no indication that other Regional Tackling Smoking and Healthy Lifestyle teams either had or were planning to link with the DGP or General Practices.

BETTER ACCESS TO SMOKING CESSATION AND HEALTHY LIFESTYLE RESOURCES - COMMUNITIES

Community awareness of the Regional Tackling Smoking and Healthy Lifestyle teams has increased since the previous reporting period.

Community members in remote sites and youth focus group discussions were less likely than those in urban and regional areas to be aware of the Regional Tackling Smoking and Healthy Lifestyle team and programs and services. This is consistent with stage of program implementation in remote sites and the limited awareness among the private General Practice sector, described above. Regional Tackling Smoking and Healthy Lifestyle teams appear not to have extended their reach to the patients of General Practices in their regions.

The level of awareness of the teams appears to be influenced by the length of time workers had been in positions and the extent to which programs have been delivered in communities. In the previous reporting period, many workers were in the 'meet and greet' phase and there was little evidence of program activity. Several focus group participants in this reporting period were able to name individual workers and describe some healthy lifestyle and tobacco related initiatives (although, not all were ICDP funded programs). This was particularly evident in focus groups held in urban sites.

There was an increased perception in this reporting period that resources available for smoking cessation have increased. The percentage of respondents who either 'strongly agreed' or 'partly agreed' 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',* has doubled since the previous reporting period, with 62% percent (29/47) of interviewees in agreement this reporting period compared with 31% percent (10/32) previously. Interviewees from the Aboriginal health sector were more likely to respond either 'partly agree' or 'strongly agree' than interviewees from the General Practice sector. This is consistent with the targeted investment in AHSs, the focus of program implementation and awareness of the Regional Tackling Smoking and Healthy Lifestyle teams.

DESIGN AND DELIVERY OF SMOKING CESSATION AND HEALTHY LIFESTYLE PROGRAMS

Interventions within communities

Services and programs developed and implemented by the Regional Tackling Smoking and Healthy Lifestyle teams have progressed since the previous reporting period with the exception of sites where there have been delays in recruitment or changes in staffing. The program of work delivered by teams varies in the Sentinel Sites. As reported previously, there are several tobacco initiatives (funded at both state and national levels) that are operating in many areas across the country, including areas covered by the Sentinel Sites. Interviewees and focus group participants commented on a range of initiatives focusing on tobacco and to a lesser extent initiatives focusing on other aspects of a healthy lifestyle. The existence of a range of initiatives in this area has made it difficult for interviewees and focus group participants to tease out whether tobacco control initiatives they were aware of were funded and delivered through the ICDP Tackling Smoking measure or through some other initiative. Some examples of the diversity of work conducted in relation to the ICDP Tackling Smoking and Healthy Lifestyle Measures include:

- ***Social marketing activities**:* raising community awareness of healthy lifestyle choices using nationally and locally developed campaign materials at events such as health expos, Healthy Community days, NAIDOC and Closing the Gap celebrations.

- ***Health education and skill development**:* activities aimed at improving knowledge and understanding of healthy lifestyle choices and developing healthy lifestyle skills. Examples include smoke check brief intervention and smoking cessation programs, cooking and walking groups, 'Deadly Choices' program and traditional Aboriginal and Torres Strait Islander games.

- ***Smoke-Free Workplaces**:* Strategies to supporting AHSs implement their smoke-free policies. In one AHS, staff that leave the building to smoke are required to cover the organisational logo on their uniform. In this and in other AHSs, QUIT groups are being organised for staff and patients.

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

Interventions within Health Services to support patients

Brief interventions, referrals to Quitline, raising awareness of medications available on PBS (e.g. patches) and encouraging patients to *'see us regularly'* are common strategies in General Practice for supporting patients in their attempts to quit smoking.

In this reporting round, an emerging theme is developing where ICDP positions are calling Quitline on behalf of patients or patients asking for the RTC/TAW support to do so. This was identified by interviewees and in community focus group discussions.

> *'No-one is going to ring up Quitline. Aunty needs someone to sit and support to give up smoking.'* (Interviewee, DGP)

> *'If someone wishes to give it up it is their choice, if they want to make that choice with medication or patches, or I can ring Quitline for them.'* (Interviewee, AHS)

An AHS clinician in a regional site identified the need for culturally appropriate and supportive tobacco counsellors who can assist Aboriginal patients in their attempts to quit smoking. This informant noted that the role of the Regional Tackling Smoking team is one that requires *'incredibly supportive counseling services'.*

Whilst Quitline could potentially play a role in one-to-one support for smoking cessation, it is plausible that face-to-face support may be more effective and appropriate for some Aboriginal and Torres Strait Islander communities. Interviewees consistently indicated that this service was not being accessed by members of remote communities, due to language barriers and low telephone ownership. In the previous reporting period, we noted that a number of participants indicated they had called the Quitline but no one had got back to them. These previous data together with the support mechanisms emerging in this reporting period may indicate the need for greater access to face-to-face support for smoking cessation for Aboriginal and Torres Strait Islander people, particularly in remote

communities. There are early indications that the TAW/RTC is offering this type of support in some cases.

Linking Tackling Smoking and Healthy Lifestyle teams to clinical teams

Enquiring about and recording smoking status is an important first step in the implementation of brief interventions and smoking cessation measures in Health Services. A number of General Practices and AHSs provided clinical indicator data on smoking status. Whilst these data have serious limitations, they do give a sense of the extent of under-documentation and accuracy of documentation of key indicators, including smoking status. More general limitations to the clinical indicator data are described in Section 19.

During this reporting period, ten AHSs and 22 private General Practices provided clinical indicator data. Data were analysed for Health Services with over 100 Aboriginal and Torres Strait Islander patients identified on their clinical information system. Amongst these Health Services, about two-thirds (15/22) provided data on smoking status of their patients. This is more than double the proportion that provided data on smoking status in the previous reporting period.

For those AHSs and private General Practices that provided clinical indicator data on smoking status, 59% and 75% of patients respectively had smoking status recorded (Table 5.2). Amongst the sub-set of patients with diabetes, 91% and 88% had smoking status recorded. Rates of current smoking reported for patients of both sectors combined were around 30%. This is notably less than for the Health Services that provided data for the previous reporting period, where the corresponding figure was 40%. This difference is likely to be in large part due to the additional services providing relevant data for this reporting period, and the difference in recorded smoking status between these services and the services that provided relevant data for the previous report. These differences highlight the sensitivity of this sort of indicator to changes in the range of services that provide relevant data. In the previous report we highlighted the limitations of these data as a result of under-documentation of smoking status, and while this continues to be a limitation, the extent of under-documentation is considerably less than in the previous report. The limitations of currently available clinical indicator data for monitoring smoking rates is also highlighted by the difference between the rates reported through these clinical information systems on smoking rates amongst the general Aboriginal and Torres Strait Islander population of close to 50%.[62] The reported rates through the clinical indicator data are nevertheless considerably higher than reported rates for the general Australian population of around 15%.[63]

Encouraging primary health care services to improve the accuracy and completeness of recording of smoking status could be a useful focus of work for the Tackling Smoking and Healthy Lifestyle Teams as a means to encourage appropriate targeting and delivery of brief interventions for smokers.

[62] AIHW 2011. Substance use among Aboriginal and Torres Strait Islander people. Cat. no. IHW 40. Canberra: AIHW. <http://www.aihw.gov.au/publication-detail/?id=10737418268>, (accessed 7 June 2012).
[63] AIHW 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

Table 5.2 Clinical indicators provided by Health Services for Aboriginal and Torres Strait Islander people

Indicator	Aboriginal Health Services				General Practice			
	Mean	n	Min	Max	Mean	n	Min	Max
Proportion of all patients who have had their smoking status recorded in the past 12 months	59.3%	5	19.0%	74.5%	74.7%	10	32.4%	95.3%
Proportion of all patients who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	38.1%	3	33.1%	47.0%	27.7%	10	9.1%	57.1%
Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months	91.3%	3	86.9%	94.0%	88.1%	10	60%	100.00%
Proportion of patients with type 2 diabetes who have had their smoking status recorded in the past 12 months and are recorded as 'smoker'	39.6%	3	35.0%	47.8%	26.0%	10	8.0%	50.0%

Note: n= number of services.

Interventions in Health Services to support smoke-free workplaces

Since the previous reporting period, there has been an increase in the percentage of stakeholder interviewees who either partly or strongly agree with the statement, *'workplaces have implemented smoke-free workplace policies as a result of the new tobacco workforce'*; 72% (26/36) in this reporting period compared to 50% (16/32) previously. This was particularly influenced by interviewees from the Aboriginal Health sector, with 91% (20/22) in agreement with this statement.

However, as in previous reports, a number of stakeholder interviewees continue to express concern over the number of Health Service staff (including board members) who smoke and that more programs are needed to support the Health Service staff and strategies to implement and enforce non-smoking environments.

> *'Services still have too many workers who smoke around services. Need more training and policies to reduce smokers in Health Services and to enforce non-smoking environment.'* (Interviewee, AHS)

At one urban focus group discussion, participants said they were aware of the smoke-free policies in Health Services, yet felt that this was *'prejudiced against smokers'.*

By contrast, in a remote site, there are early signs showing that smoke-free workplace policies are having an impact on staff smoking rates. The interviewee recognised that a smoking culture takes a long time to change and that the success was most likely due to previous work in the area. The RTC is now responsible for reviewing and updating the existing policy in line with new legislation.

> *'A smoke-free workplace requires such a big shift in culture. When I first started here six and a half years ago, 50% of the workforce would have smoked. We are*

> *currently down to about two per cent, that's been a massive smoking culture change and largely due to the smoking policy we did have in place; that came well before the ICDP.'* (Interviewee, AHS)

AWARENESS AND UPTAKE OF NICOTINE REPLACEMENT THERAPY

Awareness of the availability of NRT patches and medication was high among community focus group participants, including in the youth focus group. In this reporting period there were more comments made about *'patches and tablets'* with some community members referring specifically to 'champix'. Interviewees spoke about the availability of NRT on PBS and considered this as a positive step in supporting a larger group of patients in their attempts to quit smoking.

> *'Now that these are on PBS, people don't have to miss out.'* (Interviewee, DGP, IHPO)

> *'NRT products can be given now like we are giving medication to patients.'* (Interviewee, AHS, GP)

A review of the uptake of NRT through an examination of the PBS Co-payment data shows that over the period of implementation of ICDP, there have been overall general upward trends in numbers of Aboriginal and Torres Strait Islanders prescribed NRT. Whilst increases have been evident for both young and older adults, for all ruralities, prescribing rates are higher for older than for younger people and higher in urban areas compared to regional and remote (Figures 5.2 and 5.3).

The number of NRT prescriptions in September 2010 - November 2010 was in the range of one to two per 1000 people and a year after, in September 2011 - November 2011, the number was between four and five per 1000 people. A greater number of NRT prescriptions were given for Sentinel Sites than for the rest of Australia per 1000 people, throughout the period September 2010 to November 2011. The number of NRT prescriptions for Sentinel Sites in each quarter exceeded that of the corresponding number for the rest of Australia by one person per 1000 people. The number of NRT prescriptions showed an increasing trend during September 2010 to May 2011, leveled off in June 2011 - August 2011 and declined in September 2011 - November 2011. The pattern was identical for both Sentinel Sites and the rest of Australia. We have no clear evidence from the Sentinel Sites that explains the decline in the most recent quarter. Compared with the numbers in the September 2010 - November 2010 quarter, the number of NRT prescriptions in the rest of Australia was three-fold and in urban Sentinel Sites twice the corresponding numbers of NRT prescriptions given for each area in the September 2011 - November 2011 quarter (Figure 5.1).

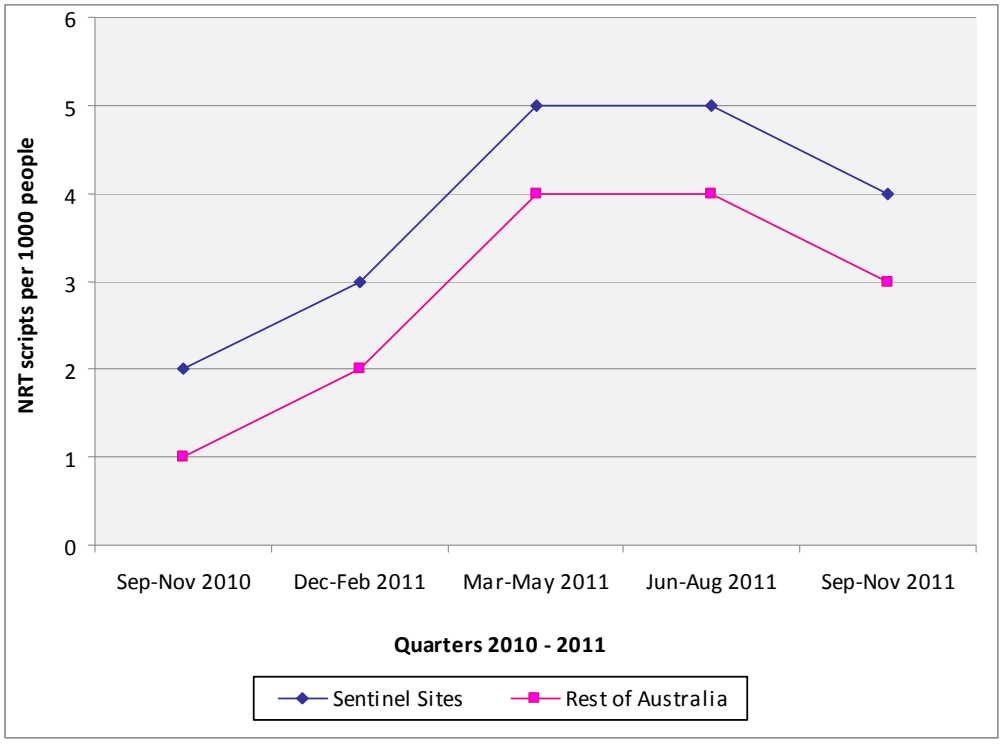


Figure 5.1: Number of prescriptions per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by quarter, September 2010 - November 2011

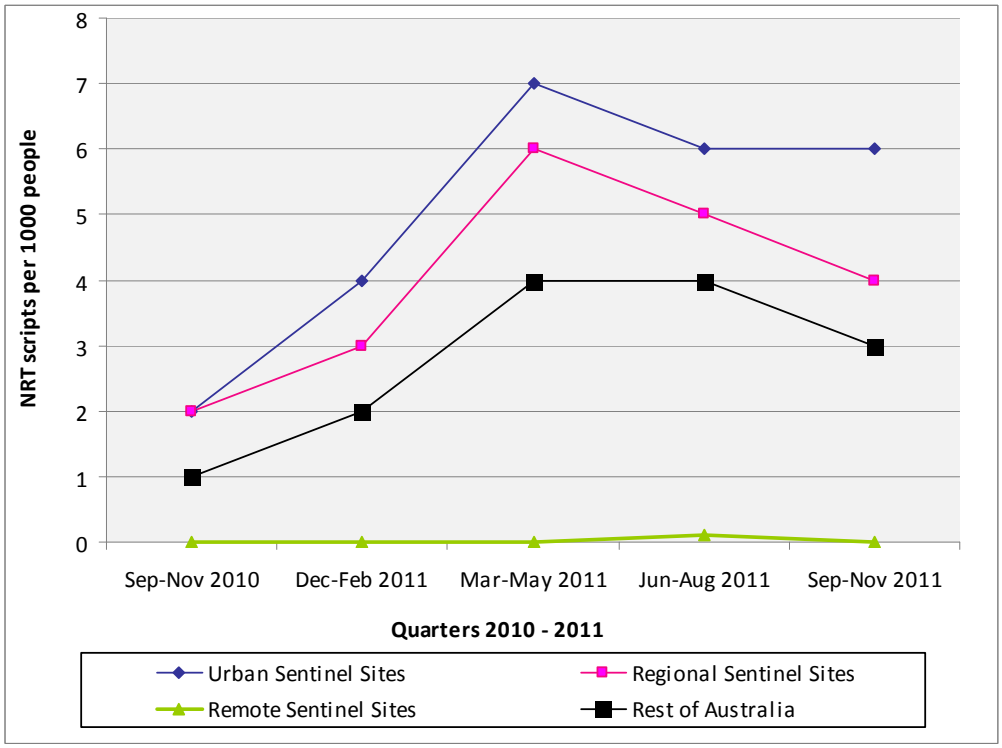


Figure 5.2: Number of prescriptions for NRT per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years by remoteness of Sentinel Sites and the rest of Australia and quarter, September 2010 - November 2011

Figure 5.2 shows that the number of NRT prescriptions given per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years was relatively high in urban Sentinel Sites compared to regional Sentinel Sites, with both urban and regional Sentinel Sites being higher than the average for the rest of Australia. There were few NRT prescriptions from remote Sentinel Sites. The number of NRT prescriptions given per 1000 people reached its peak in March 2011 - May 2011 for urban Sentinel Sites, regional Sentinel Sites and the rest of Australia.

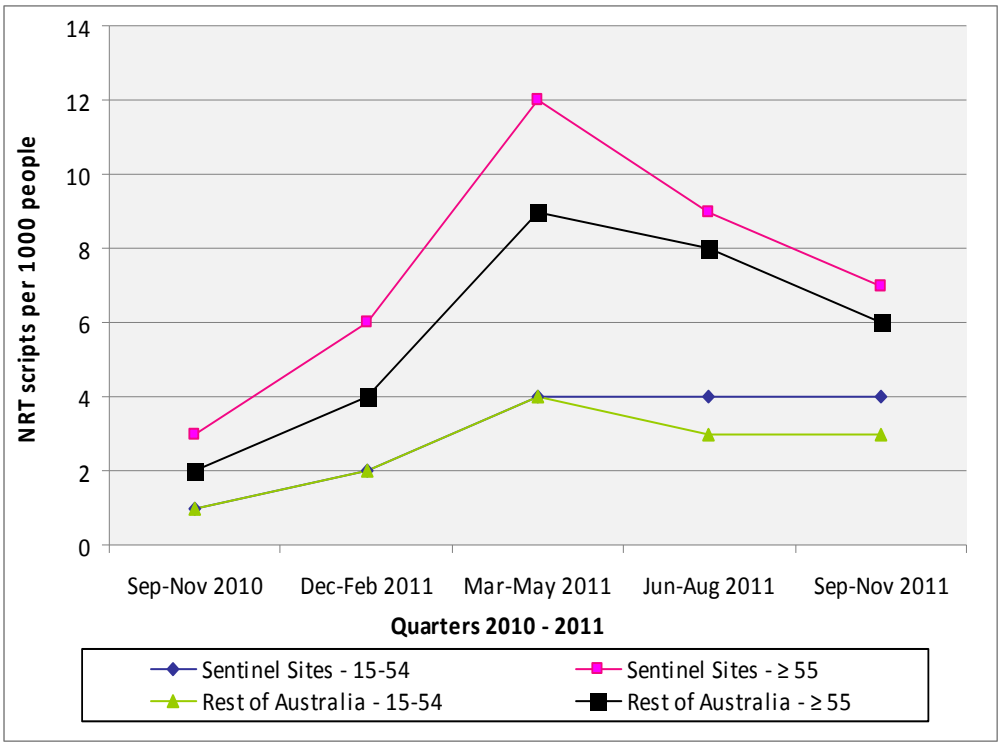


Figure 5.3: Number of prescriptions for NRT per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by quarter and age, September 2010 - November 2011

Figure 5.3 shows that the number of NRT prescriptions given per 1000 Aboriginal and Torres Strait Islander people aged ≥15 years was higher for people aged 55 years or over than those aged 15-54 for both Sentinel Sites and the rest of Australia.

As reported previously, there appears to be widespread awareness of NRT.

Whilst increasing uptake of NRT is encouraging, a number of unanswered questions remain regarding the effectiveness of NRT in achieving successful and sustained smoking cessation. There was no clear evidence available from the Sentinel Sites in this evaluation period on the extent to which NRT is integrated into evidence-based behavior change communication campaigns.

CHANGES IN HEALTH SEEKING BEHAVIOUR

Consistent with the program logic for this measure, Regional Tackling Smoking and Healthy Lifestyle teams aim to increase community awareness of risks and resources and to increase help-seeking behaviours related to smoking cessation and adoption of healthy lifestyles.

In the Sentinel Sites in relation to this measure, it was noted by a number of informants that levels of awareness of risk factors for chronic disease were already high and by implication, not an appropriate focus for intervention. In community focus groups, participants spoke of smoking, poor nutrition and lack of exercise and their consequences, including problems with heart, lungs, throat and stomach. Participants appeared to be well aware of the health issues and risks associated with chronic disease, stating *'Yeh, we live it'.*

Self-motivation was again noted in this reporting period as key for people to quit smoking and adopt healthier lifestyles. Some participants went so far as saying that this is the reason they don't feel the need to go to the clinic for help.

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

Clinicians in case study sites were asked to respond to a series of statements regarding their perceptions of community health seeking behaviours related to this measure. In contrast to the previous reporting period, in which overall trends of increasing agreement with statements regarding positive shifts in health seeking behavior and perceptions of behavior change were noted, in this reporting period, there was a decline in levels of agreement with several of the statements about health seeking behaviours and perceptions of behavior change. Although these figures may seem discouraging, they are based on small numbers of respondents and may not reflect significant changes in perceptions over the two most recent quarters. To the extent that the decline in agreement with these statements may be real, the change may reflect a more realistic understanding about the complexities of behaviour change, and this should inform a more solid platform for planning.

The proportion of clinicians agreeing with the statement *'there has been increased interest from patients to seek support to implement healthy lifestyle choices in the past six months'* has shown a general trend of increase since the implementation of the ICDP with some decline evident since the last reporting period. In the current reporting period, 55% (11/20) of clinicians either strongly or partly agreed with this compared to 13% (2/16) in Round 1, and 39% (13/33) in Round 2. In the previous reporting period (Round 3), 65% (15/23) agreed with this statement.

- The percentage of clinicians agreeing with statements about positive changes in behaviour towards healthier lifestyles among local Aboriginal and Torres Strait Islanders over the past six months has declined with 45% (9/20) agreement among clinicians in this reporting period compared with 58% (14/24) in the previous reporting period.

- Forty percent (8/20) of clinicians reported that there had been increased interest from Aboriginal and Torres Strait Islander people seeking support to quit smoking. This is lower than in the previous reporting period, where the figure was 56% (14/25).

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

Forty-five per cent of interviewees who were asked to respond 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',* either 'strongly agreed or partly agreed'

with the statement. Rurality differences were evident, with 72% (18/25) of interviewees in urban sites agreeing with the statement and 23% (3/13) in remote sites. No one agreed [0% (0/9)] with the statement in regional sites. This may reflect relatively less focus in these aspects of care by HLWs in regional and remote sites compared to urban locations. Limited capacity of the HLWs or an existing capacity within services (and therefore no need for the HLW to take on this role) were cited as reasons for the perception that HLWs had not led to increased Aboriginal Health Checks, GP Management plans or Team Care Arrangements.

A clinician (AHS) commented there has been limited success with the Healthy Lifestyle teams: the HLW role is *'poorly defined'*, '*sits on reception'* and *'haven't started any project; it's quite disappointing'*. The TAW in this site was a new recruit, having only been in the position for one month at the time of interview. In this particular site, a range of healthy lifestyle programs were being implemented, these are run by the nurses using the ICDP resources, but there had been no involvement as yet of the Regional Tackling Smoking and Healthy Lifestyle team. By contrast, HLWs were positive about their achievements in behaviour change, particularly amongst those people motivated to change. Seven of the eight 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. This was similar to the previous reporting period.

Given the early stage of implementation of this measure and the complex long-term nature of behaviour change, we would not expect the measures to have had a significant role in achieving change in levels of smoking (or healthy lifestyle behaviours more generally) at this stage. Interviewees were asked about their perceptions of change in smoking rates, as a baseline measure to track future changes. 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'*, 26% (9/35) of interviewees responded either 'strongly agree' or 'partly agree'. This is a slight improvement since the previous reporting period where only three interviewees either 'strongly or partly agreed' to this statement. Half of the small number of RTCs and TAWs (n=8) indicated that they 'strongly or partly agreed', when asked to respond with this statement. However, 51% (18/35) of interviewees responded 'don't know/can't say', with some commenting that it was difficult to determine a decline in patient smoking status with little or no clinical data to support this. Only one indicated that they 'partly disagreed' with this statement and the reason provided being that existing smoking resources and programs don't address chewing tobacco, which is common practice in their community.

There was no clear evidence in this evaluation period on the extent to which the interventions implemented at community level were in accordance with best practice. One of the strategies to increase motivation to change that was identified by informants was to target younger age groups in order to put pressure on parents – a positive impetus for change, as parents care about the effects of their behavior on young children (e.g. secondary smoke) and the respect of their children.

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

IMPACT ON OTHER PROGRAMS OR WORKFORCE GROUPS

We previously reported that there was minimal impact on other programs or workforce groups as a result of Health Service organisations losing workers as they were recruited to these new positions. In this reporting period, this perception has shifted, with a number of interviewees commenting that there has been noticeable impact on the capacity to deliver services because workers are being recruited to these new positions from other roles in the health care teams. This is partly because of the impetus of other aspects of the ICDP. For example, one clinician noted that there is increasing pressure to do more health checks in order to generate more income for the practice, however:

> *'We have problems where we are down a health worker because they have been moved over to become a healthy lifestyle worker.'* (Interviewee, AHS, GP)

A manager from an urban site said that while the Regional Tackling Smoking and Healthy Lifestyle teams are considered an important part of the workforce, they have not necessarily increased capacity of the Aboriginal and Torres Strait Islander health workforce, but have possibly just shifted the capacity.

> *'They don't necessarily add to the Aboriginal and Torres Strait Islander workforce. We're just shifting people from different positions rather than getting more Aboriginal and Torres Strait Islander people into the health workforce.'* (Interviewee, AHS)

The need to increase the Aboriginal and Torres Strait Islander health workforce was also picked up by a RTC in a regional site, where he suggested:

> *'There needs to be a good employment initiative that would create opportunities to employ people from the community to apply for vacant positions, and therefore expand the workforce.'* (Interviewee, AHS, RTC)

ORGANISATIONAL AND MANAGEMENT FACTORS

Key organisational and management factors that emerged during this reporting period as being important to the effectiveness of the teams included organisational stability, adequate supervision (particularly in sites where workers have to cover large geographic areas) and good team functioning.

It is evident from the information collected during our evaluation visits (complemented by DoHA program data) that in sites where there has been a stable workforce and supportive working environment, the program of work is more advanced with clear structure and purpose and plans to extend areas of service delivery. Additionally, individual team members have clearly described and understood roles and responsibilities. This was evident in a number of sites, including Campbelltown ('Djurali' program), Brisbane South and Logan/Woodridge ('Deadly Choices' program) and Tamworth (Health expos).

> *'We're all on the same page, and this adds capacity to the system.'* (Interviewee, AHS)

By contrast, the capacity of teams to design and implement a comprehensive program of work are limited by workforce retention and a lack of clear direction and leadership.

> *'The previous RTC was responsible for the tobacco part of it. I just had to focus on the nutrition side – so I didn't know much about the tobacco programs. That's changing now.'* (Interviewee, AHS)

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

In remote sites, interviewees emphasised the importance of creating a support and supervision structure that enabled workers in these positions to link with others who have established credibility in the community and to cover communities that are separated by large geographic distances.

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

In this reporting period 68% (30/44) of interviewees either 'party or strongly agreed' that having the workforce deployed in teams provided a supportive environment for workers. This is an increase from the previous reporting period, where less than half [46% (19/41)] of interviewees 'partly or strongly agreed' with the same statement.

Only one ICDP funded worker (RTC, TAW or HLW) responded 'partly disagree' to the statement '*the deployment of the Regional Tobacco Coordinators, Tobacco Action Workers and Healthy Lifestyle Workers as teams has provided a supportive environment for workers*'. The reason provided for this response appears to be related to issues of support at the organisational rather than the Healthy Lifestyle team level.

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

The relatively small number of positions, large distances and large service populations were again raised as issues impacting on the effectiveness of the Regional Tackling Smoking and Healthy Lifestyle teams 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.

> *'I think it is too much to expect to go out, even though they might not think that. Looking at it, you just go 'wow' to achieve the goals that COAG and Government would like them to achieve, I don't think it is possible, just because of the sheer distance and the capacity of staff to do that work.'* (Interviewee, NACCHO affiliate)

The lack of capacity to respond to requests for support from other organisations was also raised as an issue by one interviewee, who commented that it has been fortunate that there hadn't been many requests from practices to support Quit Smoking or Healthy Lifestyle programs as the teams are stretched as it is. Changes in staffing and organisational leadership have also impacted on the capacity to collaborate and to deliver programs.

5.6. Summary

1. Overall, data from the Sentinel Sites indicates that recruitment to Regional Tackling Smoking and Healthy Lifestyle teams is largely on track across urban, regional and remote sites, with eighteen of the twenty-four sites having coverage by one of these teams and 74% of positions filled. Lack of appropriately skilled applicants and high turnover of staff are issues of concern in several sites across all ruralities.
2. A range of different models for workforce deployment is emerging in the Sentinel Sites. Various models have been developed to overcome recruitment challenges, to support people working in these positions and to better suit the local context. In models where the emphasis is on teams and working together, a more advanced understanding of their roles and responsibilities by individual team members appears to have contributed to more developed programs of work.
3. Local amendments to positions to suit local context, such as pooling of funding from different sources to support generalist positions, were noted in a number of sites. These local adaptations had some training implications including the requirement to attend multiple orientation trainings for generalist workers covering a number of ICDP roles.
4. Where it had been accessed, training was generally valued by interviewees across sectors and positions. There was a high level of engagement in various training activities across the Regional Tackling Smoking and Healthy Lifestyle teams. There has also been considerable activity in development and distribution of toolkits and resources to support the workforce in their roles. Some challenges to workers being adequately equipped for their roles included:
    - 4.1. Emergence of dual role positions, requiring both clinical and non-clinical (program development) roles. Ability of workers to carry out both roles effectively was identified as problematic in some sites with no clear examples yet identified of this working well.
    - 4.2. Perceived inappropriateness of some of the national level resources to local context in some sites and inability to access available resources from a range of sources in other sites.
    - 4.3. Training content perceived to be insufficient in some cases, for example, unaddressed needs were identified by some informants related to program development, evaluation, report writing and identification and use of appropriate research evidence in programs.
5. Regional Tackling Smoking and Healthy Lifestyle teams have had a limited role in increasing access to smoking cessation and healthy lifestyle resources in private General Practices, with most work focused in AHSs. This appears to be related to lack of awareness of the roles (including their intended scope), lack of communication and/or collaborative working relationships, including capacity to engage with private practitioners, to support working across large geographic regions or populations, owing to workload in the AHSs.
6. A range of community-level activities in relation to these Measures are evident in the Sentinel Sites including social marketing events, group work and one-to-one support to motivated patients. Some of these involve linkages or brokerage between patients and other resources, for example, Regional Tackling Smoking team calling Quitline on

behalf of patients who experience barriers to doing it themselves. These activities take place in the context of a range of other pre-existing tobacco control and healthy lifestyle initiatives at both state and national levels. Community awareness of the workforce is generally high as indicated through community focus group discussions.

7. At health service level, there was a notable lack of recording of smoking status in clinical information systems; documentation of smoking status is an important first step in the implementation of brief interventions and smoking cessation measures in health services. Some progress was evident in achieving smoke-free workplaces in some sites, but this was not seen to be related specifically to the ICDP.

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

9. Findings related to early effectiveness of these measures on community awareness of risks and resources and increased help-seeking behaviours related to smoking cessation and adoption of healthy lifestyles were mixed. On the one hand, interviewees noted that levels of awareness of risk factors for chronic disease were already high, and by implication, not an appropriate focus for intervention. On the other hand, clinicians generally did not perceive that the workforce had had a positive effect on the health seeking behaviour or smoking rates of community members, whereas HLWs were in general more optimistic about their role and its impact.

10. Some negative impact of the Regional Tackling Smoking and Healthy Lifestyle teams on the capacity to deliver services was noted in this reporting period. This seemed to be because in some situations workers were being recruited from existing teams, leaving a gap in these teams. This is partly because of the impetus of other aspects of the ICDP.

11. Key organisational and management factors that emerged during this reporting period as being important to the effectiveness of the teams included a level of organisational stability, adequate supervision, particularly in sites where workers have to cover large geographic areas, and good team functioning. A particular challenge to programs implemented under this measure is how to work in a complementary way with the range of initiatives underway and the range of stakeholders and service providers in the local area.

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

6.1. Description of measure

Local Community Campaigns to Promote Better Health are being developed under measure A3. The main stated objective for the campaigns is 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 primarily includes a grants program with two rounds of funding. These campaigns are intended to be community designed and delivered. The grants are supported by national activities under the 'Get Active, Eat Good Tucker, Live Longer!' banner. These include a series of Healthy Community Day events which have been held across Australia, a national website (Live Longer)[64] 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.[65]

6.2. Program logic for Measure A3

The Program Logic for measure A3 specified in the National Framework has been reviewed and updated.[66] The following outputs and early results in relation to measure A3, and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- Local Indigenous media organisations and/or community groups involved in local or regional campaigns.
- Implemented community campaigns.
- Community Health Action Packs.

Expected early results for years 2-4:

- Participants have increased awareness of importance of accessing primary health care.
- Funds for grants and events are spent efficiently.
- Action packs are beneficial to the design and implementation of community campaigns.

[64] Live Longer! Website, <http://livelonger.health.gov.au> (accessed 2 November 2011).
[65] 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.
[66] DoHA correspondence, 7 March 2012.

6.3. State of implementation – national context

Information provided by DoHA in January 2012 about the state of implementation of measure A3 at a national level[67] that is relevant to SSE is outlined below.

- In June 2011 the first targeted round of local community campaigns grants were awarded, with 38 projects funded across Australia. A further open competitive round of grants was held, closing 30 September 2011.[68] There was a strong response to the second round of grant applications and in the first half of 2012 DoHA were in the process of awarding and establishing these. Most of the grant projects will run to May 2013, some finish in June 2012. At the time of compiling this report there were no plans for a third funding round.[69,70] In 2013 DoHA will be producing a narrative description of the first and second round grant project activity.
- Forty-eight Healthy Community Days were held throughout the period from April 2011 to December 2011. From 18 August 2011 it was made mandatory for host medical organisations to offer health checks or screening as part of the Healthy Community Day activities.[71] No particular type of health screening was specified as it depended on the capacity of the organisation. Whilst obligatory offering of follow-up services was not specified by the DoHA, this was expected to be offered.[72] Given the link with the Regional Tackling Smoking and Healthy Lifestyle workers, it is intended that this element of the program will be transferred to the A1/A2 measure area and future events will be run by Healthy lifestyle teams.
- The Get Active Live Longer! Website (www.livelonger.health.gov.au), provides information about the Local Community Campaigns measure, the local activities of grant recipients and hosts an online version of the Community Health Action Pack (CHAP). The website was launched in September 2011. It encourages Twitter communication between website users and has news and media update sections.
- CHAP has had limited hard copy distribution. Initially there was one pack distributed to each Regional Tackling Smoking and Healthy Lifestyle team. Since the intention was that these would assist grant recipients in development of local community campaigns, they were also distributed to first round grant recipients. There will be renewed distribution in June/July 2012 with a scaled down version to go to ACCHOs and extra packs distributed to members of the Regional Tackling Smoking and Healthy Lifestyle teams. With the funding agreements for new grant recipients, further distribution will occur.[73] The CHAP is also available for download online.
- An online survey to gather feedback on the CHAP has been conducted. However, response to this has been low. As of 18 November 2011, fifteen responses had been received, nine from recipients of the hard copy version and six from recipients of the online version of the CHAP.

[67] DoHA, A1, A2, A3 update, personal communication, 12 January 2012.
[68] DoHA, A3 report, 7 September 2011.
[69] DoHA, A1, A2, A3 update, personal communication, 12 January 2012.
[70] DoHA, A1, A2, A3, B4, update, personal communication, 22 May 2012.
[71] DoHA, A3 update, personal communication, 1 February 2012.
[72] DoHA, A3 update, personal communication, 28 February 2012.
[73] DoHA, A1, A2, A3, B4, update, personal communication, 22 May 2012.

- The A3 measure has also funded NACCHO affiliates and SBOs across Australia to undertake projects related to the promotion of relevant MBS items, including Aboriginal and Torres Strait Islander people's Health Assessment Item, Chronic Disease Management Items and follow-up Items. By February 2012 all states and territories had undertaken activities and promotions. There were a number of examples of collaborative projects, whilst other recipients undertook their own projects. In Queensland, there was collaboration around this measure with the SBO, NACCHO affiliate and the Improvement Foundation. In Victoria, the NACCHO affiliate agreed to reassign their funding to the SBO and worked with them in providing expertise. The South Australian and Tasmanian affiliates also undertook collaborative projects. An overview of the projects identified similar approaches including development of locally relevant resources and posters alerting and identifying MBS items and pathways of care; up-skilling through academic detailing and community and health provider events and training; social marketing; quality improvement and IT initiatives. Some areas promoted Aboriginal and Torres Strait Islander specific MBS items and chronic disease items, whereas others focused particularly on the health assessments. Some organisations included a focus on data quality, recall reminder and auditing. Others improved access to cultural awareness training. In regards to training, the Victorian affiliate identified a need for training in motivational interviewing to improve AHW confidence in promotion of health behaviour change and training was provided.[74,75]

6.4. Findings from the Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from evaluation visit interviews in case study sites. Across the eight case study sites, there were five community level projects funded under this measure, including two in Brisbane South, one in Katherine West and two in Campbelltown. Interviews were conducted in these sites and in other sites with key informants who would be expected to have some knowledge of the Local Indigenous Community Campaigns and associated grant programs.

Community focus groups discussed their awareness and perceptions of local community campaigns and their perceptions of change since the previous reporting period. The findings reported are based on focus group discussions in four case study sites.

PROGRESS WITH IMPLEMENTATION

During this evaluation period, targeted local community grants had been awarded for local Indigenous Community Campaign activity in seven of the twenty-four Sentinel Sites. These included three urban, two remote and two regional sites. Owing to geographical location of projects two additional urban sites around Brisbane were potentially exposed to local community activity related to these grants (Table 6.1). As indicated in the Table 6.1, the projects funded in the Sentinel Sites varied in the types of health behaviours targeted, with

[74] DoHA, A3 MBS promotional activities – SBO, 13 February 2012.
[75] DoHA, A3 MBS promotional activities – NACCHO, 5 September 2011.

some focusing primarily on a single area, such as physical activity, nutrition or smoking and others covering a range of issues.

Table 6.1: A3 targeted grant projects in Sentinel Sites

Site	Rurality	Grant recipient	Project overview
Case study sites			
Brisbane South	Urban	Brisbane Indigenous Media Association Incorporated	The Move project aims to raise awareness of the benefits of physical activity among Aboriginal and Torres Strait Islander peoples aged 18 and over in the greater Brisbane region through regular on air messaging, a website and community comedy events.
		Inala Indigenous Health Service (Department of Health QLD)	The Inala Youth Sports Program will involve hosting a sports and education week for young Indigenous people aged 10 – 15 years as a school holiday program.
Katherine West (including Lajamanu)	Remote	Red Dust Role Models	Red Dust Healthy Living Weeks will provide a series of targeted workshops with primary and secondary school children in a number of remote Indigenous communities in the NT including the Katherine West region. The topics covered will include nutrition, physical activity and smoking cessation, and activities will include an excursion to a medical clinic, t-shirt and poster design competitions and a competition to produce a short film.
Campbelltown	Urban	Tharawal Aboriginal Corporation	Tharawal Aboriginal Corporation's Good Tucker All Round project will develop a food distribution network to purchase fresh fruit and vegetables from the Sydney Markets on a daily basis at a subsidised cost to community members. Participants will be given health checks and Tharawal's Community Kitchen will also be used to educate community members about healthy preparation of the produce.
		Tharawal Aboriginal Corporation	The Get Active, Anytime, Anywhere project involves expanding the existing Djurali Program, a community exercise program. The funding will be used to provide equipment and professional instructors, as well as, resources such as exercise charts, exercise and nutrition diaries and a dedicated space on the Tharawal website for participants to share their experiences.

Site	Rurality	Grant recipient	Project overview
Enhanced tracking sites			
Darwin	Regional	Hoops 4 Health Aboriginal Corporation	The Hoops 4 Health Challenge aims to raise awareness of risk factors that contribute to chronic disease through a series of 'Live Longer' basketball challenges in remote communities leading up to a major basketball tournament to be held in Darwin. The tournament will invite schools from all over the NT. Radio message reinforcement.
Newcastle	Urban	Awabakal Newcastle Aboriginal Medical Service	The Lost and Found in the Smoke project will develop, produce and present an interactive play, engaging 12-14 year old students. Focusing on the health, social and financial consequences of smoking, the play will promote healthy choices and lifestyles and the benefits these deliver for individuals, families and communities. Aim for 50 performances
Derby	Remote	EON Foundation	The EON Thriving Communities Program will be delivered to seven remote Indigenous communities in the Kimberley region of WA including Looma within the Sentinel Site. The program aims to promote healthy lifestyle choices to reduce chronic disease and will include activities such as the creation and maintenance of local community gardens, education about nutrition and food hygiene, and the teaching of skills in home repair and maintenance skills for good hygiene.
		Goolarri Media Enterprises	This project involves the development and promotion of a third series of Goolarri's successful "Catch and Cook" series, which will target children and families and focus on delivering good nutrition through bush tucker and other traditional foods. To be broadcast on community networks, Goolgarri website and YouTube.
		Goolarri Media Enterprises	This project involves the production and promotion of a 15-20 minute educational DVD titled Bran Nue Leg. It will focus on primary and secondary prevention for diabetes and its sequelae. To be broadcast on community networks, Goolgarri website and YouTube.
		Nindilingarri Cultural Health Services	The Skutta Girls program will extend a pilot program targeting at-risk young women aged 12-18 years in the Fitzroy Crossing and surrounding communities. These weekly sessions, which will be community developed and implemented, will focus on nutrition, sexual health, chronic disease management and prevention and involve some light exercise.

Site	Rurality	Grant recipient	Project overview
Tracking sites			
Kalgoorlie	Regional	Bega Garnbirringu Aboriginal Health Service	The project aims to establish a Mobile Community Engagement Vehicle, which will be used to deliver a range of themed health promotion activities to ten Aboriginal communities in the Goldfields region of WA including Kalgoorlie. Different health themes will be chosen in consultation with the communities visited and will address nutrition, physical activity, use of health care services, social and emotional wellbeing, and substance misuse.

Source: DOHA, Targeted round grants projects in Sentinel Sites, 30 January 2012.

Progress with the distribution and use of the community action packs and implementation of the community day events are described in relevant sections below.

ABILITY TO ACCESS THE GRANT FUNDING TO SUPPORT LOCAL COMMUNITY CAMPAIGNS

The grant funding was competitive, depended on community organisations being aware of the funding source and submitting a competitive proposal. The local community campaigns were not intended to be designed for implementation in every community, but (presumably) in sites with capacity to utilise them effectively. Interviewees associated with two sites, Tamworth and Brisbane South, were in a position to make comment on the grant funding process from the perspective of a grant recipient and a potential applicant. Organisational capacity to develop and implement the grant appeared to be an important consideration. In Tamworth, limited capacity was a barrier to applying for the grants and a consideration in the ability to effectively support the project if they were successful, whereas in Brisbane South the available capacity through a regional support organisation appears to have been important to the development of successful grants.

In Tamworth awareness of the grant process had been through information targeted at DGPs through email list serves and at workshops. There was some interest from the DGP in the local community grants. However in this site, organisational disruption due to the transition to Medicare Locals was identified as a barrier to the development of their application, although this was seen as temporary.

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

Interviewees from the regional support organization for the Brisbane South site described a situation where they had dedicated resources and this enabled the organisation to take a lead role in preparing the grant applications including consulting with other AHSs as part of the process. This meant the organisation was a successful round 1 grant recipient for the Brisbane South case study site.

An additional two case study sites, Campbelltown and Katherine West, were recipients of the round 1 project grant funds. None of the key informants were in a position to comment on barriers and enablers to accessing the grants at the time of the evaluation visits, because they were new to their role and/or were not involved in the grant process.

USE OF NATIONAL LEVEL RESOURCES IN DEVELOPMENT OF LOCAL CAMPAIGNS

The measure intention is that the community activities draw on national level resources developed to support the measure, including the CHAP and the Get Active Live Longer! website. As outlined below, there is to date little evidence from the Sentinel Sites of widespread use of these resources in the development of local community campaigns. Information from the Sentinel Sites on the reasons for lack of use of the national resources is outlined below.

When asked if the resources had been helpful to implement local health campaigns, about half [51% (22/42)] of those interviewed responded 'don't know/can't say'. Interviewees in urban sites [68% (13/19)] were more likely to 'strongly or partly agree' that the centrally supplied resources had been useful, compared with remote [27% (3/11)] and regional sites [8% (1/12)].

When asked specifically to comment about the CHAP, key informants in Logan/Woodridge were aware of the resource although they were not using it. They explained they had designed a similar toolkit to ensure the process and resources are applicable and appropriate to local community needs.

> *'We are doing our own things anyway. We tend not to use them.'* (Interviewee, AHS)

In Campbelltown, grant funding has been used to expand existing programs (Good Tucker All Round and Djurali programs). These programs were already established and had developed their own momentum. The CHAP resources had not been used in these programs.

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

AWARENESS OF THE NATIONAL LEVEL RESOURCES IN SENTINEL SITES

All sites, whether or not they are receiving specific targeted funding for local community campaigns, have access to the national resources through the website, and in some cases, through distribution to Healthy Lifestyle and Tobacco Teams. Therefore it would be expected in all sites that informants would have some awareness of the national resources. Awareness of the resources has improved slightly since the previous reporting round. There were no clear differences in awareness of the resources between the AHS and private General Practice sectors.

While the CHAP have been purposefully distributed to the Regional Tobacco and Healthy Lifestyle teams, awareness of the CHAP and LiveLonger! website among these workers was not consistent across Sentinel Sites. In a regional site neither the Regional Tobacco Coordinator nor the Healthy Lifestyle Worker was aware of the resources. This may be a reflection on the length of time these workers had been employed in these roles, attendance at training and orientation days (where the resources have been promoted) and/or the distribution process. One interviewee suggested that the resources may not have been distributed correctly once they were received by the organisation.

> *'… unless they are distributed correctly, staff don't receive them and cannot use them.'* (Interviewee, AHS)

There seemed to be some lack of local coordination regarding how the CHAPs should be accessed. In one site, it was identified that two CHAPs were ordered separately at one service. Another interviewee commented that the distribution of resources to only the ICDP workforce contributes to inequities across the Aboriginal and Torres Strait Islander health workforce more broadly, with existing health promotion type workers and programs having less access to such resources.

> *'Only ICDP positions are well resourced; the Indigenous health workforce is not. Others have to climb high walls to access resources. I have specifically been asked to locate these resources as a worker has come and said there is no access to these resources, although it has been promoted by Ministers. This seems odd to me.'* (Interviewee, SBO)

PERCEPTIONS OF HEALTHY COMMUNITY DAYS

Based on data collected at the site evaluation visits, healthy community days had been held in three case study sites (Tamworth, Logan/Woodridge and East Pilbara) and in one enhanced tracking site (North Lakes/Caboolture). Interviewees from these sites considered their local healthy community days as a positive community initiative. These often emphasised healthy lifestyle through participation in sport.

In the Logan/Woodridge site, high profile role models (local footballers, Preston Campbell and Dean Withers) and a trailer with 'health promotion' messages were used to raise community awareness of healthy lifestyles. A 'registration card' was developed as a strategy to encourage people to participate in each activity at Healthy Community Day events. Nurses from the local AHS were also available to conduct health checks during the day. The initiative used social networking media to promote the event including websites, Facebook and Twitter. Interviewees commented that these communication mechanisms were popular with younger people.

By contrast, in Tamworth the Regional Tackling Smoking and Healthy Lifestyle team worked together to hold a 'Healthy Fun 4 Everyone' community expo. The expo included games and activities, free health information and check-ups, morning tea and lunch. A range of other local agencies and services also participated and provided resources for the day (e.g. tooth paste/brushes, paint your hands on t-shirts). The expo was also used as an opportunity to promote the importance of self-identification as Aboriginal or Torres Strait Islander. The team plans to hold another expo later in 2012.

Interviewees in East Pilbara reported that a range of local community events have been implemented to raise community awareness of healthy lifestyles. These include movie nights and community open days at the AHS. There are also plans to hold activities to raise community awareness at Harmony Day and Close the Gap celebrations as well as World No Tobacco Day.

Since the previous reporting round, DoHA has made health checks a requirement for each local Healthy Community Day.

Vignette - Incorporating health checks in local health promotion campaigns

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

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

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

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

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

While interviewees from this site spoke positively of the Healthy community day initiatives, one challenge identified was how to identify and engage the local community in an inclusive way.

> *'The struggle is getting everyone on board from a community, it's not always known to all organisations in a particular part of community. We overcome this by not going in and telling people what to do, but we go in and say "this is what we can do, how can we help?" We also get people involved in all the planning.'*
> (Interviewee, AHS)

A concern was raised in this site regarding whether or not these events were optimally targeted. Local community members suggested that smaller, targeted initiatives, particularly aimed at young people, would be more effective than large public events.

> *'If you saw them more in the community doing stuff at the grass root level it would be more of an impact. They seem to do a lot more of the big events, promotional events where you've got celebrities. It was a big event and only had a little stall. Kids really didn't get into there and be educated about it … It's just another stall …*

adults just walked straight past. They could be coming to do big promotion to youth group here … come on Friday night.' (Community focus group)

6.5. Summary

1. Overall in this reporting period there appeared to be increased awareness of the national level resources available under this Measure in the Sentinel Sites, greater awareness of targeted grant funding availability and some evidence of project level activities related to the targeted grant funding.
2. Access to targeted grant funding was seen to be at least partially dependent on organisational capacity to apply for funding and local stakeholders perceptions of capacity to effectively utilise funding.
3. It is difficult to gauge the impact of A3 related activity. In some Sentinel Sites implementation of the A3 related activities was at a very early stage, with local activity occurring on the ground after the evaluation site visit for the current reporting period.
4. Use of targeted funding varied between the sites, in some cases being used to support or expand existing initiatives, and in other cases, new one-off or occasional outreach events were implemented. There was little evidence of use and uptake of the CHAP across the Sentinel Sites, including those with targeted project funding. Some challenges with distribution were noted and in some cases the packs were not seen to be relevant to local context and needs.
5. The evidence from the Sentinel Sites to date suggests that at local level, the funding covered a diverse range of activities, messages and target audiences across the sites. Community initiatives that appeared to be most consistent with evidence based practice occurred more frequently in sites where the grant funding was being used to extend or continue existing projects that had been well designed and implemented prior to receiving the grant funding (i.e. where the projects appeared to have been previously developed with health promotion expert advice and did not originate in response to the grant funding).
6. Further to the above point, some of the grant related activity appeared to be piece-meal and lacking a strategic and coordinated approach. This, coupled with limited use of national level resources, suggests the degree to which integrated sustained campaigns drawing on evidence-based principles in behaviour change were able to be achieved at local level, was largely dependent on pre-existing capacity.
7. While the SSE was not able to gauge the impact of A3 activities at a population level within the sites, because health behaviour change requires long-term and strategic programs, and because of the short time frame for most of these newly funded projects and their limited reach, population level effects are unlikely to have been achieved at this early stage of ICDP implementation.
8. The potential for population health effects to be achieved may be enhanced by increased emphasis on integrating ICDP initiatives with existing programs, and building existing initiatives and capacity in a way that is consistent with Australian and international evidence on best practice in health promotion. Identifying and sharing of good practice between communities may be a useful focus in the future.

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

7.1. 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 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 for their PBS medicine).

Lower costs for PBS medicines will be 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 (AHSs). The measure is intended to benefit Aboriginal and Torres Strait Islander peoples of any age who present with an existing chronic disease or are at risk of chronic disease and who, in the opinion of the doctor, would experience setbacks in the prevention or ongoing management of chronic disease if the person did not take the prescribed medicine and who are unlikely to adhere to their medicines regimen without assistance under this measure.

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)[76]. Those who would normally pay the concessional rate will receive their PBS medicines without being required to pay a PBS Co-payment. However, premiums for a small number of medicines will still need 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.[77]

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

The PBS Co-payment measure was expected to supersede the pharmaceutical subsidy provided by the 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 is scheduled to continue under the Fifth Community Pharmacy Agreement from 1 July 2011.[78] QUM support services funded under QUMAX include: Dose Administration Aids (DAAs), QUM

[76] 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 Co-payment and Safety Net Amounts, 1 January, 2011. <http://www.pbs.gov.au/info/news/2011/01/2011-PBS-copayment-and-Safety-Net-amounts> (accessed 5 April 2012).

[77] DoHA, Subsidising PBS Medicines Co-payment Scheme Fact Sheet, Indigenous Chronic Disease Package, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/subsidising-pbs-medicine-co-payments/$file/DHA6136%20B1%20Factsheet.pdf> (accessed 5 April 2012).

[78] NACCHO Medical Release 21 June 2011, <http://www.naccho.org.au/Files/Documents/QUMAX-%20NACCHOMR21-6-11.pdf> (accessed 5 April 2012).

Pharmacy Support; Home Medicines Review (HMR); QUM Devices; QUM Education; Cultural Awareness; and Transport. [79]

Patients of around 170[80] remote area AHSs already had, and will continue to have, access to free medicines through Section 100 (S100) of the National Health Act 1953. This provision, introduced in 1999, provides medicines for patients of eligible remote area AHSs without a requirement for the normal PBS prescription form and without charge.[81]

On 5 July 2010, the Minister approved the ability of medical specialists to annotate 'CtG' (Close the Gap) prescriptions for registered patients when they are a) providing services at a registered urban or regional AHS or b) treating a registered patient who has been referred to them by a service in an urban or regional location and that is registered for the PIP Indigenous Health Incentive.[82]

7.2. Program logic

As specified in the National Framework, outcome hierarchies 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.

[79] DoHA, QUMAX Program Specific Guidelines, <http://www.5cpa.com.au/iwov-resources/documents/5CPA/Initiatives/ATSI_Programs/QUMAX%20Program%20Specific%20Guidelines%20v3.pdf> (accessed 5 April 2012).
[80] DoHA, Alternative Arrangements for Medicines, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-indigenous> (accessed 5 April 2012).
[81] 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, <http://www.health.gov.au/internet/main/publishing.nsf/Content/926735D382C26BC2CA256F9A000AC8D7/$File/S100%20FAQ.pdf> (accessed 5 April 2012).
[82] DoHA, Report on ICDP measure B1, 30 March 2011.

7.3. State of implementation – national context

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 31 March 2012.[83]

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

- More than 2600 Health Services had registered for the PBS Co-payment measure.
- The number of individual patients receiving a benefit was 127 379.
- There has been a consistent trend of increase in the number of people receiving a benefit each month, for example; 569 people in the month of July 2010, 17 966 people October 2010, 29 031 people March 2011, 37 133 people October 2011 and 44 082 March 2012.
- The total number of pharmacies making a claim increased by 1037 since June 2011 and was 4731 at the end of March 2012.
- The hotline statistics to September 2011 show a total of 6130 calls over 439 working days averaging around eighteen per day. The hotline is staffed by measure area personnel.
- There have been a total of 2251 email enquiries over 460 days (to March 2012), which is an average of nearly five per day (ranging between two to eight per day since inception).
- 2 034 672 PBS Co-payment prescriptions were dispensed, with uptake being highest in NSW (41.06%), followed by QLD (27.23%), WA (10.27%), VIC (9.08%), SA (8.34%), TAS (2.05%), NT (1.14%), and ACT (0.83%).
- The measure has been communicated and promoted at three conferences since October 2011: Health First (DGP) in South Australia in December 2011, QUMAX/S100 Joint Forum in Melbourne in March 2012 and the WA General Practice Network in Perth in May 2012.
- The QUMAX state-based support network (Quality Use of Medicines Support Pharmacists and NACCHO State affiliates) utilised by participating AHS was to have ceased as at 30 June 2012. A proposal has been received from the Pharmacy Guild and NACCHO to extend the period for these services until 31 December 2012, until a series of web-based resources are implemented that will assist AHSs in meeting their program requirements (e.g. developing Quality use of Medicines work plans, Dose Administration Agreements with pharmacies, and Progress Reporting).[84]

[83] DoHA, B1 report, 31 March 2012.
[84] DoHA B1 report update 5 June 2012.

7.4. Findings from Sentinel Sites

NOTES ON COLLECTION, ANALYSIS AND INTERPRETATION OF DATA

Interviews with key informants in all eight case study sites and two enhanced tracking sites included enquiry about their awareness and perceptions of the PBS Co-payment measure.

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 focus groups held in all eight case study sites.

The National Evaluation Framework program logic deals separately with the participation of AHSs and General Practices in the PBS Co-payment measure (see Appendix A for relevant program logic). We report here on both sectors together as the issues raised continued to be similar for the two sectors, as they were for earlier reporting periods.

PBS administrative data describes the medicines dispensed to Aboriginal and Torres Strait Islander people aged ≥15 years living in the postcodes of the Sentinel Sites or the rest of Australia. Sentinel Site boundaries, in most cases are determined by Statistical Local Areas. The extraction by postcodes in some cases lead to a slight mismatch between PBS data and Sentinel Site boundaries.

PBS data are updated as new claims are processed, which results in variation in data reported over time depending on the date of extraction. This variation is small for extractions that occur three months or more after the date of the service.

It is important to note that the PBS Co-payment measure is designed to operate in metropolitan to rural Australia (RRMA 1-5) but in some exceptional circumstances the measure operates in remote Australia (RRMA 6-7). Complementing the PBS Co-payment measure is the non-ICDP Section 100 Supply program, which only operates in remote Australia (RRMA 6-7). Accordingly, patients living in remote Australia may be included in the ICDP PBS Co-payment analyses because they may be eligible PBS Co-payment patients and access the program when visiting a less remote locality or may consult with a practice in remote Australia that participates in the PBS Co-payment measure.

The PBS administrative data describes the medicines dispensed to patients. These data do not necessarily provide accurate information on the quality use of medicines prescribed by doctors or used by patients.

AWARENESS OF THE PBS CO-PAYMENT MEASURE

There continues to be a high level of awareness among stakeholders of the PBS Co-payment measure (Table 7.1). Ninety-nine per cent (71/72) of interviewees indicated that they were aware of the PBS Co-payment measure.

Awareness was universal among interviewees in urban and regional sites (100%). It is important to bear in mind that the selection of interviewees from Health Services is focused on those who have an identified interest in Aboriginal health.

In remote sites, while data are limited by small numbers of interviewees, there was some evidence of continued increasing awareness with eleven out of twelve interviewees in this

reporting period saying they were aware of the measure compared to seventeen out of 21 interviewees for the previous reporting period.

This universally high level of awareness among Health Service staff in urban and regional sites does not extend to community members. While awareness within community focus groups of the PBS Co-payment measure was generally high, members of the focus groups consistently identified examples of individuals who are still paying large amounts of money for medications and who are not aware of the PBS Co-payment measure. A number of community focus groups identified Elders as not being well informed.

> *'Our Elders do not even know about CtG.'* (Community focus group)

Community awareness of the PBS Co-payment measure was lower in remote areas, probably due to the presence of S100.

There continues to be room for improvement in awareness of the PBS Co-payment measure among community members.

Table 7.1: Awareness of the new PBS Co-payment for medicines available for Aboriginal and Torres Strait Islander people (% who responded 'yes' to being aware of the measure), overall and by rurality

	Rurality	Dec 2010	Jun 2011	Dec 2011	Jun 2012
Are you aware of the new PBS Co-payments for medicines initiative available for Aboriginal and Torres Strait Islander people? MS, CS, PM[a]	Overall	86% (n=36)	91% (n=81)	95% (n=86)	99% (n=72)
	Remote	43% (n=7)	69% (n=16)	81% (n= 21)	92% (n=12)
	Regional	100% (n=15)	95% (n=40)	100% (n= 33)	100% (n=27)
	Urban	100% (n=13)	100% (n=25)	100% (n= 32)	100% (n=33)

[a] Type of interview respondent, see Appendix D for listing of interview and respondent types.
Note: n = number of people who responded.

There continue to be a number of areas of concern regarding access to the PBS Co-payment measure for people in remote locations including:

- 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 ten years. However, the PBS Co-payment measure is not intended to be specific to non-remote locations and it has the potential to provide additional benefits for people living in these locations, as well as, for people in other locations.

- The mobile nature of the population means patients may be getting access to S100 in one location, but not when they move out of an S100 area. They are less likely to be aware of their eligibility for the PBS Co-payment measure as a way of obtaining affordable medications.

  > *'The big challenge in organising access is the remote people coming down to Port Augusta. The patients used to getting their medications through S100 remote scheme. They come to town not realising they are not eligible for CtG.'* (Interviewee, Pharmacist)

'The whole CtG script and S100 is messy and does not adequately address the transient nature of the population.' (Interviewee, AHS)

'People who come down to Port Augusta from the Lands have to pay for their medications; they would not know that as they get their medications for free.' (Community focus group)

- Another challenge highlighted by a regional area was that patients in remote areas were being signed up for the PIP Indigenous Health Incentive and not for the PBS Co-payment, because in the remote areas they have access to S100 arrangements. When the patient then visits an area that is not covered by S100 the Health Service has difficulty determining if the patient is registered for PBS Co-payment. It was consistently suggested by interviewees (not only from remote sites, but also across urban, regional sites) that there needs to be a mechanism to determine if a patient is registered for PBS Co-payment to avoid unnecessary paperwork in signing people up for the measure when they may already be registered. If they are not signed up then the Health Service or the patient ends up carrying the cost of the medications.

  'Concerned that in remote areas patients may be signed up for PIP but as they are covered by S100 they are not signing patient for PBS Co-payment. They then arrive in Darwin and not covered by S100 and need to be signed up for PBS Co-payment. Unsure how to know if patient is signed up for PBS Co-payment. Just sign them up in case.' (Feedback from enhanced tracking site)

- There is uncertainty among some clinicians in remote sites about the S100 and PBS Co-payment measure. In one remote site the GP at the AHS was writing both PBS Co-payment measure and S100 prescriptions. The GP was uncertain about the PBS Co-payment measure and unsure which ones to write. The GP indicated that the pharmacist was encouraging them to write 'bush scripts' (S100) due to a perception of minimal paperwork for pharmacists using S100.

- There were a number of examples in remote sites of the AHS continuing to cover gap payments for brand medications directly to the pharmacist.

PROVISION OF INFORMATION ON THE PBS CO-PAYMENT MEASURE

As in the previous reporting periods, there was a high level of agreement among interviewees [80% (56/70)] that Health Services were provided with adequate and timely information about the PBS Co-payment measure. Interviewees in urban and regional sites continued to show particularly high levels of agreement (82% and 85% respectively) whereas remote sites continued to be less likely to agree with this statement (six out of ten).

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 better informed than when the PBS Co-payment measure was initially released. An increase in awareness among managers should contribute to increasing awareness more broadly over time.

Interviewees identified a variety of information sources on the PBS Co-payment measure in this reporting period:

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

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

- One GP in private General Practice found out about it from the Pharmacist ringing to request a prescription to be rewritten as a PBS Co-payment prescription.

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

- Medicare Liaison officers were again identified as important sources of information. AHSs in particular noted the role of the Medicare Liaison officer who visited and spoke about all of the Medicare items including PBS Co-payment. The face to face contact was especially valued. As reported previously and despite some perceptions of inconsistent information from hotlines and Medicare Liaison officers, the resources available to support the PIP Indigenous Health Incentive and PBS Co-payment measures were described as valuable, particularly in AHSs.

  'I'm constantly searching the net, and if you don't do it yourself you're damned. I keep my staff well informed and we had training with Medicare.' (Interviewee, AHS, practice manager)

- A number of clinicians this reporting period indicated that they were receiving information from patients attending the Health Service. Patients were also reminding them to annotate the prescriptions in some instances.

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

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

- Across sites the SSE team were noted as playing an important role in providing information about the PBS Co-payment measure and the ICDP more broadly.

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

Despite the high awareness there is still some misinformation about the PBS Co-payment measure and its interaction with the PIP Indigenous Health Incentive (and for S100 with some stakeholders). The following quote from a GP in an AHS highlights this confusion between S100, PBS Co-payment and the PIP Indigenous Health Incentive.

'I enquired about the PBS Co-payment and was informed that patients on the S100 would not be eligible for the PBS Co-payment. Apparently the PIP payment would be impacted. However, on further investigation, if a GP in Newman wrote a CtG script for

> *a patient and it was presented to the local pharmacy they would receive the medication however the PIP-IHI would not be affected.'* (Interviewee, AHS, GP)

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.

In addition to the Medicare Liaison officers, stakeholder interviewees at DGPs and State-Based Organisations again consistently highlighted that the measure manager for this area was very responsive to requests for clarifications by email and telephone. The SBOs have been managing state-based email lists for ICDP workers based in the DGPs and these were noted as a good method for dissemination of information.

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

The Pharmacy Guild was identified by pharmacists as a source of information about the PBS Co-payment measure. However, the Pharmacy Guild may not be adequately informed of newly emerging services that have a potentially important role in implementation of the ICDP (e.g. the IUIH in South East Queensland).

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

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

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

Community focus groups highlighted the value of 'word of mouth' about this measure. The PBS Co-payment measure is clearly highly valued by community members and community focus groups indicated that there was a great deal of discussion and information sharing about the measure within communities. AHWs, OWs in both the DGP and AHS and IHPOs were noted as providing information about the PBS Co-payment at community events and by one-on-one discussions.

In spite of this high level of awareness in the community there continued to be comments from interviewees and community focus groups about the need to inform the Aboriginal and

Torres Islander communities of the PBS Co-payment measure. A number of interviewees continued to highlight gaps in understanding of the measure among community members regarding access to specialists prescribing under the PBS Co-payment, confusion about hospital doctors' eligibility to prescribe and access to PBS Co-payment prescriptions when visiting another location. Education about the PBS Co-payment measure appears to require continuing refinement.

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

PARTICIPATION BY HEALTH SERVICES IN THE PBS CO-PAYMENT MEASURE

Participation in the PBS Co-payment measure by Health Services in Sentinel Sites has been generally high. As indicated above, there is confusion about the most appropriate way for Health Services in remote locations to participation in this measure.

As previously reported, there is continued feedback that at times staff of private General Practices may be aware of the PBS Co-payment, but have made a decision not to participate as they believe they do not have a sufficient number of Aboriginal and Torres Strait Islander patients to make it worthwhile for the practice. This attitude is not specific to the PBS Co-payment measure, rather an emerging issue across the implementation of the ICDP.

> *'The issue for the practice is that it does not have the volume of Aboriginal and Torres Strait Islander patients to be able to consolidate (be fully aware and have a working knowledge) of the information regarding the PBS Co-payment.'* (Interviewee, private General Practice, practice manager)

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 prescriptions. This continues to appear a particular issue in private General Practices and it is likely to be related to Aboriginal patients being a minority of the service population in this context. Pharmacists continued to highlight this as an issue.

> *'Not all doctors prescribe, some of them won't do it, some will do it and some of them do it but I don't think they really know what they are doing.'* (Interviewee, Pharmacist)

> *'Some of the doctors in the practice are part-time doctors and they do not get access to the PIP money therefore they are not interested to prescribe under the PBS Co-payment.'* (Interviewee, private General Practice, GP)

> *'There is also an equity issue for patients in practices where Aboriginal patients are in small numbers. I have heard of GPs saying that they have only one or two Aboriginal patients so why register as a PIP practice. This means that their Aboriginal patients may be missing out on accessing the ICDP measures.'* (Interviewee, NACCHO affiliate)

The clinical indicator data presented from General Practices indicated that many practices have only a small proportion of Aboriginal patients or they are not identifying them on the patient information system (Section 19). Without good systems for identification of Aboriginal

and Torres Strait Islander people, Health Services are not easily able to identify who is eligible for the PBS Co-payment measure and practice computer software will not automatically annotate prescriptions when Indigenous status is not recorded.

As highlighted in the previous reporting periods, barriers to participating in the PBS Co-payment measure continued to include the requirement for Health Service registration for the PIP Indigenous Health Incentive, uncertainty regarding patient's eligibility for the PBS Co-payment and systems for identifying Aboriginal and Torres Strait Islander patients. These issues are discussed further below, and Sections 9 and 19 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.

Generally, in order for a Health Service to be eligible to participate in the PBS Co-payment measure they must be registered for the PIP Indigenous Health Incentive. It should be noted that a small number of AHSs that are not eligible for the PIP Indigenous Health Incentive are able to access the PBS measure.[85] To assess uptake of the PBS Co-payment measure by Health Services it is therefore necessary to examine the uptake of the PIP Indigenous Health Incentive.

PATTERNS OF UTILISATION OF THE PBS CO-PAYMENT MEASURE BETWEEN DIFFERENT AGE GROUPS AND GEOGRAPHIC LOCATIONS

The number of Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites who had accessed medicines through the PBS Co-payment measure increased by 85% in the September 2011 - November 2011 quarter compared to September 2010 - November 2010. A similar increase (74%) was observed in the rest of Australia (Figure 7.1). The number and type of people accessing the PBS Co-payment measure in relation to the population and the total number of people are detailed in Appendix G, Tables G2 and G3.

[85] DoHA, Special Arrangements for Indigenous Health Services not currently Participating in PIP, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/non-pip-participants/$file/Special%20arrangements%20Indigenous%20Health%20Services%20not%20participating%20in%20Practice%20Incentives%20Program%20(PIP).pdf> (accessed 25 May 2012).

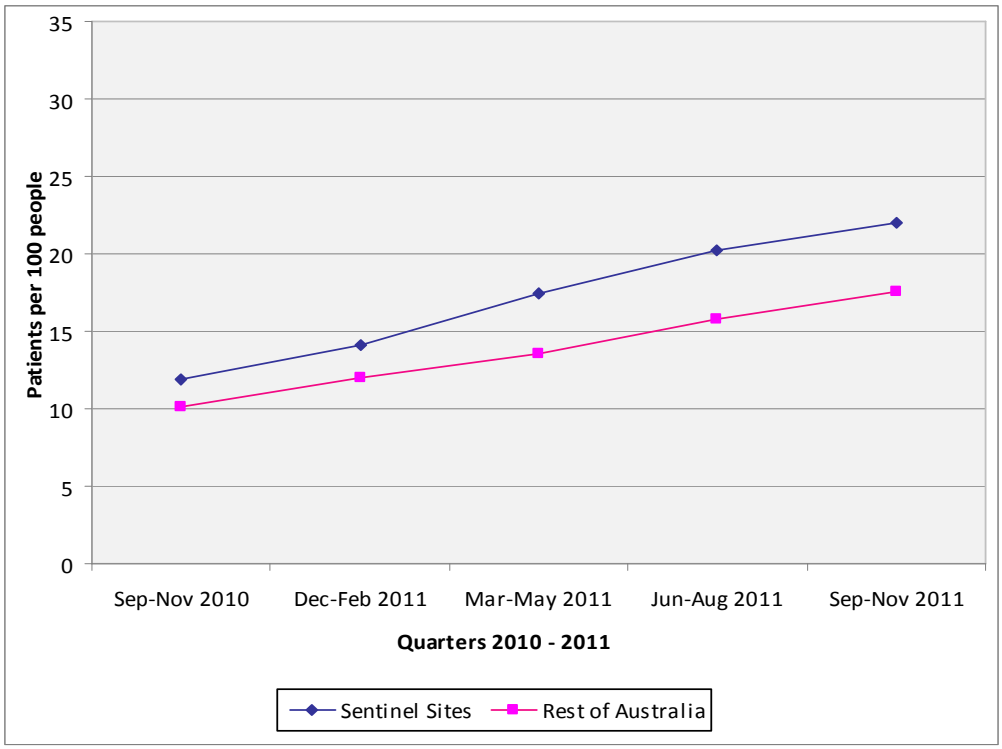


Figure 7.1: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia by quarter, September 2010 - November 2011

The number of people who had accessed medicines through the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people was higher in regional areas than urban areas in Sentinel Sites (average urban=13, average regional=19 per 100 people) and the rest of Australia (average urban=11, average regional=16 per 100 people) from September 2010 - November 2011. As expected (because of S100), the number of people accessing medicines through the PBS Co-payment measure was much lower in remote areas (average remote Sentinel Sites =1, average rest of remote Australia =6 per 100 people)

The number of people accessing medicines through the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people was higher in urban Sentinel Sites than in the rest of urban Australia (Figure 7.2). In urban Sentinel Sites (96%) and the rest of urban Australia (82%) there was a substantial increase in the uptake of the PBS Co-payment per 100 Aboriginal and Torres Strait Islander people in the September 2011 - November 2011 quarter compared to the September 2010 - November 2010 quarter. The larger increase among urban Sentinel Sites compared to urban rest of Australia may reflect a higher proportion of AHSs in urban Sentinel Sites, with AHSs likely to be providing PBS Co-payment prescriptions to larger numbers of people.

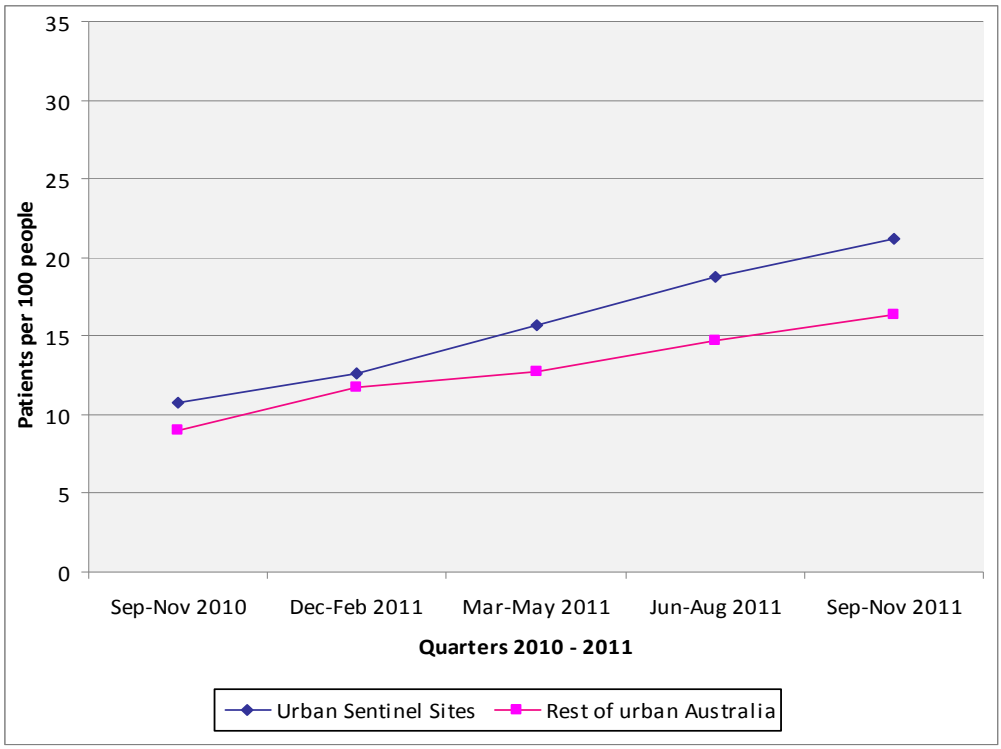


Figure 7.2: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, by quarter, September 2010 - November 2011

In regional areas the number of people accessing medicines through the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people was higher in regional Sentinel Sites than in the rest of regional Australia (Figure 7.3). In regional Sentinel Sites (78%) and the rest of regional Australia (68%) there was a substantial increase in the uptake of the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people in the September 2011 - November 2011 quarter compared to the September 2010 - November 2010 quarter. As for the urban situation, the larger increase among regional Sentinel Sites compared to regional rest of Australia may reflect a higher proportion of AHSs in regional Sentinel Sites.

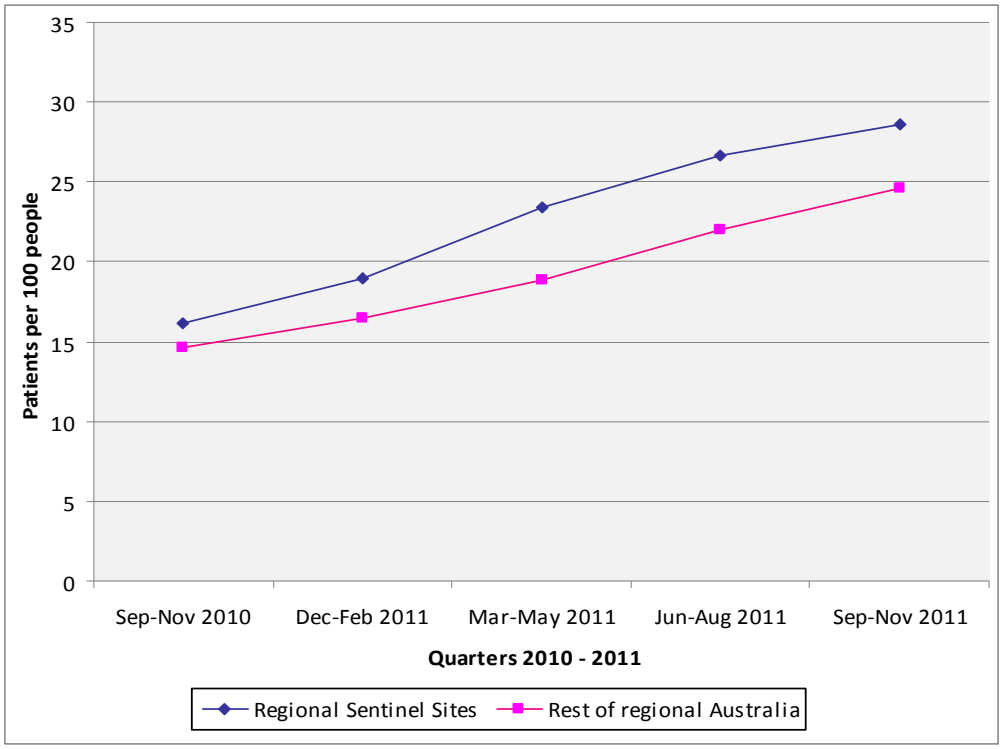


Figure 7.3: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional Sentinel Sites and the rest of regional Australia, by quarter, September 2010 - November 2011

In remote areas the number of people accessing medicines through the PBS Co-payment measure was higher in the rest of remote Australia than in remote Sentinel Sites (Figure 7.4). In remote Sentinel Sites, although use of the PBS Co-payment measure remained relatively low, the number of people accessing medicines through the PBS Co-payment measure doubled from the September 2011 - November 2011 quarter compared to the September 2010 - November 2010 quarter. In the rest of remote Australia there was an 89% increase in the September 2011 - November 2011 quarter compared to the September 2010 - November 2010 quarter. Relatively greater access to AHSs in remote Sentinel Sites is probably contributing to lower use of the PBS Co-payment measure because these services have access to medicines through S100.

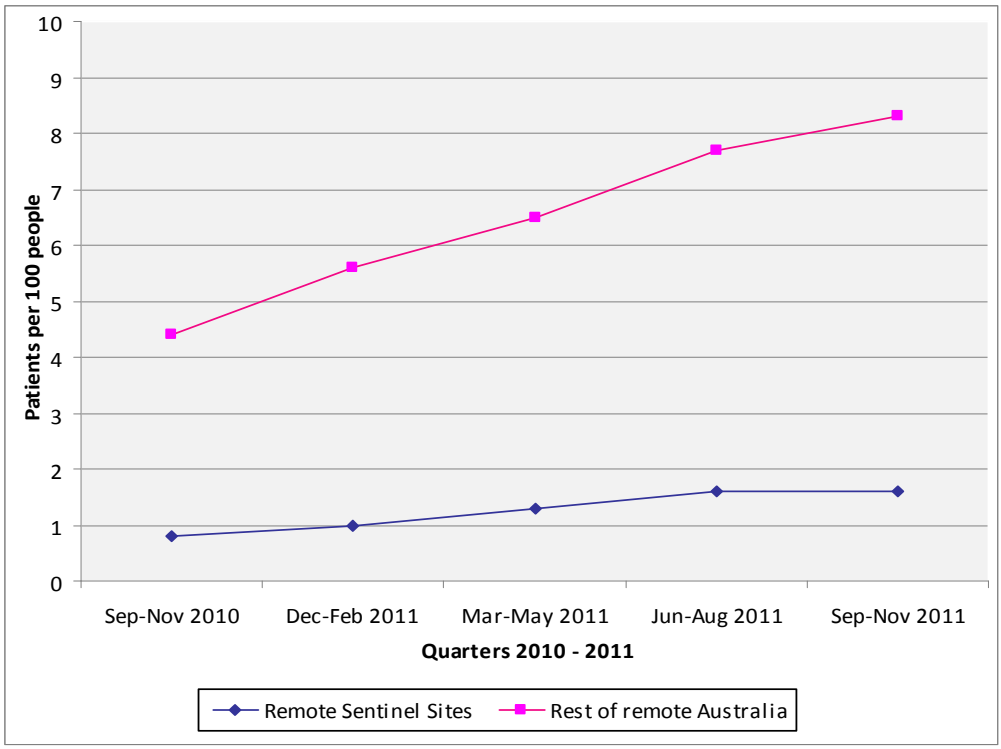


Figure 7.4: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, by quarter, September 2010 - November 2011

In Sentinel Sites over half of Aboriginal and Torres Strait Islander people aged ≥55 years had accessed medicines through the PBS Co-payment measure compared to about 18 per 100 Aboriginal and Torres Strait Islander people aged 15-54 years in September 2011 - November 2011 (Figure 7.5). In the rest of Australia 40 per 100 Aboriginal and Torres Strait Islander people aged ≥55 years had accessed medicines through the PBS Co-payment measure compared to about 14 per 100 Aboriginal and Torres Strait Islanders aged 15-54 years in September 2011 - November 2011 (Figure 7.5). This represented an 87% increase for people aged 15-54 years and 78% increase for people aged ≥55 years in Sentinel Sites from September 2010 - November 2010. In the rest of Australia the increases were 81% and 63% for people aged 15-54 years and people aged 55 years respectively.

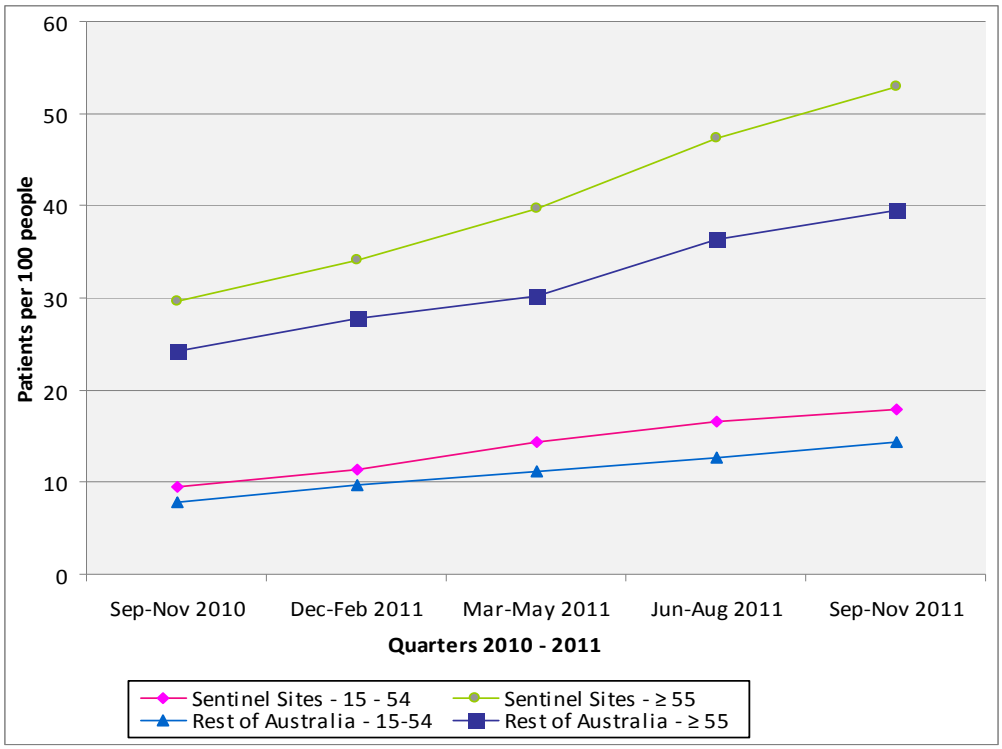


Figure 7.5: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, by quarter and age, September 2010 - November 2011

SITE VARIATION IN PEOPLE ACCESSING MEDICINES THROUGH THE PBS CO-PAYMENT

In urban Sentinel Sites, the number of people accessing the PBS Co-payment measure ranged from 10 to about 69 per 100 Aboriginal and Torres Strait Islander people with the figure for the rest of Australia being 16 per 100 (Figure 7.6). In September 2011 - November 2011 the number of people accessing medicines through the PBS Co-payment was higher in all urban Sentinel Sites than the rest of urban Australia with the exception of Dandenong. All urban Sentinel Sites and the rest of urban Australia showed increases in the number of people accessing the PBS Co-payment in the September 2011 - November 2011 quarter compared to the same time in the previous year. In Campbelltown, Elizabeth, Newcastle and Logan/Woodridge the number of people accessing medicines through the PBS Co-payment doubled (or more than doubled) in the September 2011 - November 2011 quarter compared to the September 2010 - November 2010 quarter. In North Lakes/Caboolture the increase was three-fold in the same period.

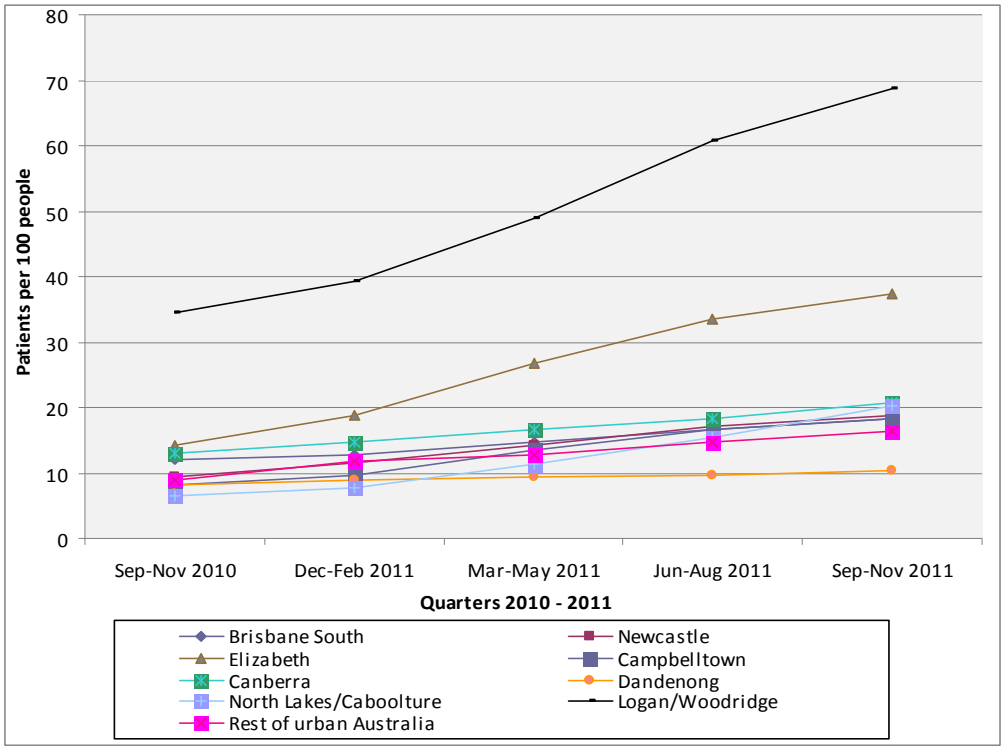


Figure 7.6: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, by site and quarter, September 2010 - November 2011

In regional Sentinel Sites the number of people accessing medicines through the PBS Co-payment ranged from 10 to 54 per 100 Aboriginal and Torres Strait Islander people in the September 2011 - November 2011 quarter (Figure 7.7 and 7.8). The figure for the rest of regional Australia was about 25 per 100 Aboriginal and Torres Strait Islander people. Most regional Sentinel Sites had higher numbers of people per 100 Aboriginal and Torres Strait Islander people accessing medicines through the PBS Co-payment than the rest of regional Australia in the most recent quarter reported here. Sites with uptakes that were lower than the rest of regional Australia in the most recent quarter were Darwin, Gladstone, Hobart and Kalgoorlie. Access in Darwin was lower than any other site (Figure 7.8). Reasons for this variation are almost certainly to some extent related to cross boundary flows in utilisation of health services, issues of identification of Aboriginal and Torres Strait Islander peoples and to availability of S100 in some locations. In Bairnsdale, Dubbo, Geraldton, Grafton and Port Augusta over 40 per 100 Aboriginal and Torres Strait Islander people were accessing medicines through the PBS Co-payment in the most recent quarter.

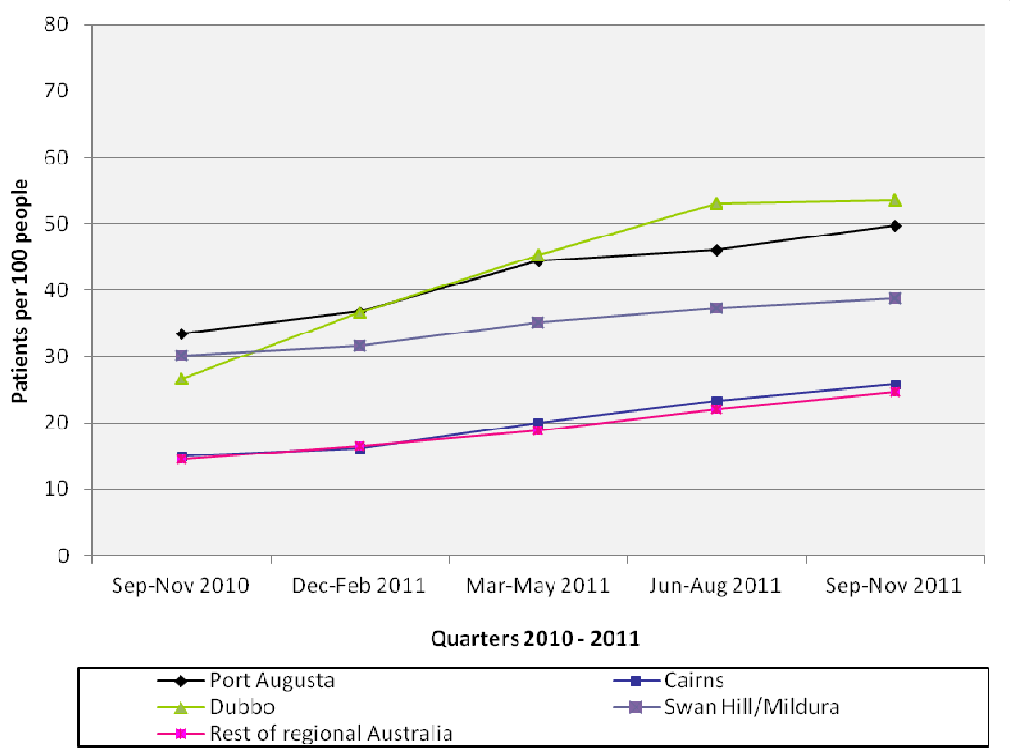


Figure 7.7: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for stage 1 regional Sentinel Sites and the rest of regional Australia, by site and quarter, September 2010 - November 2011

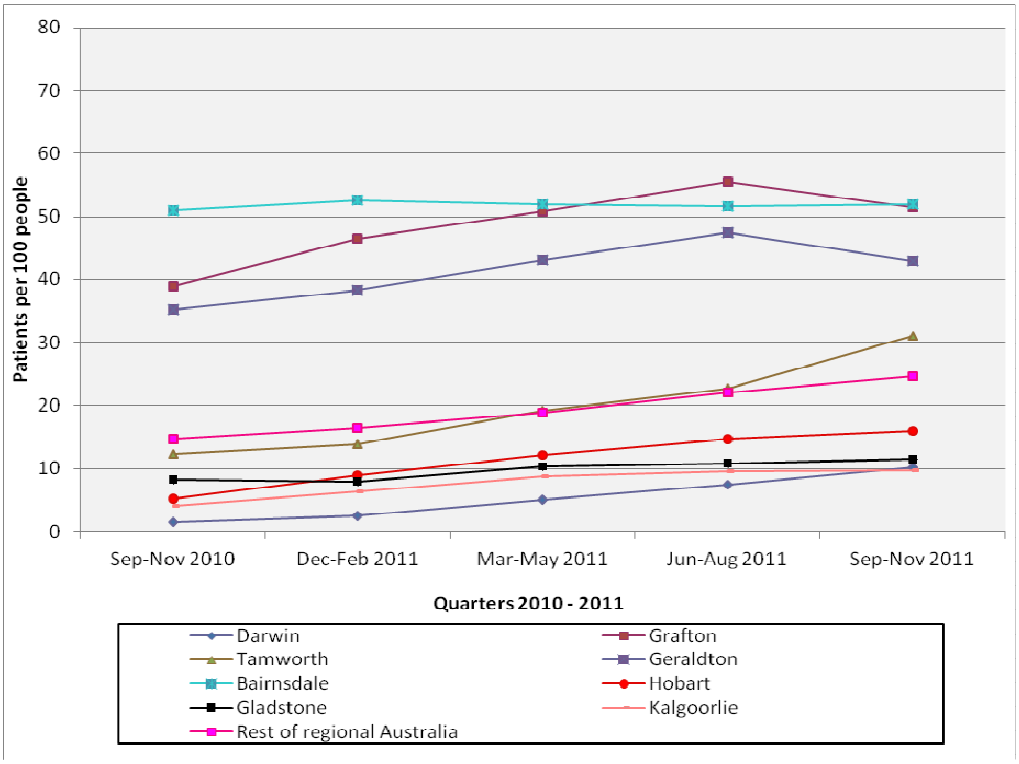


Figure 7.8: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for stage 2 regional Sentinel Sites and the rest of regional Australia, by site and quarter, September 2010 - November 2011

In remote areas the number of people accessing medicines through the PBS Co-payment measure in the period covered by this report (September 2010 - November 2011) ranged from 0.4 to 8.3 people per 100 Aboriginal and Torres Strait Islander people (Figure 7.9). The rest of remote Australia was at the top of the range. East Pilbara showed higher numbers of people accessing medicines through the PBS Co-payment measure than other Sentinel Sites. All sites showed an increase in the number of people accessing medicines through the PBS Co-payment measure In September 2011 - November 2011 compared to September 2010 - November 2010.

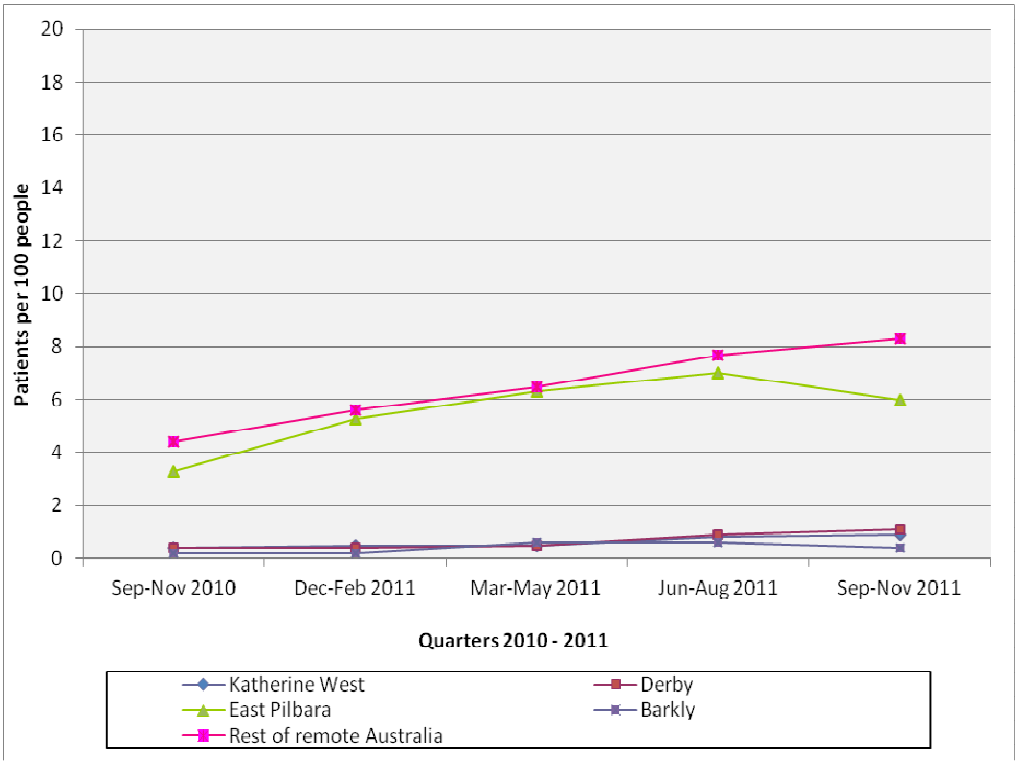


Figure 7.9: Number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, by site and quarter, September 2010 - November 2011

QUMAX AND UPTAKE OF THE PBS CO-PAYMENT

An analysis was undertaken on whether the uptake of the new PBS Co-payment measure might be slower in sites that are transitioning from QUMAX. AHSs in ten out of twelve regional Sentinel Sites and five out of eight urban Sentinel Sites were participating in QUMAX (Appendix F for a listing of AHSs in Sentinel Sites that are participating in QUMAX). Figure 7.10 shows that the number of people accessing medicines under the PBS Co-payment measure per 100 Aboriginal and Torres Strait Islander peoples in urban Sentinel Sites was similar, with sites where the AHS had not been participating in QUMAX having slightly higher uptake than sites where the AHS had been participating in QUMAX. In contrast, in regional Sentinel Sites where the AHS had been participating in QUMAX had about a three-fold higher uptake of PBS Co-payments than sites where the AHS had not participated in QUMAX. In regional sites experience with QUMAX may have therefore been an important enabler to implementation of the PBS Co-payment measure, but this does not appear to have been the case in urban sites. The reasons for this large difference between urban and regional patterns are not clear.

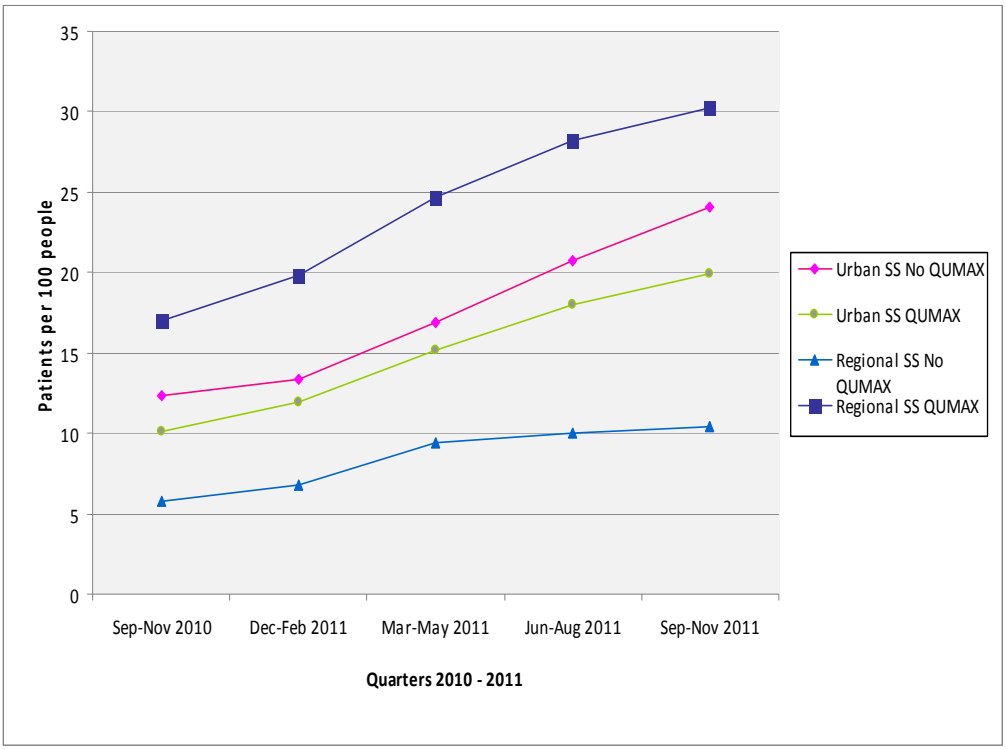


Figure 7.10: Number of people accessing PBS Co-payment medicines per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites with QUMAX compared to Sentinel Sites with no QUMAX, by quarter and rurality, September 2010 - November 2011

INDICES OF DISADVANTAGE AND USE OF PBS CO-PAYMENT

The PBS patient categories include two indices of disadvantage; concessional and people eligible for safety net. People in the concessional category include low-income people who qualify for a health care card, pensioners and people who are eligible for a national senior's card. People who are eligible for safety net have exceeded the threshold for expenditure on medicines and are therefore likely to be in worse health than other people. People in all categories utilised the PBS Co-payment measure. Over two-thirds of people accessing medicines through the measure were people in the concessional category (Appendix G Table G4). Around six per cent of people using the measure were in the safety net category. This latter category is perhaps lower than might be expected based on the number of Aboriginal and Torres Strait Islander people reporting long-term health conditions.[86] However, this is difficult to assess in the absence of baseline data. The PBS Co-payment measure removes any financial incentive for people in the concessional category to apply for safety net eligibility so it may be that this group is included in the concessional ordinary category. The percentage of people in each patient category was similar for Sentinel Sites and the rest of Australia and varied little by rurality or time. However, there were differences between age groups. As would be expected more people aged ≥ 55 years were in the concessional safety net category than people aged 15-54 years. More people aged 15-54 years were in the general ordinary category compared to people aged ≥ 55 years. The results suggest that the PBS Co-payment

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

measure is being accessed by people who are disadvantaged by worse health and/or poorer socioeconomic status. It is particularly benefiting people aged >55 years (Figure 7.11).

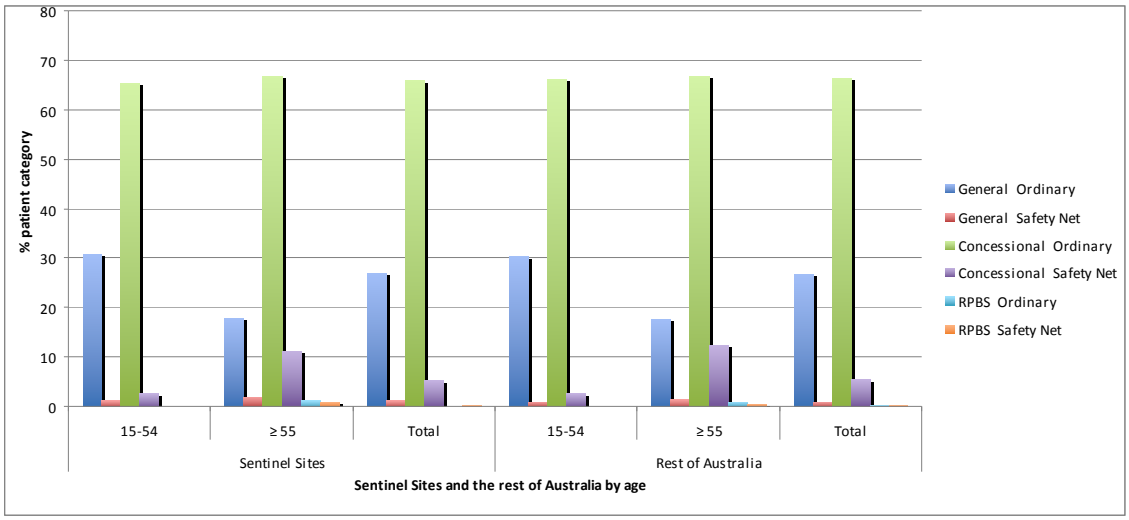


Figure 7.11: PBS Co-payment medicines dispensed by patient category for Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, September 2010 - November 2011[87]

PBS CO-PAYMENT MEASURE INCREASING ACCESS TO MEDICATIONS

There has been a steady increase 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) and 89% (50/56) over the three most recent reporting periods. In the current reporting period no respondents disagreed with the statement and eleven per cent said they 'didn't know or couldn't say'.

Clinician's continued to have high levels of agreement [85% (23/27)] that medications are more accessible, and this agreement was evident in both the General Practice and AHS sectors (Figure 7.12).

[87] The Repatriation Pharmaceutical Benefits Scheme (RPBS) provides a wide range of Pharmaceuticals and dressings at a concession rate for the treatment of *eligible* veterans, war widows/widowers, and their dependants. Department of Veterans Affairs [website], <http://www.dva.gov.au/service_providers/doctors/Pages/rpbs.aspx> (accessed 7 June 2012).

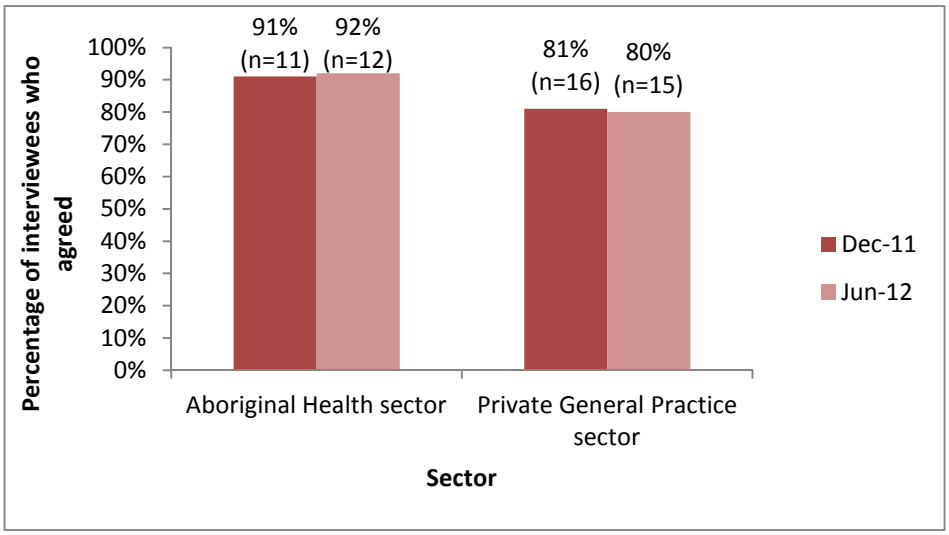


Figure 7.12: Clinicians' responses to the statement 'Medications are more accessible for Aboriginal and Torres Strait Islander people than they have been previously' (% who responded 'strongly agree' or 'partly agree')

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 has resulted in improved access to medications and subsequent improved adherence to taking medications as prescribed.

Similar to the previous reporting period, two-thirds of clinicians [66% (18/27)] agreed with the statement '*medication adherence has improved because of the PBS Co-payment measure'*. Within AHS clinicians tended to be more positive (with 10/12 agreeing) than clinicians based in General Practice (8/15) (Figure 7.13).

To the extent that the data allow 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 of perceptions that medications were becoming more accessible across all urban, regional and remote areas.

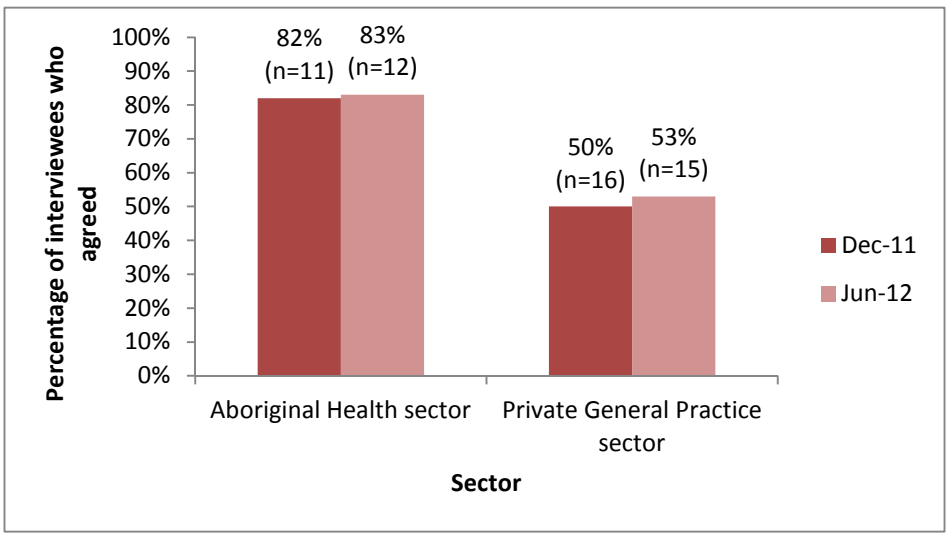


Figure 7.13: Clinicians' responses to the statement 'Medication adherence has improved because of the PBS Co-payment measure' (% who responded 'strongly agree' or 'partly agree')

There continues to be a perception that patients were previously prioritising the use of their income to purchase other items ahead of purchasing medications due to cost of medications.

A number of stakeholder interviewees again emphasised the need to increase patient awareness about medication use and highlighted a concern that clinicians are not spending adequate time explaining medications.

> *'GPs and practice nurses are time poor so they don't have time to explain to their Aboriginal patients.'* (Interviewee, DGP)

There were suggestions about encouraging the use of home medication reviews (HMRs)[88] as patients were now more likely to be accessing all their medications but not necessarily understanding how to use them. One GP in an urban private General Practice indicated that they use their practice nurse to provide education on medications and then bill a Medicare item number for this. They also use GP Management Plans to cover education in medications. This GP noted that he had no difficulty organising a pharmacist to undertake a HMR and the challenge was more about ensuring the patient was at home when the pharmacist visits to do the HMR.

A small number of interviewees continued to argue that medication adherence was not necessarily improving.

With the high level of awareness of the measure it seems timely to increase the focus on promoting safe use of medications and providing medication reviews and advice and support in safe use of medications. The Quality Use of Medicines Program, through the National Prescribing Service[89] (NPS) offers community education material and training and support for clinicians on prescribing. The NPS has also been running training sessions on medications for AHSs.

[88] DoHA website, Home Medications Review. <http://www.medicareaustralia.gov.au/provider/pbs/fourth-agreement/hmr.jsp> (accessed 5 April 2012).
[89] NPS [website], <http://www.nps.org.au/about_us/what_we_do/about_quality_use_of_medicines> (accessed 5 April 2012).

Vignette – Improved understanding of, and access to, medications

Community focus group participants in a regional site attribute the PBS Co-payment measure to their improved access to, and understanding of, prescription medications and a motivator for medication compliance. Affordability is no longer a barrier - a recent further drop in the cost of prescription medicines has made a significant difference for some patients with chronic illnesses.

'There has been a price drop, $3.70 each instead of $5.70 which makes a difference when you have to take quite a few medications - makes you want to keep taking medicine'.

Most said their GPs explain what the medicines are for when prescribing, making the language simple to ensure a better understanding. Some pharmacies at the site are taking a similar approach when issuing prescriptions.

'I take about 16 tablets a day. The Pharmacist at [private pharmacy business] visited me at my home to explain what the medicine is about, wrote everything down as he was explaining. The majority of the medication is for my heart.'

ROLE OF THE OUTREACH WORKER IN RELATION TO THE PBS CO-PAYMENT MEASURE

To date the OWs role 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 the number of trips made to support patients with access to medications is one of the key performance indicators for OWs. As reported previously, 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. As reported previously, there was some evidence of role expansion occurring; some OWs have assisted patients by translating or explaining information during consultations.

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

In this reporting period OWs explained that they were providing community education on the PBS Co-payment, for example, how to access the Co-payment, encouraging community

members to attend Health Services to get access and providing assistance with picking up prescriptions.

INCREASED ACCESS TO HEALTH SERVICES AS A RESULT OF THE PBS CO-PAYMENT

As previously reported, a number of stakeholder interviewees indicated that patients were now coming back more readily for repeat prescriptions, with a consequent general increase to access to Health Services. This has the two-fold benefit of patients accessing medications more readily and also attending more regularly for care. The quotes below are illustrative of this perception:

> *'CtG PBS Scripts have encouraged patients to go to General Practice and they've found that it's not that bad and they go from there. This measure has got them in the door. OW worker has helped get scripts and repeat scripts.'* (Interviewee, SBOs)

> *'There has been an increase over time because their friends are getting it and word of mouth spreads and I also think the number of patients who visit [AHS] has increased as a result also.'* (Interviewee, Pharmacist)

> *'We had quite a few come to our surgery and joined the program and then they get CtG and then they keep coming back to see our doctors.'* (Interviewee, private General Practice, nurse)

> *'PBS Co-payment has been helpful to retain and engage patient with the Health Service. The patients now tend to stick to the one practice as a main service provider, before they would go from doctor to doctor.'* (Interviewee, AHS, GP)

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 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 prescriptions, particularly for patients in remote sites when they travel from an area covered by S100.

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 previously), but rather on where consumers can access these programs, and to work towards a consistent approach to making information widely available and easily understandable. 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 prescription can be obtained.

The PBS Co-payment measure continued to be described by Health Service staff and community members as 'the carrot' for registration with the PIP Indigenous Health Incentive. There have been some reports of patients changing providers in order to access the PBS Co-payment measure.

> *'I have had a few patients coming to [Health Service] now as their regular doctor won't get PIP accredited so they can dispense CtG scripts. This is because the patient base is perceived to be too low to bother or the doctor is not accredited and therefore ineligible. They are coming not because they want to sign up for PIP but because they want CtG scripts.'* (Interviewee, AHS, GP)

Similarly, there were challenges for Health Services when a patient who was not a regular patient presented and asked for a CtG annotated prescription. GP interviewees in some services indicated some reluctance to annotate a prescription 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 managed this situation 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 prescription. 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 prescriptions.[90] There was no indication from community focus groups that community members were aware of the development of a register. There was no evidence that members of community focus groups or from interviewees in service organisations were aware of any information available from DGPs (or elsewhere) showing which practices were registered or where patients could access the PBS Co-payment measure. This lack of information on registered practices continues to be an issue for people who are travelling.

> *'With opt in register how do patients hear about this as the register is not supposed to be available to the public (said the department). Divisions provide lists of General Practices with permission that dispense CtG scripts, distribution depends on local plan, e.g. IHPO and OW take lists to community events.'* (Interviewee, SBO)

PERCEPTIONS OF PBS CO-PAYMENT ELIGIBILITY CRITERIA

There was an increasing agreement amongst interviewees with the statement *'patient eligibility criteria for the PBS Co-payment are workable in practice'* [81% (66/92) compared to [72% (65/92)] since the previous reporting period. These high levels of agreement with the statement were high in urban, regional and remote sites.

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

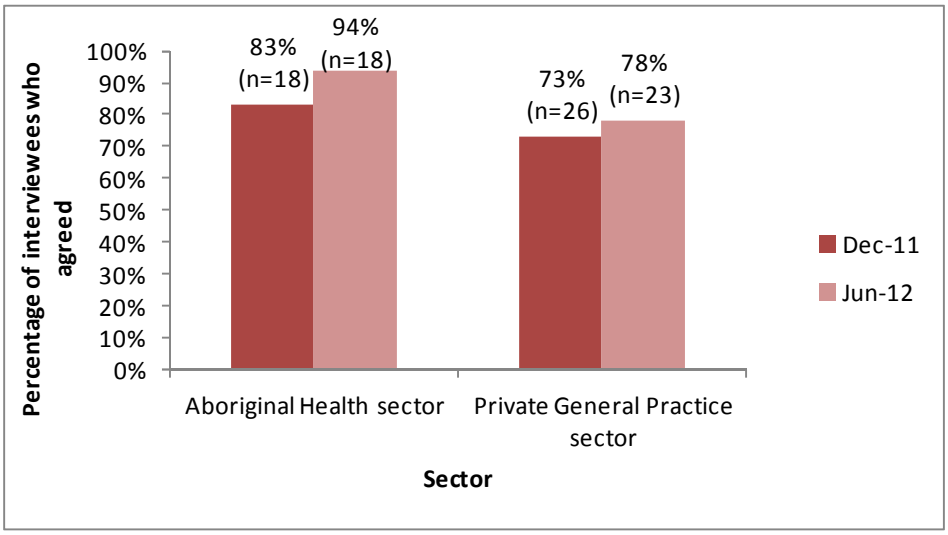


Figure 7.14: Clinicians' and practice managers' responses to the statement 'Eligibility criteria for Aboriginal and Torres Strait Islander people to access the PBS Co-payment measure are workable in practice' (% who responded 'strongly agree' or 'partly agree')

Practice managers [93% (13/14)] tended to be slightly more positive about the eligibility criteria being workable than clinicians [81% (22/27)]. Similarly, clinicians and practice managers in AHS tended to be more positive than those in General Practice [94% (17/18) and 78% (18/23) respectively] (Figure 7.14).

Despite this high level of agreement from interviewees in different roles and different sectors that the eligibility criteria were workable, a number of interviewees continued to express concern that some aspects of the eligibility criteria have the potential to impact on patient participation in the PBS Co-payment measure. Consistent with previous reports, concerns included:

- Confusion between age and health requirements for the PBS Co-payment measure and the PIP Indigenous Health Incentive registration. This continues to cause confusion as the programs have different eligibility criteria but registration is done using the same form. There were continued suggestions to have separate registration forms for PIP Indigenous Health Incentive and the PBS Co-payment.

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

- Practical application of the 'at risk' and needs-based eligibility criteria

- Lack of access to the PBS Co-payment measure for non-Indigenous partners/family members

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

- Uncertainty regarding whether patients are registered for the PBS Co-payment measure, with no easy way to determine registration status.

> *'An issue for the General Practices and their Aboriginal patients is the lack of communication/confirmation of a patient/patient's registration. After patients have registered and documentation has been sent to Medicare, there is no confirmation that the registration has been [processed] and the patient is eligible.'* (Interviewee, DGP*)*

> *'Sometimes transient patients come to the practice, verbally tell that he/she is registered and ask for CtG scripts or repeat scripts ... nowhere to check or confirm this.'* (Interviewee, private General Practice, GP)

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 and Torres Strait Islander peoples, as there was a perception that the criteria are generally being applied in a way that includes all Aboriginal and Torres Strait Islander people.

A number of interviewees continued to express concern that non-Aboriginal people were signing up for the PBS Co-payment to gain access to free or lower cost medication. This concern does not appear to be wide-spread.

> *'Some non-Aboriginal parents have registered for PIP-IHI so that their children can get access to the PBS Co-payment.'* (Interviewee, DGP)

Pharmacists occasionally expressed concern that there *'was possible rorting'* through non-Aboriginal people accessing the PBS Co-payment measure. These judgments were possibly made in relation to questioning the validity of some people's self-identification as Aboriginal. Pharmacists generally held the view that it was not up to them to *'enforce or police the application of the eligibility criteria for the PBS Co-payment'.*

PERCEPTIONS OF ADMINISTRATIVE WORKLOAD

In this reporting period there was a decrease in the percentage of interviewees who agreed with the statement *'The PBS Co-payment has added a large administrative workload'* from 44% (16/36) in the previous reporting to 35% (38/81) in this reporting period. This decrease was evident in the data on responses from practice managers and clinicians only and it was also evident across both sectors (Figure 7.15).

In the previous reporting period, practice managers tended to be more likely to regard the measure as being an administrative burden than clinicians. This may have been due to practice managers generally managing the paperwork processes within the practice and being responsible for establishing systems to support this new measure. In this reporting period, clinicians and practice managers responses were more similar.

Twenty-six per cent (6/23) of practice managers and clinicians in General Practices agreed that the measure had caused a large administrative burden compared to 44% (8/18) in AHS (Figure 7.15). The relatively higher burden of administering the PBS Co-payment in AHS is probably related to the much larger numbers of Aboriginal and Torres Strait Islander patients in these services.

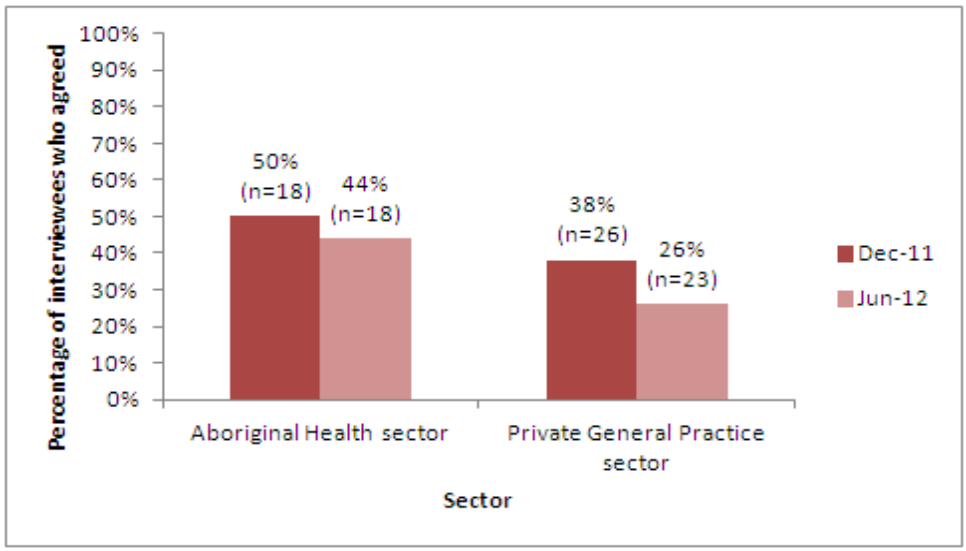


Figure 7.15: Clinicians' and practice managers' responses to the statement 'The PBS Co-payment measure has caused a large administration burden' (% who responded 'strongly agree' or 'partly agree')

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 prescriptions and register patients (as opposed to the ongoing registration process for the PIP Indigenous Health Incentive).

There are a number of aspects of administrative burden identified in the PIP section of this report that are also relevant to the PBS Co-payment measure. As previously reported the 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 patient 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'.
- Patients presenting at primary health care services to get prescriptions annotated after not having their prescriptions annotated by specialists or hospital doctors.
- Some difficulties with patient information system software not annotating prescriptions, or practitioners forgetting to annotate prescriptions, and then having to reissue them.

In contrast to perceptions of administrative workload, over three-quarters [78% (73/93)] of interviewees agreed with the statement *'organising access for Aboriginal and Torres Strait Islander peoples to the PBS Co-payment measure has been easy*'. There was indication of a positive trend in responses to this statement 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. Nevertheless, interviewees in remote sites have indicated that they struggle with administrative aspects of registering patients to the measure.

Clinicians and practice managers across both sectors were increasingly positive about the ease of organising access to the PBS Co-payment measure (Figure 7.16).

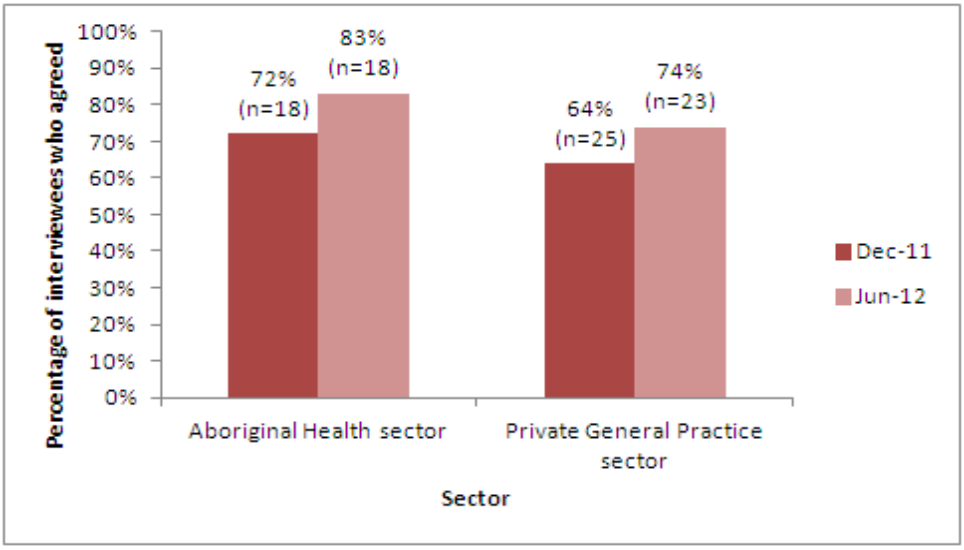


Figure 7.16: Clinicians' and practice managers' responses to the statement 'Organising access to the PBS Co-payment measure has been easy' (% who responded 'strongly agree' or 'partly agree')

SOFTWARE SYSTEMS IN HEALTH SERVICES TO SUPPORT USE OF THE PBS CO-PAYMENT MEASURE

Under the PBS Co-payment measure, GPs and pharmacists have access to new software that enables them to write and dispense prescriptions using an annotated PBS Co-payment prescription. Stakeholders continued to raise a number of concerns 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 in Health Services continue to indicate difficulties with linking records of Aboriginal status in existing information systems with the CtG annotation system.

Pharmacists indicated that often the prescriptions are being presented handwritten with 'CtG' on them and that there are many instances of having to send patients back to the Health Service to get them annotated or the pharmacist is ringing the Health Service. There were a number of comments from a variety of interviewees (often pharmacists) that AHSs are generally using electronically annotated prescriptions and that often (though not always) private General Practices were using hand annotated prescriptions. However, our interviews with private General Practice in the Sentinel Sites indicated that they were using electronically annotated prescriptions and that this presented no particular difficulties. This may be due to participation in the SSE of a select group of private General Practices; practices that have a particular interest in Aboriginal health and therefore more likely to have made the time to install the required systems.

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 patients' access to the program. These barriers were described in the previous reporting periods and continue in this period. They 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 among specialists, there is a lack of awareness among GPs that in writing referral letters to specialists they should indicate that a patient is registered for the PBS Co-payment.

A number of Health Services reported having patients coming back to get non-annotated prescriptions from specialists annotated at the Health Service.

> *'Doctors at [AHS name] educate patients to tell specialists to sign CtG scripts, and if they don't [AHS name] will replace the scripts.'* (Interviewee, AHS, GP)

There appears to be a need for continuing work on raising awareness of specialists of their ability to annotate prescriptions, for patients to indicate they are eligible and also for GPs to indicate patients' eligibility for the PBS Co-payment in their referral letters.

A number of interviewees noted the need for an automatic system whereby people's eligibility is recorded on pharmacy systems and thus allaying the need for GPs or specialists to annotate prescriptions.

HOSPITAL DOCTORS

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 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 prescription.

As a result patients are going back to their Health Service and getting prescriptions rewritten and annotated by the Health Service. At times patients are taking a long time to commence medications because they have to wait until they are able to get back to the Health Service. In some cases hospital doctors are indicating to patients to attend the local AHS for a prescription although the AHS may not necessarily be the patient's usual primary health care provider. One AHS indicated 'this is not really fair on us' as they have to write prescriptions without being the patient's usual provider.

> *'With hospital scripts there is no CtG – doctors here will replace scripts – to get their script replaced with a CtG script patients have to come here and they are sick.'* (Interviewee, AHS, RN)

Interviewees also indicated that Aboriginal and Torres Strait Islander peoples often use hospital outpatients for accessing primary care and that they are missing out because hospitals doctors are not able to annotate prescriptions.

> *'Challenge is patients can't access the PBS Co-payment if they go through the emergency hospital system. There are lot people access the hospital rather than going to the GPs or an AMS. It is a disadvantage if patients can't access the CtG scripts at the hospital.'* (Interviewee, SBO)

ENABLERS AND BARRIERS IN THE PHARMACY

There was an increase since the previous reporting period in the perception amongst interviewees that pharmacies are 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'* 69% (48/70) 'strongly or partly agreed', compared to 55% (44/80) in the previous reporting period. Levels of agreement with the statement were high across urban, regional and remote sites.

Despite this perception that pharmacists have implemented systems there was consistent feedback from interviewees and community focus groups that there were still pharmacists indicating that they are not participating in the PBS Co-payment measure. It was noted that this was more evident in urban settings, especially with increasing distance from an AHS.

Despite increasing participation from pharmacists there continued to be concern expressed by 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.

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, but there were often challenges finding someone to deliver the training and challenges in engaging pharmacists to undertake the training, even though the training is part of their agreement.

As previously reported, 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 focus group participants indicated that more work needs to be done with some pharmacists to ensure the measure is implemented in a way that will provide maximal benefit to the Aboriginal and Torres Strait Islander community.

As reported previously, the potential for suspicion and inappropriate questioning regarding Aboriginal or Torres Strait Islander status present barriers to accessing medications through the PBS Co-payment scheme limiting the potential for the program to benefit Aboriginal and Torres Strait Islander peoples. This continued to be greater than problems related to 'leakage' to people who were not eligible for the scheme. 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.

PBS LISTED MEDICINES, GENERICS AND THE AVAILABILITY OF OTHER MEDICATIONS

Under the PBS Co-payment measure, pharmacists can only dispense medicines listed on the PBS at the reduced rate. As described in the previous report, availability of only a limited number of brands at reduced cost through the PBS Co-payment measure continued to cause confusion amongst patients who have previously used brands that are not available through the measure. Some patients were still 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.

Similarly, pharmacists continued to raise this as an issue and indicated that they consistently need to explain to patients why a different brand of medication has been dispensed.

A small number of Health Service interviewees also continued to express some concern that easier access to drugs under the PBS Co-payment measure, such as benzodiazepines and codeine, may lead to patient misuse. This issue should only be of concern to the extent that cost is a barrier to inappropriate use of addictive drugs.

TYPES OF MEDICATIONS DISPENSED UNDER THE PBS CO-PAYMENT MEASURE

It should be noted that PBS data describe the medicines dispensed to people. This does not necessarily provide accurate information on how medicines are prescribed by doctors or used by people. There was a small number of interviewees who expressed some confusion about restrictions on the types of medications able to be prescribed under the measure. There was uncertainty if medications were for chronic disease management only or for other conditions.

> *'Some GPs need to learn that access is for all medications not just those relating to the chronic disease … if your patient has diabetes it is not just diabetes medication that they have access to.'* (Interviewee, SBO)

The number and type of prescriptions covered by the PBS Co-payment measure in relation to the population and the total number of people accessing the measure is shown in Appendix G, Tables G5-G7.

Prescriptions for all medicines were slightly higher in Sentinel Sites than the rest of Australia. Prescriptions using the PBS Co-payment measure in the September 2011 - November 2011 quarter were double or more than double than those in September 2010 - November 2010 quarter (Figures 7.17 and 7.18). The only exception was anti-bacterial medicines in the rest of Australia where the increase was 88%. Cardiac medicines continue to be the most frequently prescribed category of medications, while the category of medications with the largest proportional increase over the course of the SSE is anti-psychotic medicines (increase in Sentinel Sites =147%; Rest of Australia =135%).

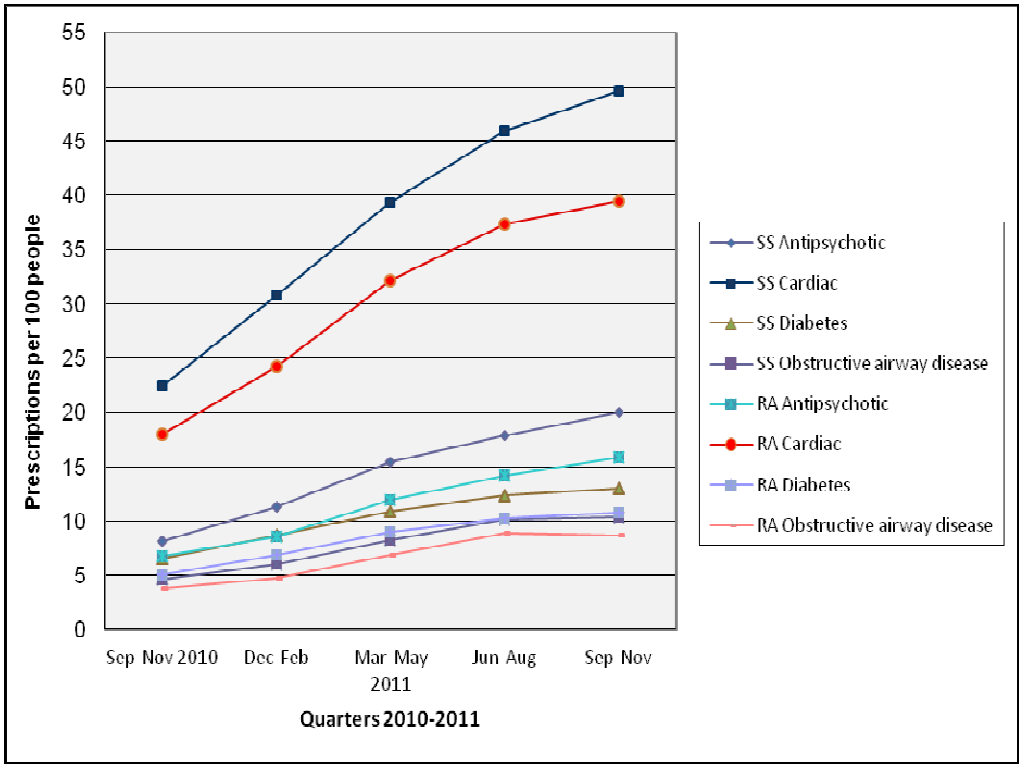


Figure 7.17: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by ATC category (anti-psychotic, cardiac, diabetes and obstructive airway disease) and quarter, September 2010 - November 2011

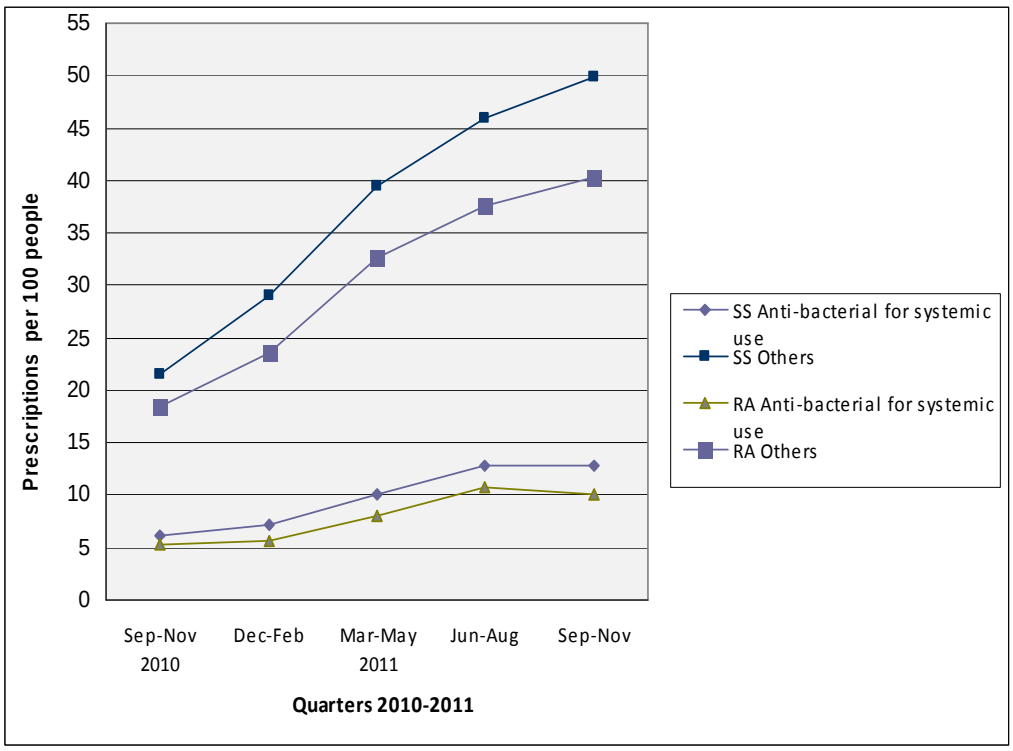


Figure 7.18: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by ATC category (anti-bacterial for systemic use and others) and quarter, September 2010 - November 2011

More prescriptions were provided to people aged >55 years than people aged 15-54 years, however, the pattern of increase over time was very similar for the two age groups (Figures 7.19-7.22). Figures 7.19 and 7.20 show prescriptions for people aged 15-54 years. Prescriptions for people aged 15-54 years in the September 2011 - November 2011 quarter were double or more than double than those in September 2010 - November 2010 quarter (Figures 7.19 and 7.20). The only exception was anti-bacterial medicines in the rest of Australia where the increase was 88%.

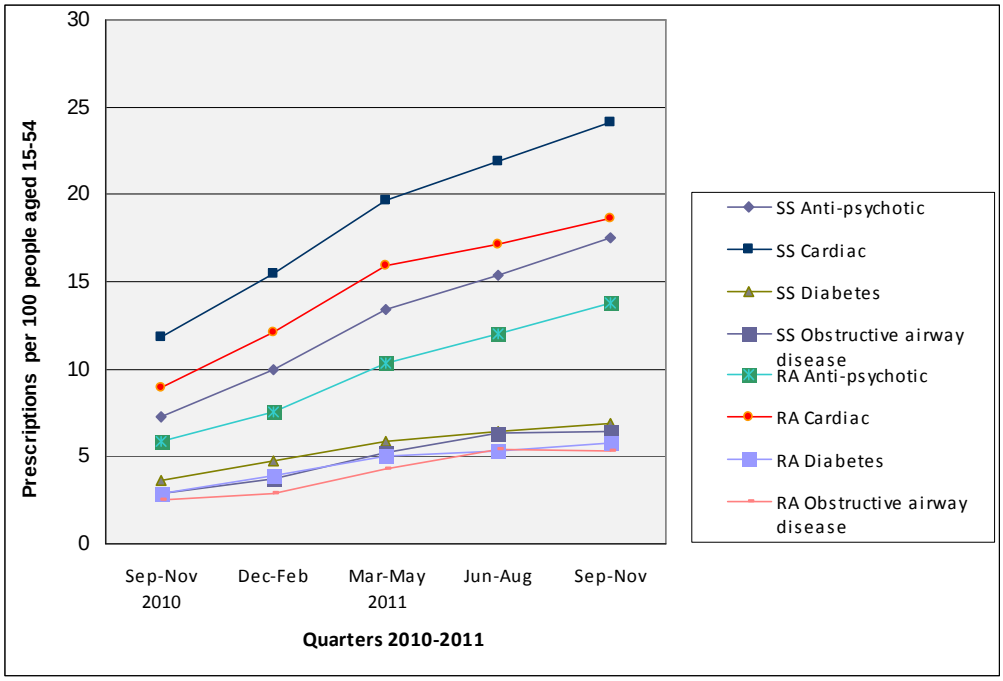


Figure 7.19: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged 15-54 years in Sentinel Sites and the rest of Australia, by ATC category (anti-psychotic, cardiac, diabetes and obstructive airway disease) and quarter, September 2010 - November 2011

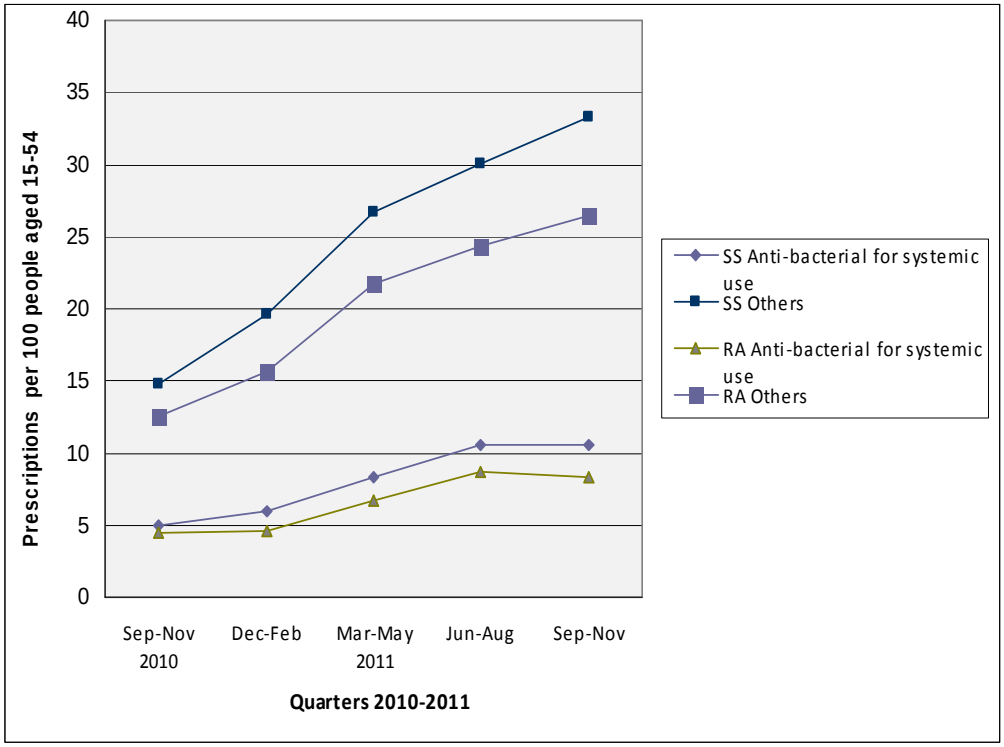


Figure 7.20: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged 15-54 years in Sentinel Sites and the rest of Australia, by ATC category (anti-bacterial for systemic use and others) and quarter, September 2010 - November 2011

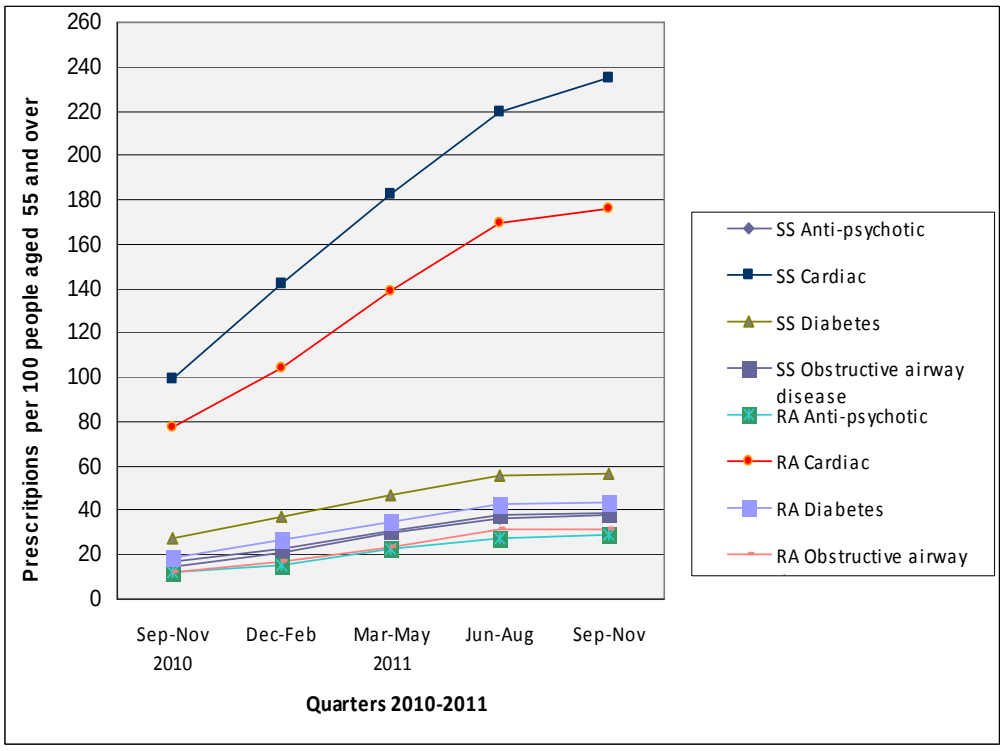


Figure 7.21: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥55 years in Sentinel Sites and the rest of Australia, by ATC category (anti-psychotic, cardiac, diabetes and obstructive airway disease) and quarter, September 2010 - November 2011

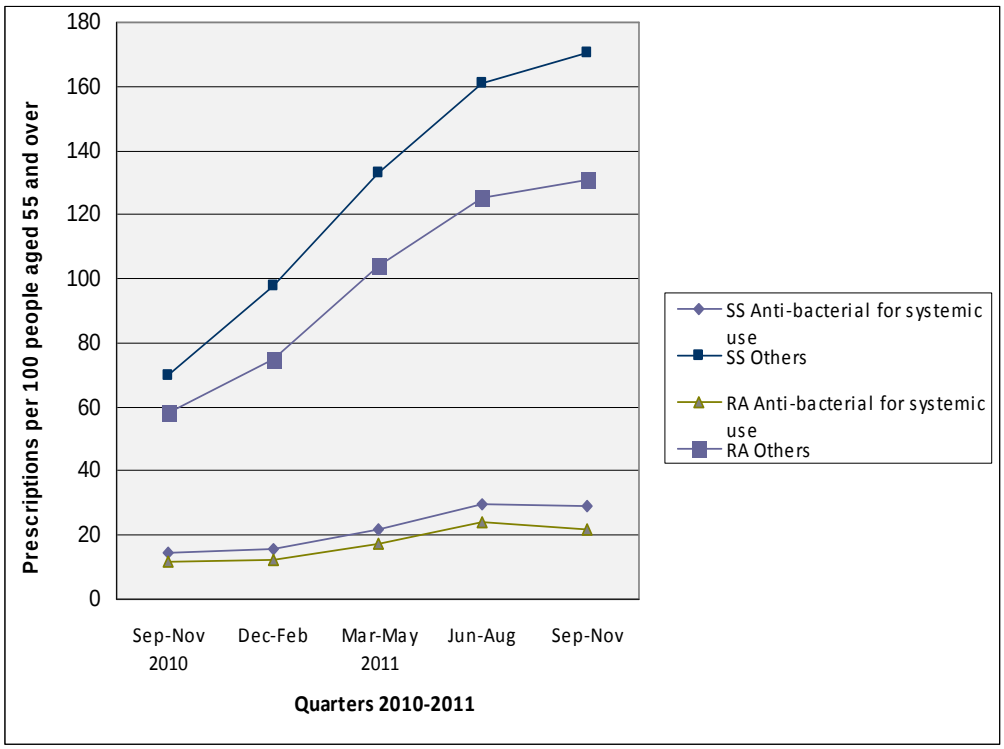


Figure 7.22: PBS Co-payment prescriptions per 100 Aboriginal and Torres Strait Islander people aged ≥55 years in Sentinel Sites and the rest of Australia, by ATC category (anti-bacterial for systemic use and others) and quarter, September 2010 - November 2011

TYPES OF MEDICATIONS DISPENSED UNDER THE PBS CO-PAYMENT MEASURE BY GEOGRAPHIC LOCATION

The number of prescriptions per 100 Aboriginal and Torres Strait Islander people was greater in regional areas than urban areas. The pattern of the increase in different categories of medicine was very similar to the overall trends in urban and regional Sentinel Sites (Appendix G Table G6 and Figure 7.23). The rate of increase was much higher in remote Sentinel Sites (Anti-Psychotics 271%, Diabetes 343% and Obstructive airway disease 375%) than other remote areas although this translated to relatively few prescriptions due to low take-up in these sites (Appendix G Table G6 and Figure 7.23).

Figure 7.23 and Appendix G Table G7 show the proportion of prescribed medications dispensed under the PBS Co-payment measure. In almost all areas over 60% of prescriptions were for the management of four chronic diseases: mental health, diabetes, cardiac conditions and obstructive airway diseases. The most commonly dispensed medications were relevant to the management of cardiac conditions followed by medications relevant to the management of diabetes. A significant number of prescriptions were provided for the management of bacterial infections. The distribution of medicines was consistent for Sentinel Sites and the rest of Australia and across urban and regional areas. In remote areas there were fewer prescriptions for anti-psychotic medicines and more prescriptions for cardiac conditions and diabetes. In remote Sentinel Sites there were also fewer prescriptions for obstructive airway disease.

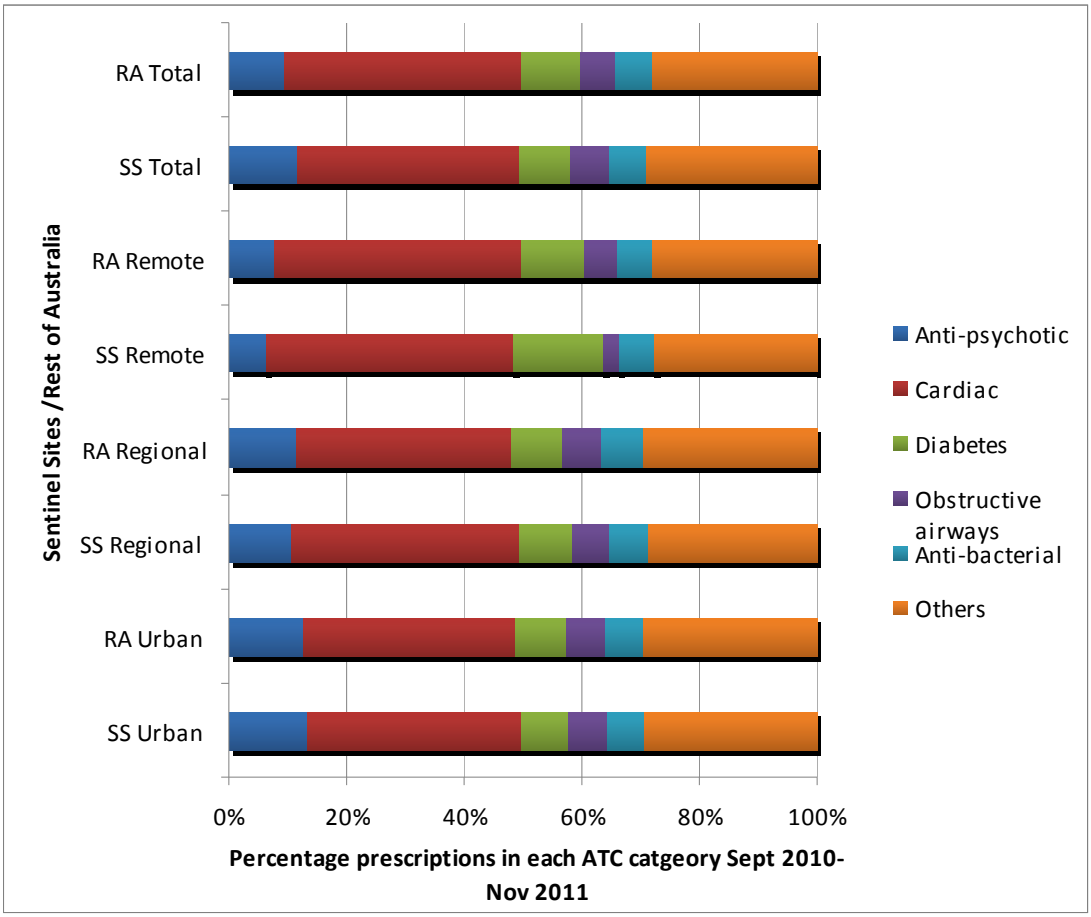


Figure 7.23: Percentage PBS Co-payment prescriptions dispensed for Aboriginal and Torres Strait Islander people aged ≥15 years by ATC category for Sentinel Sites and the rest of Australia, September 2010 - November 2011

7.5. Summary

1. There is an increasingly high level of awareness of this measure among stakeholders in the case study sites and positive perceptions of the information available to support 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, pharmacists, hospital staff and stakeholders in remote sites) continue to be identified as areas where further work is required.

2. 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. In order for Health Services to participate in the PBS Co-payment measure the Health Service must be PIP Indigenous Health Incentive registered. There is increasing evidence of some GPs with relatively small numbers of Aboriginal and Torres Strait Islander patients being reluctant to participate in the PIP Indigenous Health Incentive because they do not see it as time and cost effective to implement the required systems, hence limiting access for patients to the PBS Co-payment measure. Feedback from community focus groups identifies this as a concern for patients accessing private

General Practice services that are not participating in this measure, but who do not wish to move to another Health Service.

3. There has been a steady increase in the number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment. Rates of access have been generally higher in regional than in urban locations, and relatively low in remote locations (due to the S100 arrangements). As expected, rates of access are also relatively high amongst people over the age of 55 years.

4. Rates of access to the PBS Co-payment are also generally higher in the Sentinel Sites than in the rest of Australia. This pattern is evident in the urban and regional sites, probably at least in part because of relatively greater access to AHSs in the Sentinel Sites than in the rest of Australia. In contrast, the rates of access in remote areas are considerably lower in the Sentinel Sites than in the rest of remote Australia, probably due to use of S100 by AHSs in the remote Sentinel Sites, with relatively fewer AHSs in the rest of remote Australia and therefore greater reliance on providers who prescribe using PBS Co-payment rather than S100.

5. There has been a steady increase in use of all major categories of medications through the PBS Co-payment measure. Cardiac medications continue to be the most commonly prescribed medications under the PBS Co-payment measure. The largest proportional increase in use of the PBS Co-payment since the first quarter for which data were available was for anti-psychotic medications.

6. There is not a clear and consistent understanding of which medications are available through the PBS Co-payment measure. There is a patchy understanding amongst community members regarding their entitlements under the PBS Co-payment measure. It is also evident that there is some variation among clinicians in their perceptions of which categories of medications can or should be prescribed under the PBS Co-payment.

7. The role of the IHPOs and OWs in promoting the use of the measure continues to be positively regarded, as does the role of the Medicare liaison officers. The influence of the OW (and possibly also the IHPO) in increasing community awareness of the measure is also reflected in the emerging evidence that community networks are becoming important in disseminating information on the PBS Co-payment, with increasing reports of patients informing doctors about the program. This may be reflective of the advocacy role of OWs & IHPOs. Interviewees also cited the SSE team as a source of information on the PBS Co-payment.

8. Continuing the trend reflected in the previous report, there is an increasingly widely held perception amongst stakeholders that the PBS Co-payment has made medications more accessible, and that the improved access through removal (or reduction) in cost is translating into improved adherence to prescribed medications and is also encouraging more regular attendance for health care in general. There are increasingly strong suggestions from stakeholders that it is timely to increase emphasis on Home Medication Reviews as a way to enhance safe use of medication and adherence to prescribed medication schedules.

9. Concerns continue to be expressed regarding the in-eligibility of non-Indigenous members of Aboriginal and Torres Strait Islander families, for the same reasons as identified in the previous report.

10. There are ongoing concerns regarding the application of the ‘at-risk’ aspect of the eligibility criteria and the registration for the PBS Co-payment being on the same form as the PIP Indigenous Health Incentive registration. However, there is a continuing increasing trend in the perception that the eligibility criteria are workable in practice and

a decreasing trend in the perceptions that the PBS involves a high administrative workload.

11. Issues around identification of Aboriginal and Torres Strait Islander people continue to present barriers to utilisation of the PBS Co-payment measure, and systems to improve identification processes continue to be the focus of strategies to increase utilisation of the PBS Co-payment measure.

12. There is an ongoing need to improve consistency in annotating PBS Co-payment prescriptions by GPs, and for systems to ensure prescriptions issued by the specialists to whom GPs refer are appropriately annotated. This may require increasing specialists' understanding of patients' eligibility for the PBS Co-payment, systems to encourage GPs to inform specialists that patients are eligible for the PBS Co-payment and systems to encourage specialists to annotate prescriptions appropriately.

13. The need to improve the effectiveness of software systems to support the implementation of the PBS Co-payment measure in primary health care services has emerged as both a barrier to access and as an area for further work.

14. As reflected in the previous report, patients continue to report difficulty with identifying PIP Indigenous Health Incentive registered practices, particularly when they are visiting locations away from their regular care provider. This is a barrier to patients accessing prescriptions under the PBS Co-payment measure.

15. Health Service staff continue to report difficulties with determining if non-regular patients are registered for PBS Co-payment. There is an ongoing need for a system to allow staff to ascertain if patients are already registered for the PBS Co-payment. Some strategies to address this have been suggested e.g. patient held record cards.

16. A related issue is the need for further development of clear and workable processes for people from remote locations (where they are covered by S100) to also have access to prescriptions through the PBS Co-payment when they attend services in locations that are not covered by S100 (including when travelling to other centres to access hospital treatments and for other medical treatments and services or visiting family). The high mobility of people between remote locations and regional towns (often related to accessing Health Services) makes this an important issue for many residents of remote communities.

17. There is evidence that the Pharmacy Guild has become a more important source of information on the PBS Co-payment for pharmacists. There continues to be evidence of a need to enhance cultural awareness among some pharmacists, and to raise awareness of the importance of participating in the PBS Co-payment and issues of cultural safety and cultural awareness among pharmacy staff more generally. The Pharmacy Guild could potentially play a more important role in this area.

8. HIGHER UTILISATION COSTS FOR MBS AND PBS (*MEASURE B2*)

8.1. 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 private 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.[91] Specifically, it would be anticipated that increased staffing capacity available through various ICDP measures, would lead to increased utilisation of adult health assessments, due to potential roles in facilitating demand for assessments, and facilitating return visits for follow up.

8.2. Data sources and analysis

Data reported derive from routinely available data sourced from Medicare claims for specified items, supplemented with explanatory data obtained from in-depth interviews and/or focus group discussions with key informants at case study sites, enhanced tracking sites, tracking sites and state-wide organisations. Discussions with key informants at site-level specifically sought to elicit informants' views on reasons for the trends that were observed in uptake of the adult health assessment and the relevant follow-up items as outlined below.

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. The analysis excludes 0-14 years from the MBS 715 claims. The analysis includes exploration of the uptake and trends of adult health assessments per 100 Aboriginal and Torres Strait Islander people, overall, disaggregated by rurality, and disaggregated at site level. We also similarly report the number of GPs who are billing for adult health assessments and the average number of adult health assessments per GP. This is because comparing sites in relation to these patterns provide some insight into underlying factors driving trends in various contexts.

[91] DoHA, Higher Utilisation Costs for MBS and PBS - Fact Sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/meeting-the-costs/$file/Copy%20of%20DHA6136%20B2%20Factsheet.pdf> (accessed 5 April 2012).

We also report on the uptake of the relevant MBS follow-up items for adult health assessments: follow-up services by a practice nurse or registered AHW (MBS item number 10987) and follow-up by allied health professionals (MBS item numbers 81300-81360). These are presented as absolute numbers and also as a proportion of adult health assessments. As will be evident below, uptake of these items was overall fairly low, restricting ability to present disaggregated data on these items. Therefore the focus of report on the MBS follow-up items was on information derived from qualitative interviews at site level, exploring why uptake was low.

- 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 include services delivered to patients visiting from outside the site boundaries.
- 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.
- 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 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.
- MBS data extraction is based on the date of service. However, MBS data are only captured when a claim has been processed by Medicare, 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 thirty-three month period between March 2009 and November 2011 inclusive. This includes a twelve month 'baseline' period (March 2009 to February 2010 inclusive) which preceded the implementation of the ICDP and a twenty-one month period (March 2010 to November 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.

8.3. Adult health assessments - overall trends

OVERALL TRENDS 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 - November 2011 following the introduction of the ICDP (Figure 8.1, Table 8.1, Appendix H, Table H1). The only

exception was in the December 2010 - February 2011 quarter where there was a decrease in the number of adult health assessments items claimed. This probably reflects seasonal variation over the summer holiday period, as the trajectory of increasing adult health assessments continued in subsequent quarters.

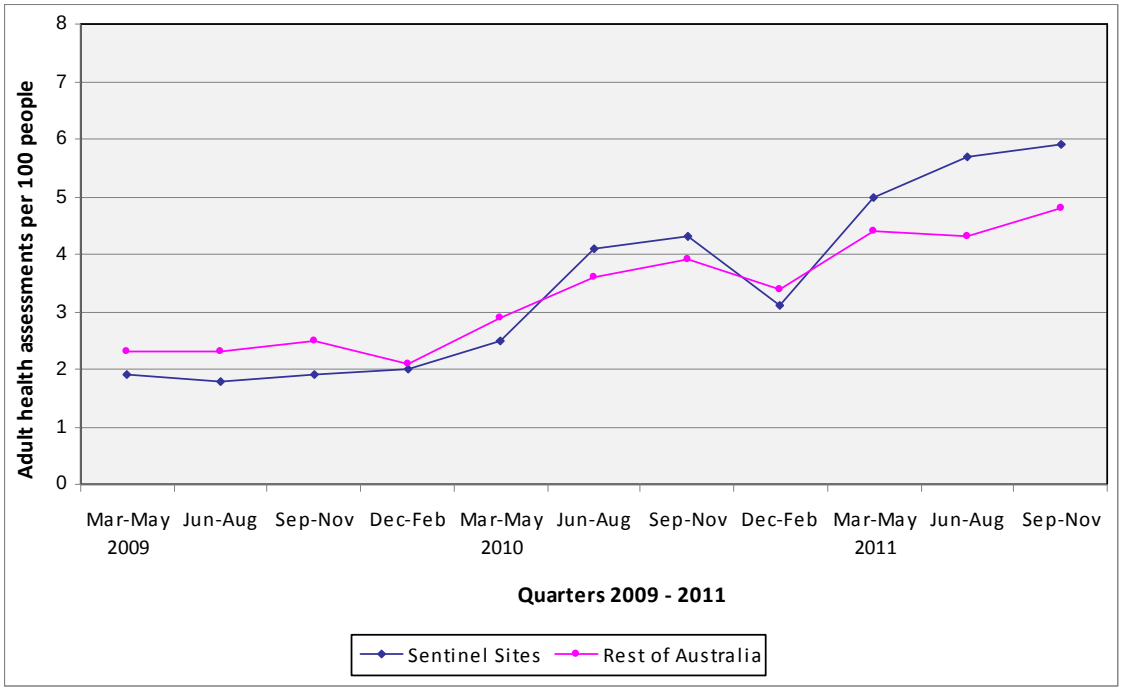


Figure 8.1: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by quarter, March 2009 - November 2011

Table 8.1: Number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, March 2009 - November 2011

Sentinel Site/ rest of Australia	Adult health assessments claimed										
	2009				2010				2011		
	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov
Sentinel Sites	1144	1069	1113	1165	1496	2433	2566	1880	3068	3480	3581
Rest of Australia	5512	5480	5938	5115	7187	8918	9729	8378	11 058	10 859	12 023

Claims for adult health assessments in both the Sentinel Sites and the rest of Australia have increased since baseline (March 2010 - May 2010). This time period coincides with a number of other initiatives:

- Changes 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.
- Introduction of the PIP Indigenous Health Incentive and PBS Co-payment measures as part of the ICDP.

- Employment of ICDP related workers such as IHPOs and OWs.

Some clinicians are not fully supportive of the Health Assessment Medicare item because of lack of evidence that health assessments in themselves contribute to improved health. A number of interviewees continue to raise concern that there is minimal evidence to indicate that adult health assessments contribute to improved health outcomes. For health assessments to contribute to quality of care and health outcomes it is necessary to ensure follow-up of issues identified in the health assessment. Some clinicians also argue that they are already conducting health assessments as a routine part of their care (often over the course of consecutive consultations). Unless they make special effort to complete the requirements to claim the health assessment item number, this work is not reflected in the health assessment data and the service does not receive the relevant Medicare payment.

> *'Is the number of health assessments inferring an outcome? Health is more than an item number. Do all the patients really need a health assessment?'* (Interviewee, AHS)

> *'The outcome should be that something changes not that a health check happens.'* (Interviewee, AHS)

Whilst some of the increase in uptake of adult health assessments may be due to billing of health assessments for the same patients on an annual basis instead of a biannual basis, a number of factors suggest that a substantial part of the overall increase in uptake is due to adult health assessments being done for patients who have not previously received these assessments. First, the uptake of adult health assessments in the final quarter of the period covered by this report is nearly three times the average number per quarter at baseline. Second, as referred to below, there was an increase in adult health assessments for people aged ≥55 years and people aged 15-54 years. Adult 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 adult health assessments was more rapid among people aged ≥55 years than people aged 15-54 years (Appendix H, Table H2).

The PIP Indigenous Health Incentive and PBS Co-payment measure may also have contributed to the increased overall uptake of adult health assessments. Health Services have reported that on signing a patient up for the PIP Indigenous Health Incentive and PBS Co-payment they are also offering an adult health assessment as 'part of the package'. Interviewees and community focus groups continue to raise concern that the access to free and/or subsidised medications through the PBS Co-payment measure acted as the 'carrot' for patients to sign up for the PIP Indigenous Health Incentive. Once this access has been granted (PBS is a once off sign up) there may be minimal incentive for patients to re-register as part of the PIP Indigenous Health Incentive. There is likely to be a subsequent drop-off in adult health assessments, as these are not getting done as part of the sign up process. The plateau of adult health assessment rates for older people, who are more likely to derive benefit from accessing PBS Co-payment than younger people (due to higher rates of chronic disease), lends some support to this concern. There was a relatively higher proportion of people aged ≥55 years registering for the PBS Co-payment and PIP Indigenous Health Incentive compared to the 15-54 age group (see Section 7 and 9) respectively.

OWs based in both the DGP and AHS and IHPOs are reported to play a significant role in working with both the community and Health Services to increase the number of adult health assessments. The community approach has been by encouraging community members to be proactive in asking for an adult health assessment at their Health Service and also raising

awareness about the value of having an adult health assessment. The Health Service approach has been about raising awareness of the Medicare item numbers and how the OW can support the Health Service to bring people into the Health Service to access the range of services including the adult health assessment.

Sites identified a number of other programs and policies as contributing to increases in adult health assessments. These include the Healthy for Life Program[92], State initiatives to increase health assessments such as 'Hero Awards' and 'Deadly Choices' in Queensland[93,94] and the Expanded Health Service Delivery Initiative[95] in the Northern Territory sites. Eighteen of the twenty-four Sentinel Sites are identified Healthy for Life sites. A major focus of the Healthy for Life program is increasing health assessments.

Overall, trends in number of adult health assessments claimed per 100 people were very similar in Sentinel Sites and the rest of Australia up until March 2010 - May 2010 quarter, following which rates increased in Sentinel Sites to a greater degree than the rest of Australia. 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 5.9 per 100 people in the September 2011 - November 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 4.8 per 100 people in the September 2011 - November 2011 quarter. Reasons for this divergent pattern were not able to be ascertained, but may relate to a) increased awareness raising of the various ICDP supporting measures, as an unintended consequence of the SSE, leading to increased uptake of these items in sites b) different drivers of uptake in sites with an AHS (a feature of all sites, as this was one of the site selection criteria).

TRENDS IN NUMBER OF GENERAL PRACTITIONERS CLAIMING ADULT HEALTH ASSESSMENTS

We also examined the trends in the number of General Practitioners who claimed adult health assessments. 'General Practitioner' refers to GPs working in both AHSs and in private General Practice.

Overall, in both the Sentinel Sites and the rest of Australia, there is clear evidence that the number of GPs who are claiming for adult health assessments has steadily increased over the period of ICDP implementation. The timing of the commencement of the increasing trend in GPs claiming adult health assessments coincides with the introduction of the ICDP (March 2010 - May 2010). The sustained increase in the number of GPs over the period of ICDP implementation suggests that the capacity of the program to improve the uptake of MBS items is still growing (Figure 8.2).

The trends in the number of GPs claiming for adult health assessment items were very similar in the Sentinel Sites and the rest of Australia (Figure 8.2). In the Sentinel Sites, the number of GPs claiming for adult health assessment items in the baseline period (March 2009 - February 2010) was around 0.3 per 100 Aboriginal and Torres Strait Islander people aged ≥15 years then increased to about 0.7 per 100 people by March 2011 - May 2011 and has stayed at that level

[92] DoHA, Healthy for Life [website], <http://www.health.gov.au/internet/h4l/publishing.nsf/Content/home-1> (accessed 17 April 2012).
[93] QAIHC, Hero Awards [website], <http://www.herorewards.com.au/> (accessed 17 April 2012).
[94] IUIH, Deadly Choices [website], <http://www.deadlychoices.com.au/about/> (accessed 24 May 2012).
[95] NT Government, EHSDI [website], <http://www.health.nt.gov.au/Expanding_Health_Service_Delivery_Initiative/index.aspx> (accessed 17 April 2012).

(Figure 8.2, Appendix H Table H3). For the rest of Australia, the number of GPs who claimed for adult health assessment items was around 0.4 per 100 people for the baseline period (March 2009 - February 2010) and increased to 0.7 per 100 people in the March 2011 - May 2011 quarter and then to 0.8 per 100 people by the September 2011 - November 2011 quarter (Figure 8.2).

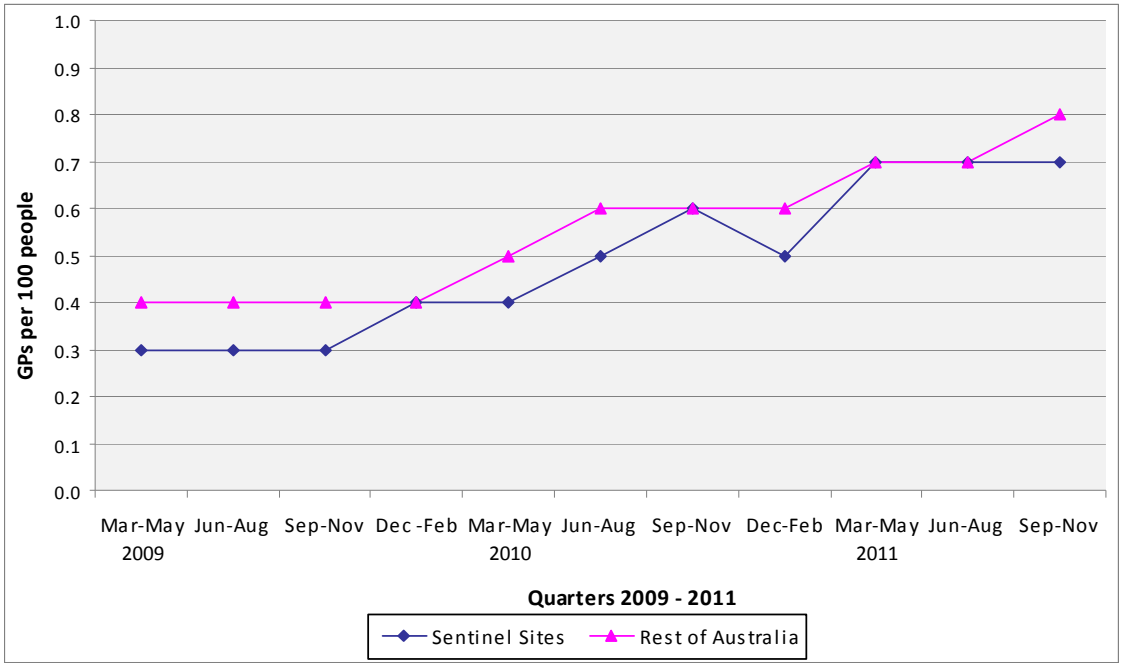


Figure 8.2: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, by quarter, March 2009 - November 2011

TRENDS IN ADULT HEALTH ASSESSMENTS PER GENERAL PRACTITIONER

The coverage of adult health assessments in the population may be influenced by the numbers of GPs involved and the number of ICDP relevant MBS items (such as adult health assessments) each GP completes.

For the Sentinel Sites, Figure 8.3 (and Appendix H Table H7) shows that the average number of adult health assessments per GP fluctuated between about 5 and 6 adult health assessments per quarter for the baseline period (March 2009 - February 2010). There was a small increase in the period of ICDP implementation (from March 2010 - May 2010 quarter onwards). This increase was more evident in Sentinel Sites with the average number of adult health assessments reaching 7.9 per GP. The average number of health assessments per GP for the rest of Australia was relatively stable in the period observed in this report.

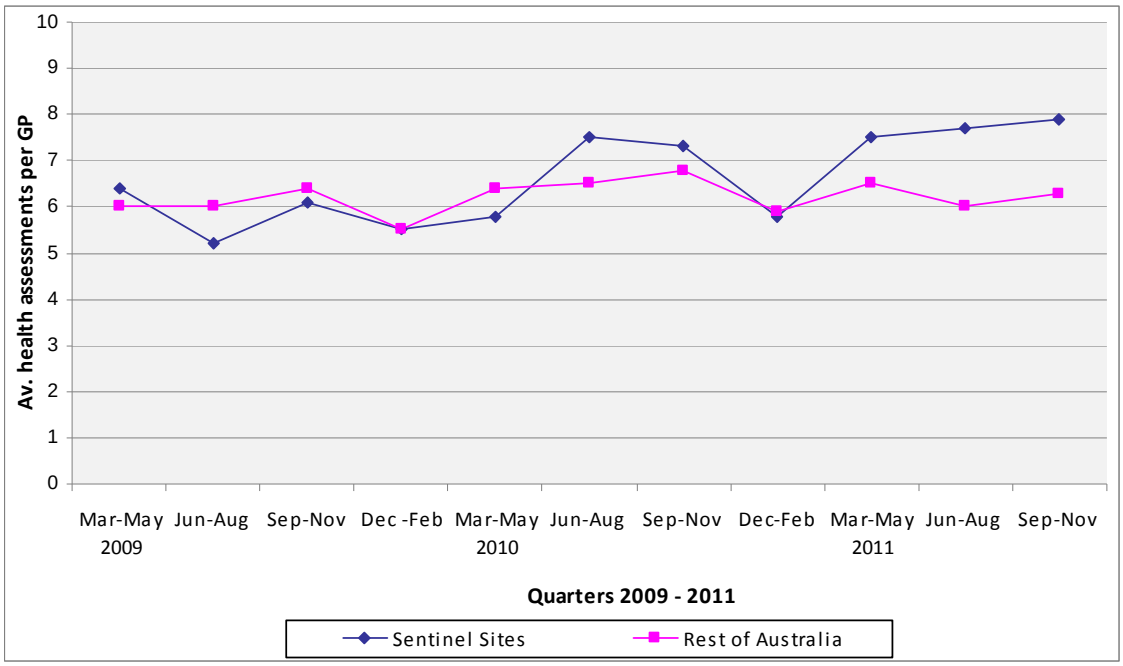


Figure 8.3: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in Sentinel Sites and the rest of Australia, by quarter, March 2009 - November 2011

TRENDS BY AGE AND GENDER

The number of adult health assessments per 100 Aboriginal and Torres Strait Islander people aged 55 years and over was higher than for people aged 15-54 years throughout the period covered by this report. As reported previously the older population are often considered to be 'the low hanging fruit' as they generally attend Health Services more regularly.

There has been a leveling off of uptake during the past three quarters for both age groups in the rest of Australia. However, within the Sentinel Sites, different patterns of increase in uptake were observed for younger and older people over the period covered by the report with uptake slowing for older people but not for younger people. There was a similar relative increase in the number of adult health assessments per 100 people for those aged ≥55 years and aged from 15-54 years following the baseline period up until the March 2011 - May 2011 quarter (Figure 8.4). However, following this initial steady increase for older and younger adults, there has been a continuing increase for people aged 15-54 years, while the ≥55 year age group has remained steady at around 9.5 adult health assessments per 100 people. Reasons for this different pattern of increase cannot be conclusively ascertained, but may have been related to increased PIP registrations amongst older people in Sentinel Sites reaching saturation. This possible factor influencing uptake is discussed further below.

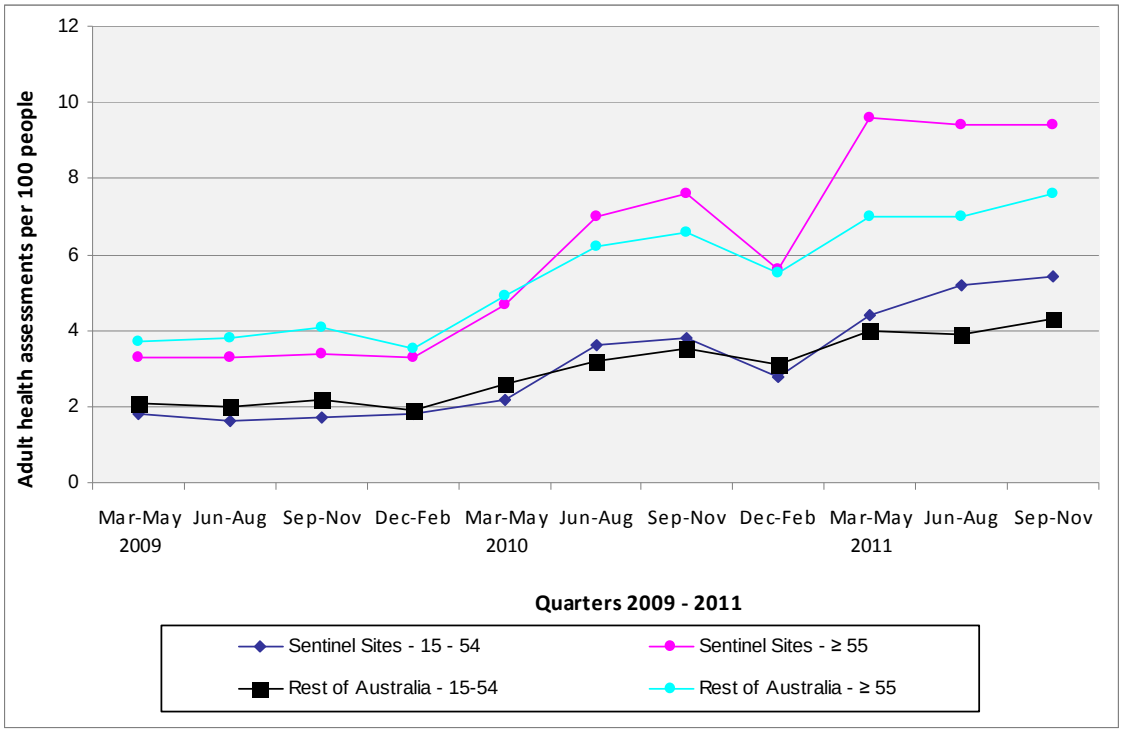


Figure 8.4: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - November 2011

The increase in adult health assessments per 100 people appears to have been slightly lower for men than for women (Figure 8.5), 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.

There were a number of Sentinel Sites that have achieved higher uptake by males of adult health assessments. Where this occurred, it was reported to be due to a concerted effort to focus on men through the establishment of dedicated men's clinics either as a one-off activity or as part of regular service delivery.

> *'High rates of men's health checks because of dedicated men's health clinic with dedicated staffing at the AHS.'* (Feedback from enhanced tracking site)

> *'They [EHSDI team] had two teams come one male and one female team and were done in conjunction with NT Govt who provided staff. There were two doctors, four nurses and drivers. It was focused on a list of people who were 'falling through the cracks.' Not sure why we had such high rates of males having health checks and follow-up as there was not a specific focus on males though they did go and pick up males from men's centre and take them. The teams had vans parked in football oval which was viewed as less confronting for people and probably males.'* (Feedback from enhanced tracking site)

Higher uptake by males may also be associated with the Health Service workforce arrangements. As previously reported, a number of sites have actively encouraged males to apply for OW positions or splitting of one full-time position to two part-time positions with one male and one female to facilitate engagement with Aboriginal and Torres Strait Islander males.

These and other factors that may explain different patterns in the different Sentinel Sites are described in Section 8.4 below in relation to specific sites.

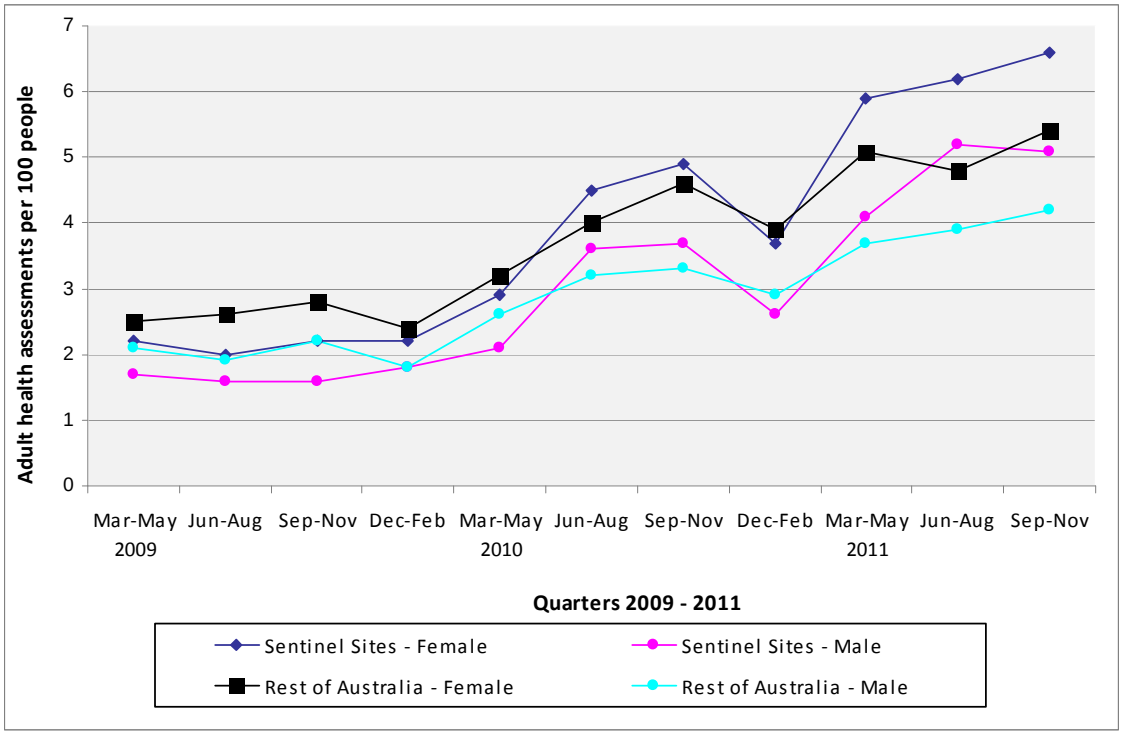


Figure 8.5: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by sex and quarter, March 2009 - November 2011

TRENDS BY GEOGRAPHIC LOCATION

Number of adult health assessments claimed per 100 people during the baseline period (March 2009 - February 2010) varied by rurality. Higher rates were found in regional and remote areas compared to urban areas (Figures 8.6, 8.9, 8.12). All areas showed increases in adult health assessment rates from the quarters of March 2010 - May 2010 to September 2010 - November 2010. Following this, adult health assessments in the rest of urban Australia and in remote Australia have been fairly steady, whilst those in urban and regional Sentinel Sites continued to increase.

Trends in the number of GPs claiming for health assessments varied with rurality (Figures 8.7, 8.10, 8.13, Appendix H Tables H4-H6). While there were increases in the number of GPs claiming per 100 people in urban and regional areas there was little change in remote areas. The increase in urban Sentinel Sites was slightly greater than the rest of urban Australia (Figure 8.7).The increase in regional Sentinel Sites was slightly less than the rest of regional Australia (Figure 8.10).

Trends in the average number of adult health assessments conducted per GP also varied by rurality (Figures 8.8, 8.11, 8.14, Appendix H, Tables H8-H10). The average number of adult health assessments in the period of ICDP implementation (from March 2010 - May 2010 quarter onwards) was greatest in remote areas followed by regional and urban areas. Higher rates of adult health assessments per GP in remote areas is probably at least partly a result of smaller numbers of GPs per 100 Aboriginal and Torres Strait Islander people, with these GPs being more heavily involved in providing care to Aboriginal and Torres Strait Islander people.

Patterns by geographic location are described in more detail below.

Urban areas

Urban areas in general show low rates of adult health assessments claimed per 100 Aboriginal and Torres Strait Islander people at less than 3 per 100 per quarter. To the extent that older people are more likely to receive health assessments consistent with their greater utilisation of Health Services and their greater likelihood to be registered with PIP in particular, some of the rurality difference may be due to different age structure of the population in urban compared to rural areas. It may also reflect the different types of service provision in urban areas.

Urban areas in the rest of Australia showed a steady increase through the June 2010 - August 2010 quarter. The increase plateaued in the September 2010 - November 2010 quarter and declined in the December 2010 - February 2011 quarter. Since the March 2011 - May 2011 quarter there has been a substantially greater increase in the urban Sentinel Sites compared to the rest of urban Australia (Figure 8.6). As is evident in the section below examining variation in uptake of adult health assessments, the increase in adult health assessment rates in urban Sentinel Sites is largely driven by changes in two particular sites.

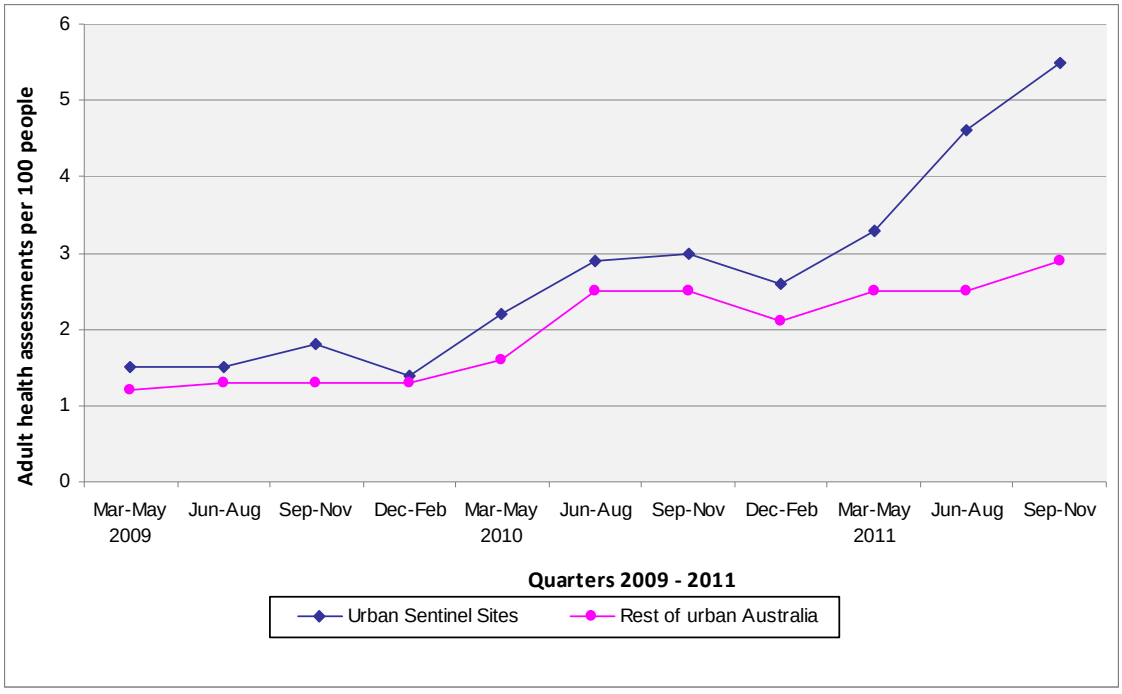


Figure 8.6: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - November 2011

There was evidence of increasing numbers of GPs claiming for adult health assessments in urban areas during the period of implementation (Figure 8.7).

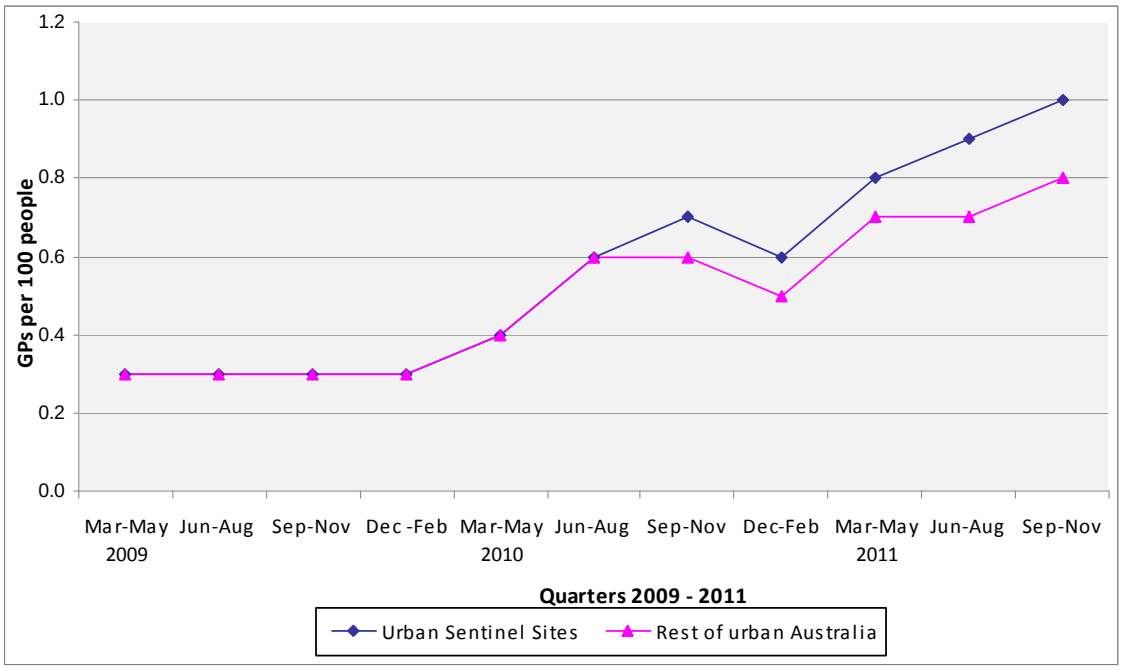


Figure 8.7: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - November 2011

There was no clear trend in the average number of adult health assessments conducted per GPs in urban Sentinel Sites or in the rest of urban Australia following the introduction of the ICDP (March 2010 - May 2010) (Figure 8.8). The average numbers of adult health assessments per GP was slightly higher in urban Sentinel Sites than in the rest of urban Australia over the period covered by this report.

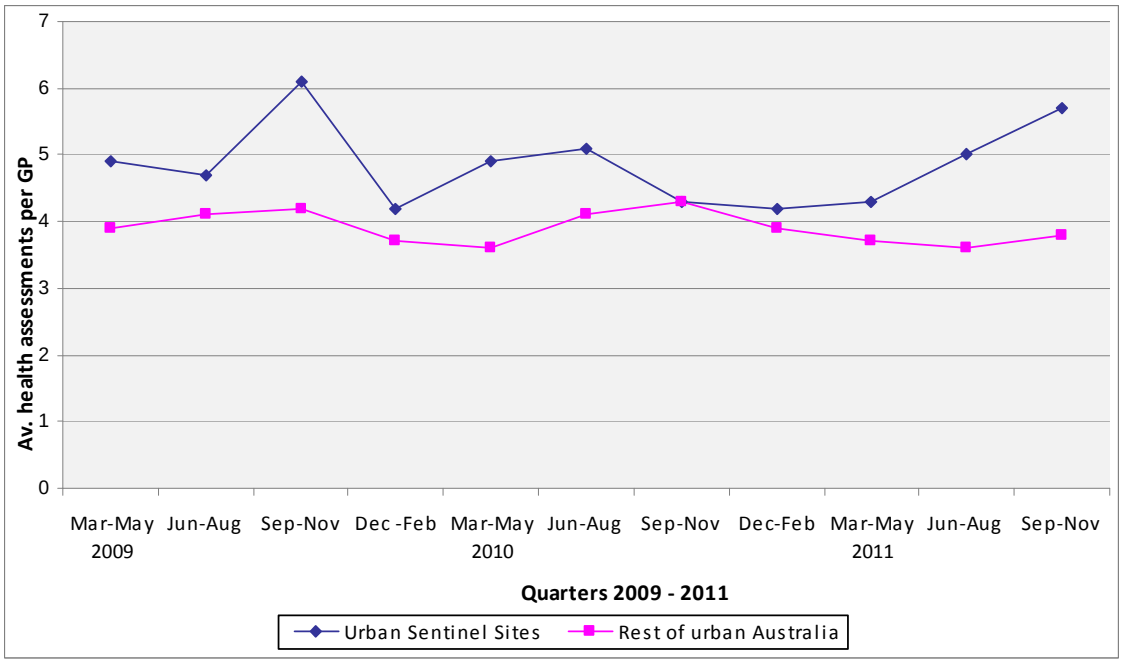


Figure 8.8: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715 claimed per General Practitioner in urban Sentinel Sites and the rest of urban Australia, by quarter, March 2009 - November 2011

Regional Areas

Regional areas in the rest of Australia have continued to show increases in number of adult health assessments claimed per 100 people. There was a decline in the December 2010 - February 2011 quarter (Figure 8.9) followed by an increase. The analysis of specific Sentinel Sites below show several sites contributing to the steady increase in the regional Sentinel Sites.

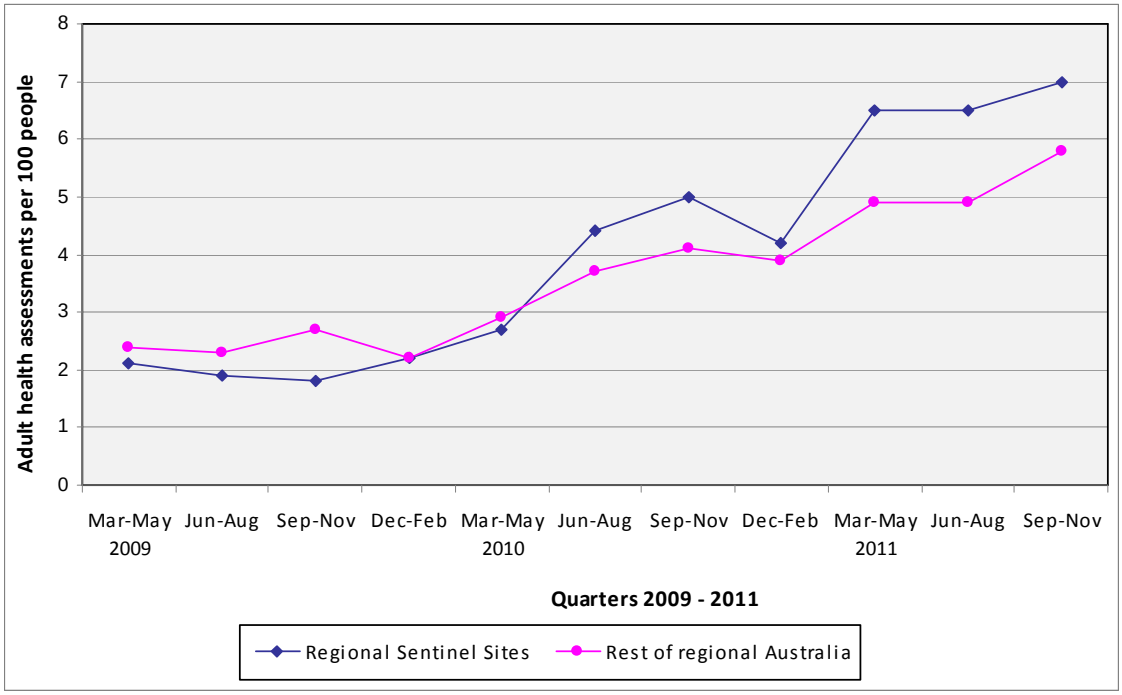


Figure 8.9: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - November 2011

The number of GPs claiming for adult health assessments showed an increase in the regional Sentinel Sites and in the rest of Australia during the period of implementation (Figure 8.10).

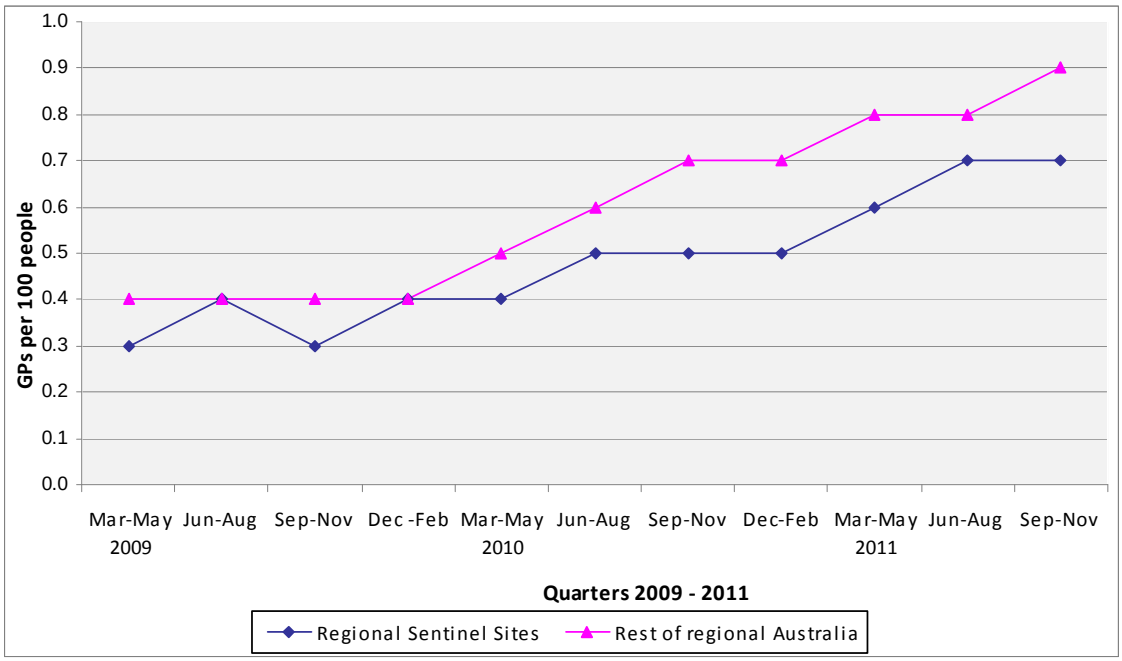


Figure 8.10: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - November 2011

In regional Sentinel Sites the number of adult health assessments per GP 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 observed in this report (September 2011 - November 2011). The rest of regional Australia showed little or no change in the average number of health assessments per GP over the period observed in this report (Figure 8.11).

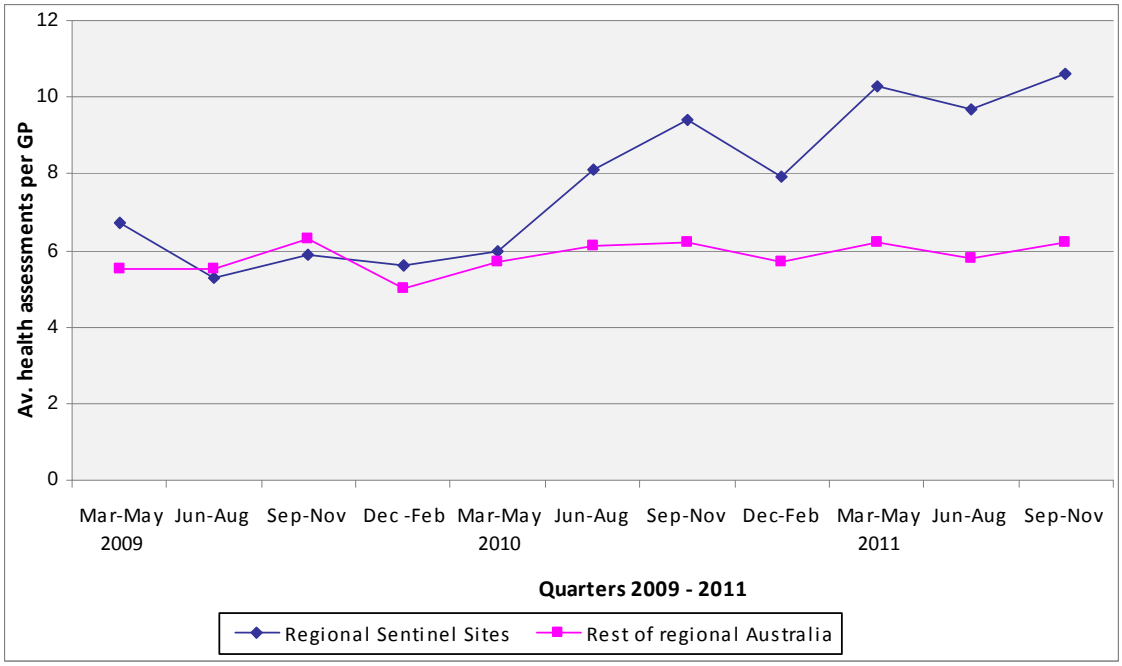


Figure 8.11: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in regional Sentinel Sites and the rest of regional Australia, by quarter, March 2009 - November 2011

Remote areas

Adult health assessment rates in remote Sentinel Sites show considerable variability. For both the rest of remote Australia, and the remote Sentinel Sites, a dip in the December 2010 - February 2011 quarter is likely to be related to the holiday period. Following an initial increase, there has been little change over the three most recent quarters (Figure 8.12).

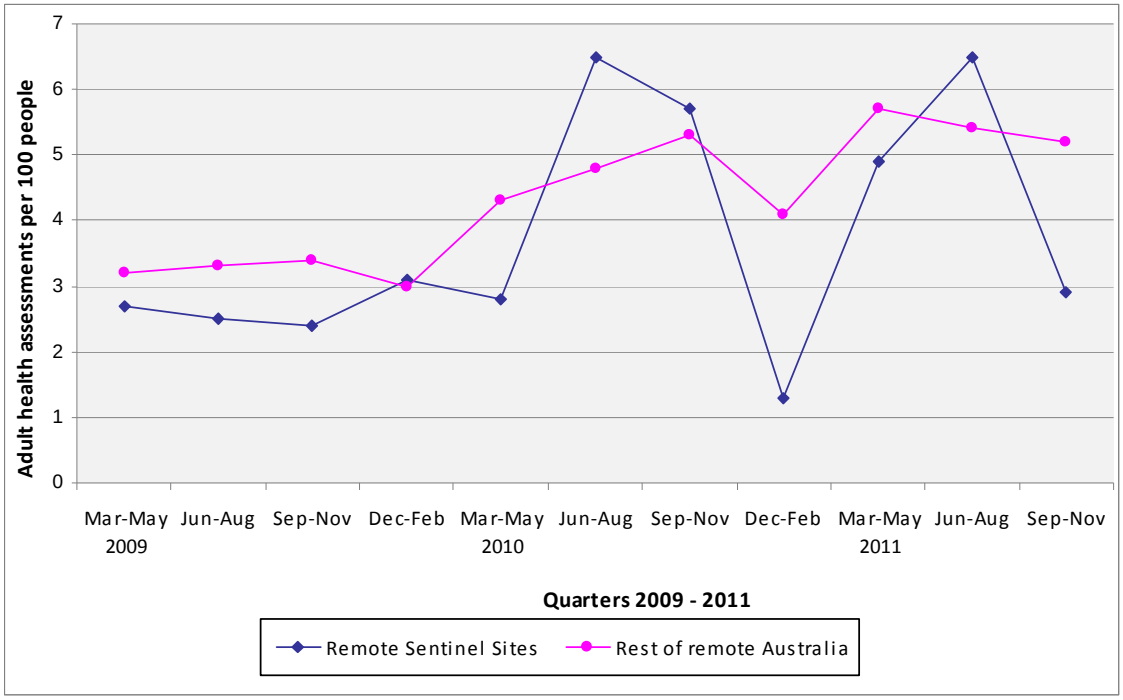


Figure 8.12: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - November 2011

The number of GPs in remote areas claiming for adult health assessments showed little change during the period of implementation (Figure 8.13).

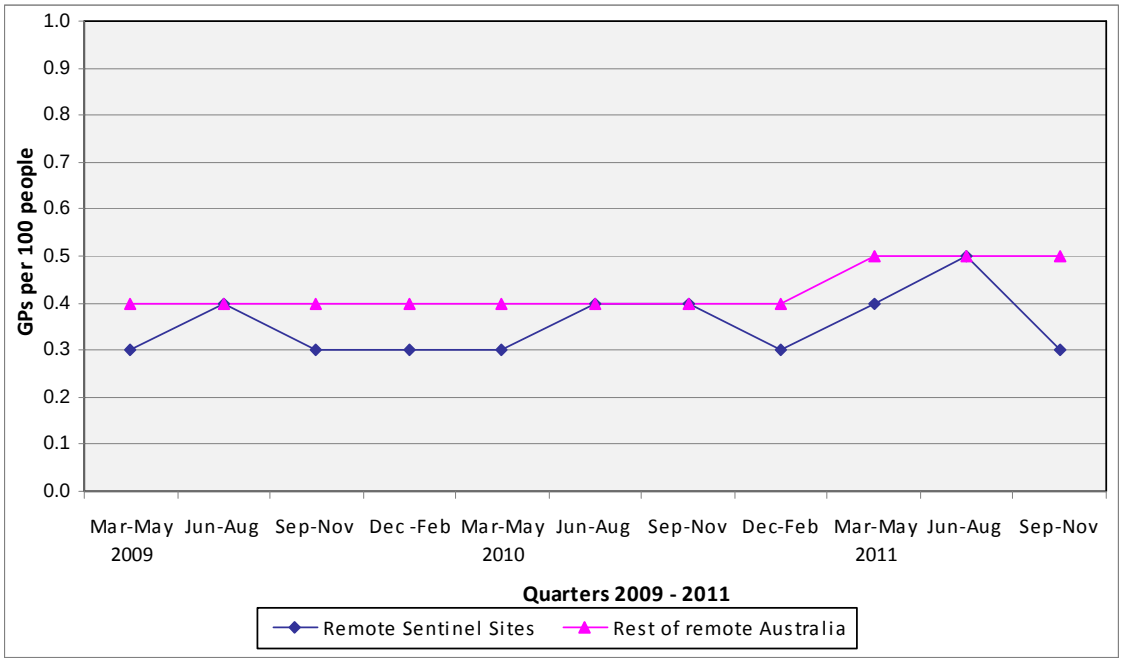


Figure 8.13: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - November 2011

In remote Sentinel Sites and the rest of remote Australia there was an increase in the average number of adult health assessments per GP. 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 between 12 and 15 per GP in four of the six quarters since March 2010 - May 2010. The marked dip in the December 2010 - February 2011 quarter and the September 2011 - November 2011 quarter makes it difficult to assess the trend. The rest of remote Australia shows an increase from between about 8 and 9 per GP for each quarter over the baseline period to between 10 and 12 for each quarter since March 2010 - May 2010 except for the December 2010 - February 2011 quarter (Figure 8.14).

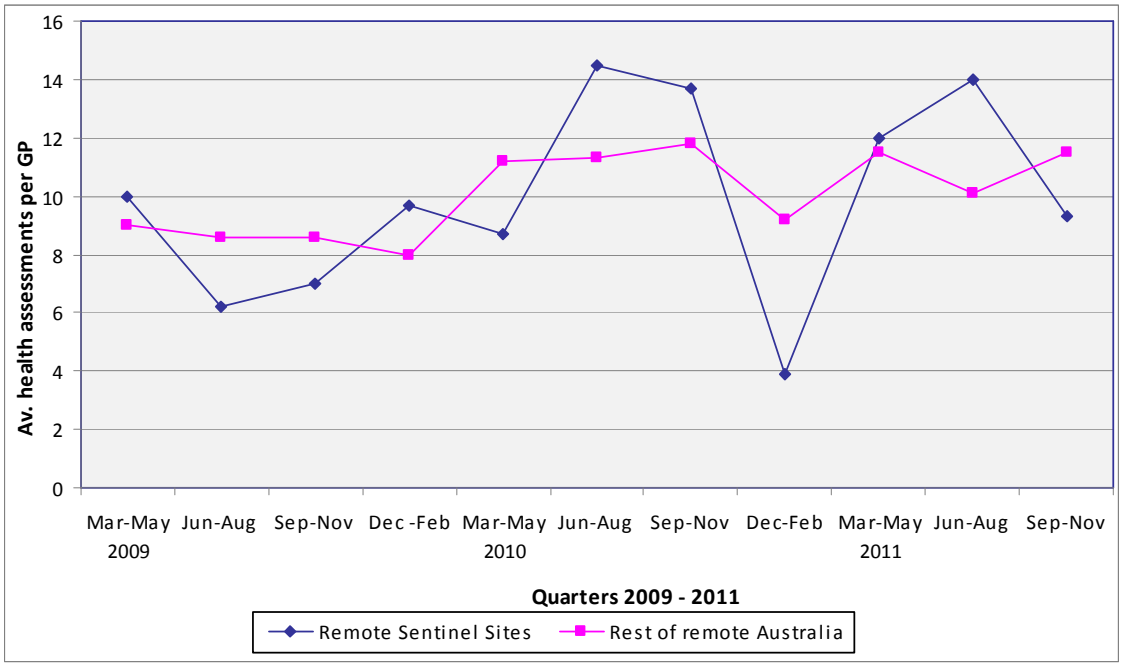


Figure 8.14: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in remote Sentinel Sites and the rest of remote Australia, by quarter, March 2009 - November 2011

SUMMARY OF KEY ISSUES

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 September 2011 - November 2011 quarter was about three times greater than the number in the baseline period (March 2009 - February 2010). The increase in the rest of Australia over the same period was less marked with an increase of about two-fold over baseline. This may reflect a generally larger and earlier investment in Sentinel Sites than the rest of Australia but it may also reflect that Sentinel Sites are not typical in that they all have the presence of an AHS in the site.
- Overall, in both the Sentinel Sites and the rest of Australia, there is clear evidence that the number of GPs who are claiming for adult health assessments has been steadily increasing over the period of ICDP implementation. On the one hand, this suggests that the capacity of the program to improve the uptake of MBS items is still growing. On the other hand, the number of assessments per GP has not increased, however, this overall figure masks considerable variation between different areas.
- Claims for adult health assessments per 100 Aboriginal and Torres Strait Islander people aged ≥55 years 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. However, the increase in claims between the Decembers 2011 - February 2011 quarters was greater for people aged ≥55 years in Sentinel Sites than for all other groups.
- Uptake of health assessments increased for both males and females, although male health assessment rates lag behind those for females. This lag probably reflects lower service utilisation in general for males. This was countered in some sites by specific outreach activities targeting males.

- Number of adult health assessments per 100 people was greater in remote and regional areas than in urban areas. The greatest increases in the number of adult health assessments per 100 people have been in regional areas, with remote sites showing little increase in the past three quarters. The marked increases in urban Sentinel Sites are largely driven by specific sites. The number of GPs claiming for assessments per 100 people has been steadily increasing in urban and regional areas, but has not shown a clear increase in remote areas. The number of assessments conducted per GPs shows some variability in all areas, with no clear trend evident. The only exception to this pattern was for the regional Sentinel Sites, where assessments per GP appeared to be increasing.

The section below examines the trends in uptake in specific Sentinel Sites and explores some of the underlying factors responsible for these trends. Owing to different drivers evident in urban, regional and remote areas in Australia, these are each discussed separately.

8.4. Variation in adult health assessments in Sentinel Sites

Examining the variation in uptake of adult health assessments between the Sentinel Sites in more detail provides some insight into the enabling factors and barriers related to increasing adult health assessment uptake in different contexts.

The sections below compare trends in uptake of adult health assessments in specific sites in urban, regional sites and remote areas. We also examine and integrate data by rurality, showing trends in number of GPs claiming adult health assessments per site, average number of assessments claimed per provider and qualitative data deriving from interviews with key informants in the Sentinel Sites. The overall purpose is to understand key factors influencing the observed trends.

URBAN AREAS

Whilst adult health assessment rates are low overall for urban Australia and show little increase in the last three quarters as indicated above, there was wide variation in trends in the different urban Sentinel Sites. This is shown in Figure 8.15. Examining the variation between the Sentinel Sites in more detail provides some insight into the enabling factors and barriers related to increasing adult health assessment uptake in urban areas.

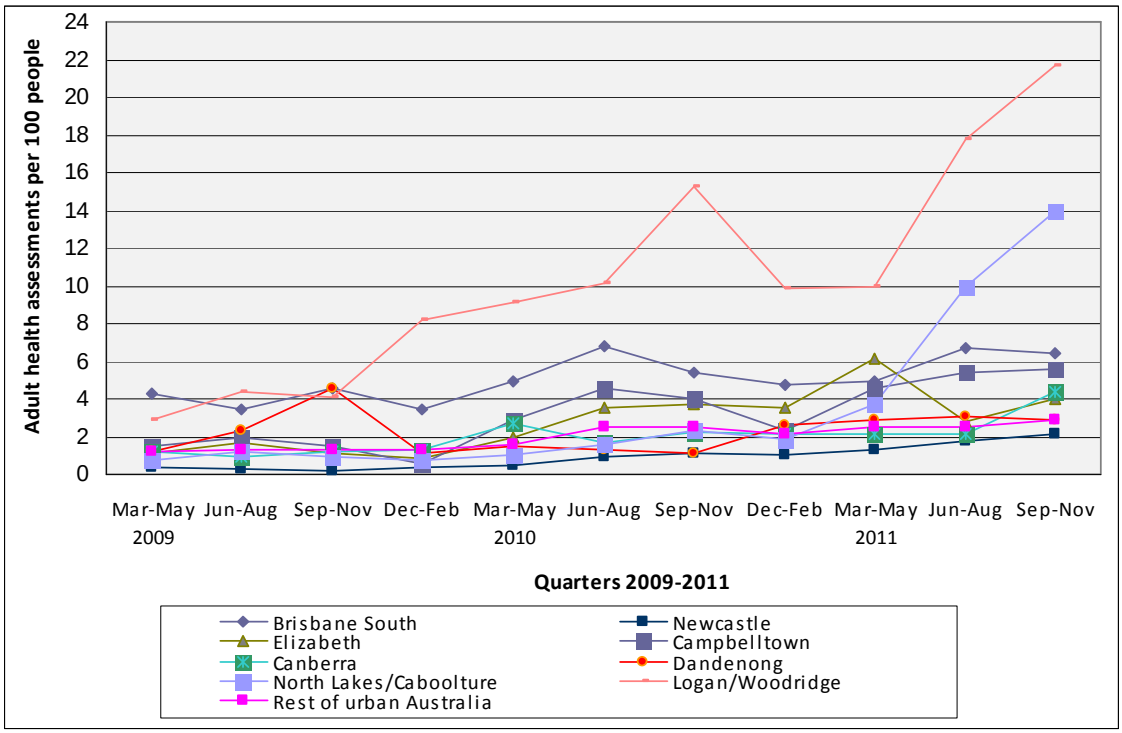


Figure 8.15: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in urban Sentinel Sites and the rest of urban Australia, by site and quarter, March 2009 - November 2011

Logan/Woodridge and North Lakes/Caboolture stand out as the two urban Sentinel Sites with a marked increase over the most recent two quarters. During the period of implementation Logan/Woodridge had a much greater increase in the number of GPs claiming than any other site (Figure 8.16). It was noted in Logan/Woodridge that private General Practice had an important role to play in contributing to the high uptake, along with the AHS. This was borne out by the analysis of number of GPs who were claiming for adult health assessments by site (Figure 8.16).

In North Lakes/Caboolture, a number of Health Services commenced operation during the period of implementation, including the Strathpine Super clinic[96] (January 2010) and a not-for-profit Aboriginal owned and operated Health Service[97] (June 2011), and subsequently (though would not be shown in the data yet) a clinic at the Institute of Urban Indigenous Health. The Super clinic employs an Aboriginal registered nurse with a focus on undertaking health assessments. In this one site there are a number of Health Services engaged in the provision of care to Aboriginal and Torres Strait Islander people. Similar to Logan/Woodridge, this site also shows a higher number of GPs who were claiming for adult health assessments, and higher increases than for most other urban sites (Figure 8.16).

Brisbane South and Campbelltown also show relatively higher uptake compared to the other sites and to the rest of urban Australia. Both Brisbane South and Campbelltown also showed a higher average number of adult health assessments per GP than most other sites (Figure 8.17).

[96] Strathpine Super clinic [website], <http://www.strathpinesuperclinic.com.au/index.php?option=com_content&view=article&id=3&Itemid=2> (accessed 17 April 2012).
[97] Murray Teilah [website], <http://www.murrimedical.com.au/> (accessed 17 April 2012).

Although Brisbane South showed relatively high uptake, it was perceived by the interviewees that the majority of the adult health assessments had been undertaken by the AHS in the area and that the private General Practices were not engaged. The site indicated that they do not expect to see an increase in adult health assessments for the period covered by this report due to capacity constraints. In Campbelltown, the higher uptake was explained by the commencement of a GP in March 2010. This GP focused on completing adult health assessments as part of building up his patient list.

> *'I have been consciously completing health checks since I started in March 2010, I was new so building up patients, the shift now is to care plans for chronic disease. This accounts for the increase from March 2010 ...'* (Interviewee, AHS)

Figure 8.16 shows the number of GPs who claimed an adult health assessment item by quarter in the urban Sentinel Sites, and Figure 8.17 shows the average number of adult health assessments per GP.

At the individual Sentinel Site level, the number of GPs 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 over the period of ICDP implementation (March 2010 - May 2010) with number of GPs ranging from 0.2 to 4.3 per 100 Aboriginal and Torres Strait Islander people for the most recent quarter of data included in this report. 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 8.16-8.17)].

The trends in the number of GPs who claimed for adult health assessments in urban Sentinel Sites overall were similar to the rest of urban Australia, with an increase of between 0 and 0.5 GPs per 100 people at baseline to between 0.5 and 1.0 GPs per 100 people in the most recent quarter for which data were available for this report.

The exceptions to this general pattern were:

- Logan/Woodridge which showed the highest level at baseline and has showed the most marked increase over the period of ICDP implementation to be eight times higher than the rest of urban Australia.
- North Lakes/Caboolture which showed a similar patter to the other urban Sentinel Sites up to the December 2010 - February 2011 quarter with a substantial increase over the most recent quarters to a level more than three times higher than the rest of urban Australia.
- Elizabeth which showed a steady increasing pattern over the period June 2010 - August 2010 to March 2011 - May 2011 with a subsequent decline over the most recent two quarters but continues to be at a level higher than most other urban Sentinel Sites.

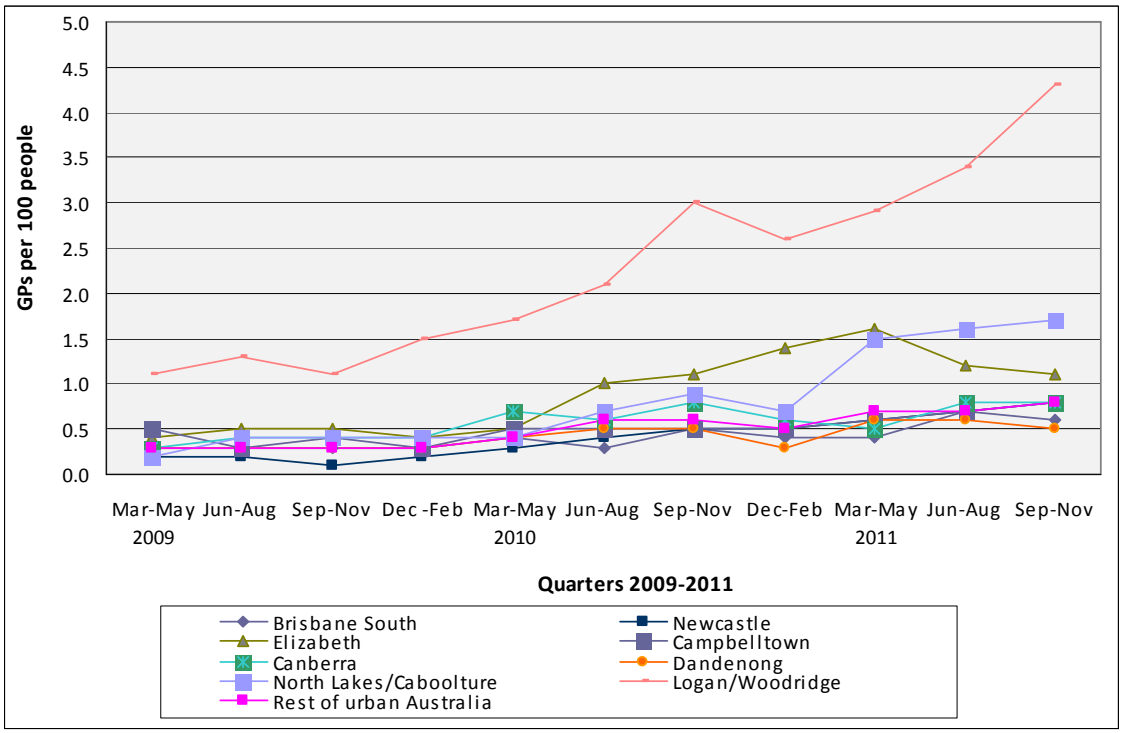


Figure 8.16: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites, by quarter, March 2009 - November 2011

Most urban Sentinel Sites, like the rest of urban Australia, showed very little change in the average number of adult health assessments per GP in the period of ICDP implementation (from March 2010 - May 2010 quarter onwards) (Figure 8.17). Over the most recent three quarters most sites were similar to the rest of urban Australia in terms of the average number of health assessments per GP (with between about 2.5 and 5 per GP). Three sites stand out as being different to the other urban sites over the most recent quarters:

- Brisbane South has consistently shown the highest number of adult health assessments per GP over the period of observation.
- North Lakes/Caboolture has shown a marked increase in the average number of adult health assessments per GP in the most recent two quarters.
- Campbelltown has shown the second highest number of adult health assessments per GP (after Brisbane South) over most of period of ICDP implementation.

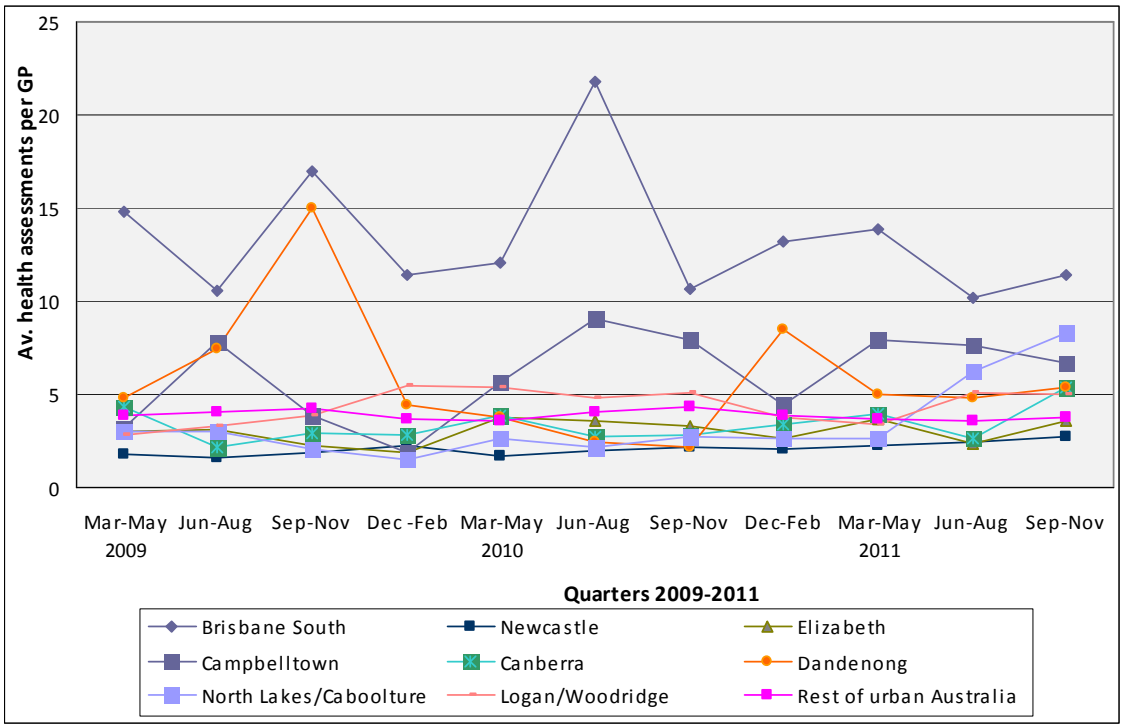


Figure 8.17: Average number of adult health assessments (MBS items 704, 706, 710 and to 1 May 2010 thereafter 715) claimed per General Practitioner in urban Sentinel Sites, by quarter, March 2009 - November 2011

As illustrated above, factors identified as responsible for the ability of urban sites to demonstrate relatively higher uptake of the adult health assessment include: both AHS and private GP involvement in providing adult health assessments and staff who have a particular focus on provision of adult health assessments. Increased numbers of GPs claiming for adult health assessments was a key factor underlying the increased rates of adult health assessment that were achieved in urban sites.

REGIONAL AREAS

The rest of regional Australia, and the regional Sentinel Sites, showed higher overall uptake of adult health assessments compared to urban areas and also showed steady overall increase during the period of implementation. There was wide variation in trends in the different regional Sentinel Sites. These figures are presented separately by stage of implementation (Figures 8.18-8.20).

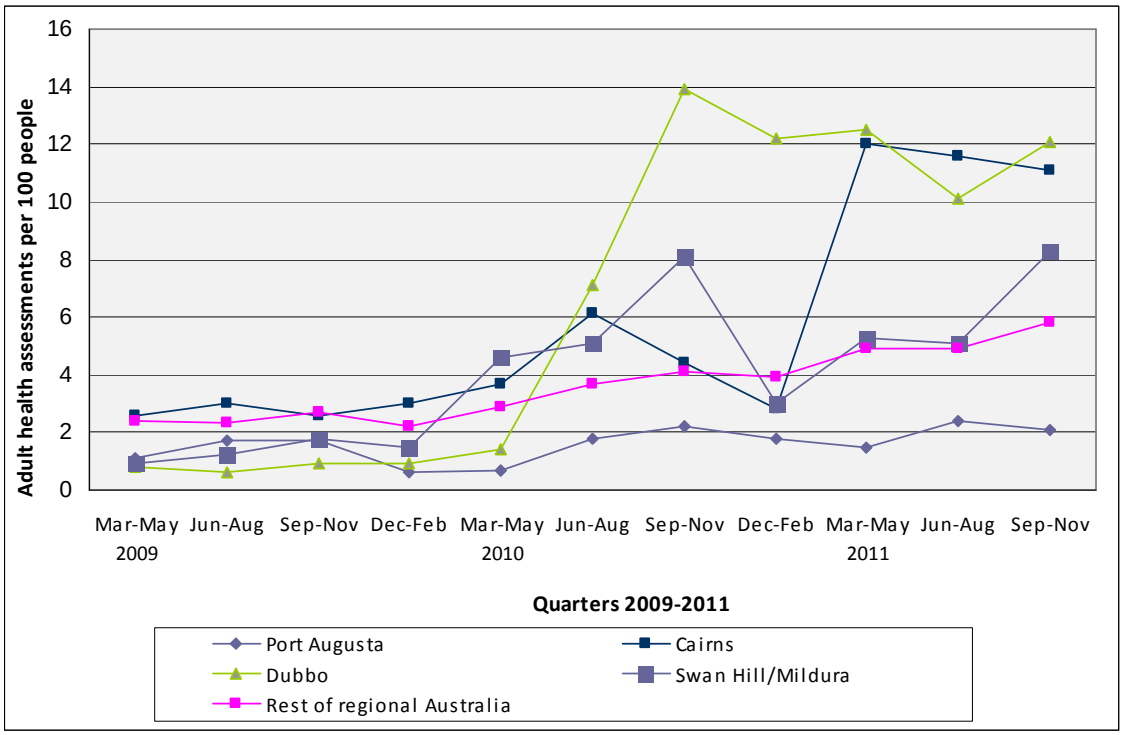


Figure 8.18: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 1 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - November 2011

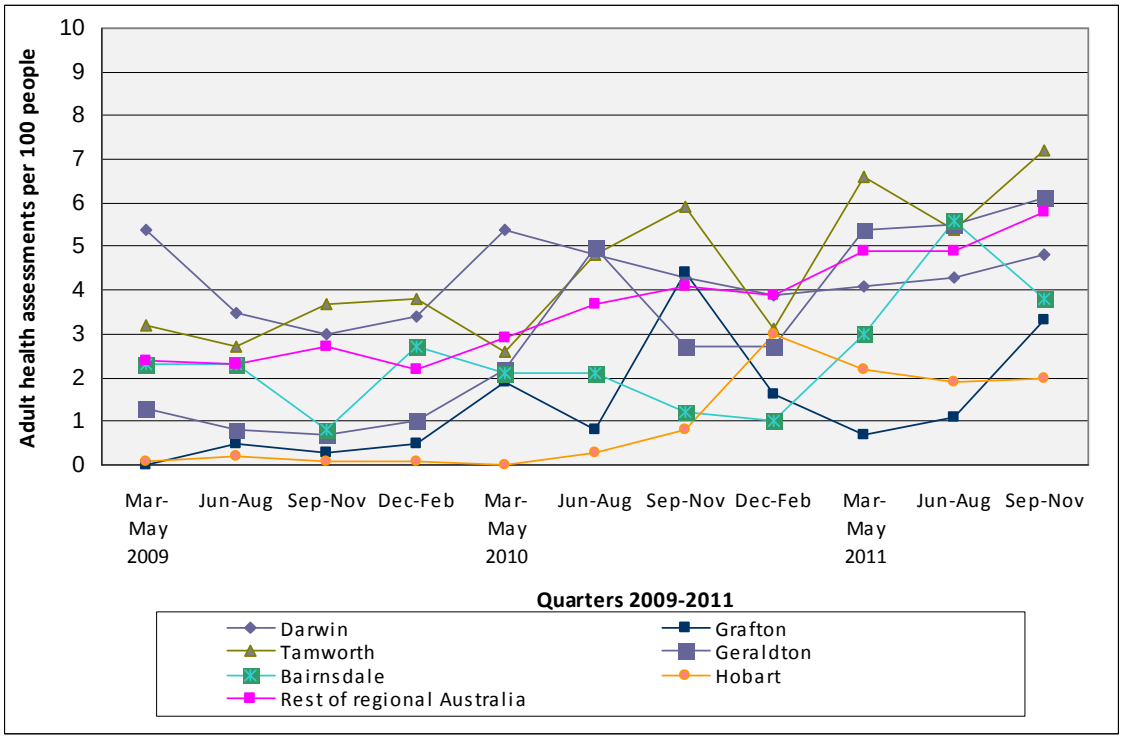


Figure 8.19: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 2 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - November 2011

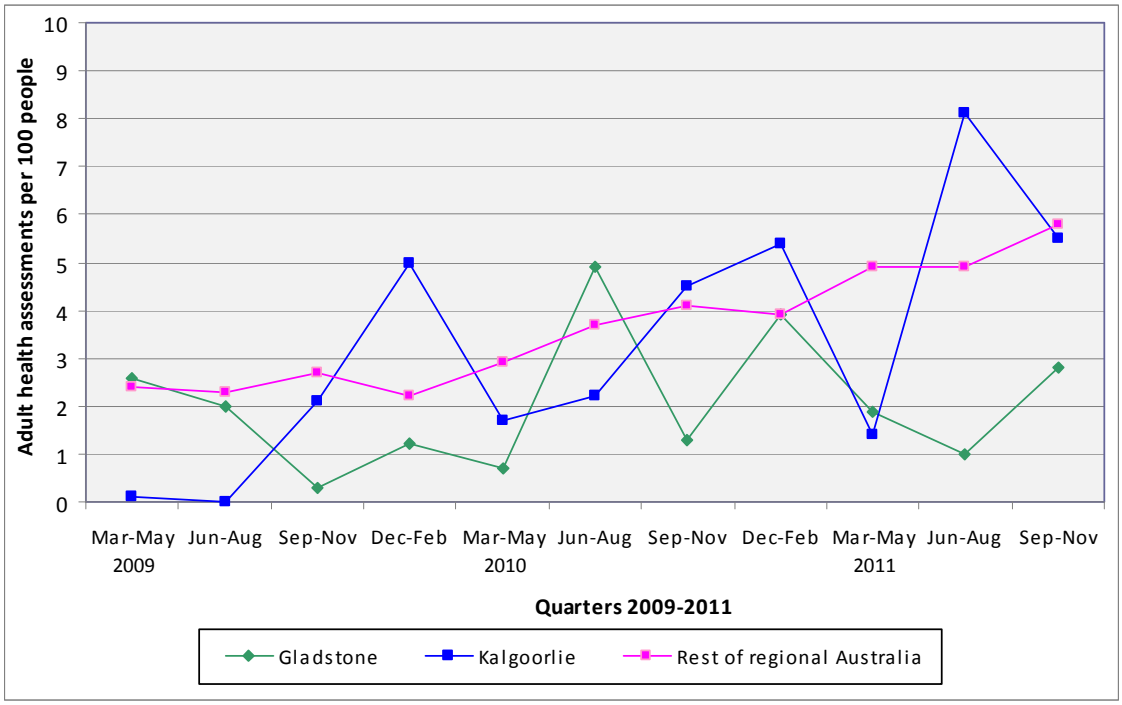


Figure 8.20: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in regional stage 3 Sentinel Sites and the rest of regional Australia, by site and quarter, March 2009 - November 2011

There were four sites that showed higher rates of adult health assessments in this period than the rest of regional Australia. These sites were located across three jurisdictions and included one case study site (Tamworth) and three enhanced tracking sites (Dubbo, Swan Hill/Mildura and Cairns).

In addition to higher rates of adult health assessments overall, both Tamworth and Dubbo also showed a fairly steady increase in the number of GPs who were providing adult health assessments (Figures 8.21 and 8.22), and also had a high average number of adult health assessments per GP (Figures 8.24-8.25). In the Dubbo site, there are two AHS as key stakeholders within the site (unlike the other sites, which generally only have one AHS). In addition to having two AHSs there is a not-for-profit Aboriginal owned Health Service[98] established in December 2010 and a number of private General Practices. The number of GPs involved in provision of services specifically for Aboriginal and Torres Strait islander people may have been a factor contributing to higher uptake of adult health assessments in this site.

Similar to Dubbo and Tamworth, Cairns also showed a high average number of adult health assessments per GP. In Cairns, contributing to the relatively high rates of adult health assessments was the appointment of a new Medical Director at the AHS. This Medical Director was implementing a business model approach in the AHS and developing new systems within the Health Service to maximise this revenue and care for patients. The Medical Director commenced in the December 2010 - February 2011 quarter in the previous reporting period. In addition in Cairns there are a number of large private General Practices that provide care to Aboriginal and Torres Strait islander patients. These GPs are likely to have a role in contributing to the increases in adult health assessments. This is supported by data in Figure 8.21 which shows a steady increase in the number of GPs in Cairns providing adult health assessments.

[98] Bawrunga Medical Service [website] <http://bawrunga.org.au/> (accessed 17 April 2012).

By contrast, for Hobart and Port Augusta, the number of adult health assessments per 100 people in these two sites has been amongst the lowest over most of the period covered by this report.

In Darwin the spikes in the quarters of March 2009 - May 2009 and March 2009 - May 2010 were perceived to be due to the EHSDI.

> *'In March-May 2009 and 2010 higher rates due to EHSDI teams coming in and doing health checks. Though focus was on child health checks there was just a whole increase across the board due to focus on health checks.' (Interviewee, AHS)*

Vignette - A creative approach to engaging patients in the ICDP

The ICDP funded DGP team in a regional site has taken a creative approach to raising public awareness of the ICDP and encouraging Aboriginal and Torres Strait Islander people to have health assessments.

The DGP team has used carry over funds from a community 'Close the Gap Day' to buy four bicycles. Over a four month period, anyone within the site who has an adult health assessment at a PIP Indigenous Health Incentive registered Health Service goes into a draw to win a bike.

'We promote exercise and community engagement … We will raffle a bike every month for the next four months, for those people who had done a complete health check at any GP or Aboriginal Health Service in our region'.

The local TV channel, radio station and newspaper publicise information about the ICDP and have been promoting the bike draw. The newspaper published a promotion that featured a large photo of the ICDP team with the bikes. Flyers have been distributed at community venues. A sign on the historic passenger train which passes through the town also promotes the program.

This innovative strategy (with its health promoting message) demonstrates the positive links between the IHPO, OW and Care Coordinator in the DGP and the AHS and General Practices in the site. Community focus groups were aware of the bike draw (and bemused by it) and entry criteria. One participant was an entrant in the draw.

In regional Sentinel Sites, the prevailing pattern was one of increasing numbers of GPs claiming adult health assessments per 100 people over the period of ICDP implementation (from March 2010 - May 2010 quarter onwards) compared to the baseline. The only exceptions were Darwin and Gladstone where the number of GPs was relatively consistent. However, there was a high degree of variability amongst regional Sentinel Sites (Figures 8.21-8.23). The number of GPs claiming adult health assessments per 100 people was higher in Geraldton than the rest of regional Australia. (This may be related to the way this site was defined with a relatively tighter boundary around the city compared to other regional sites). The number of GPs claiming health assessments per 100 people in the most recent quarter was similar to the rest of regional Australia, in Cairns, Dubbo, Swan Hill/Mildura, Tamworth and Bairnsdale. The average number of GPs claiming health assessments per 100 people in the most recent quarter was lower than the rest of regional Australia in Darwin, Grafton, Hobart, Kalgoorlie, Gladstone and Port Augusta.

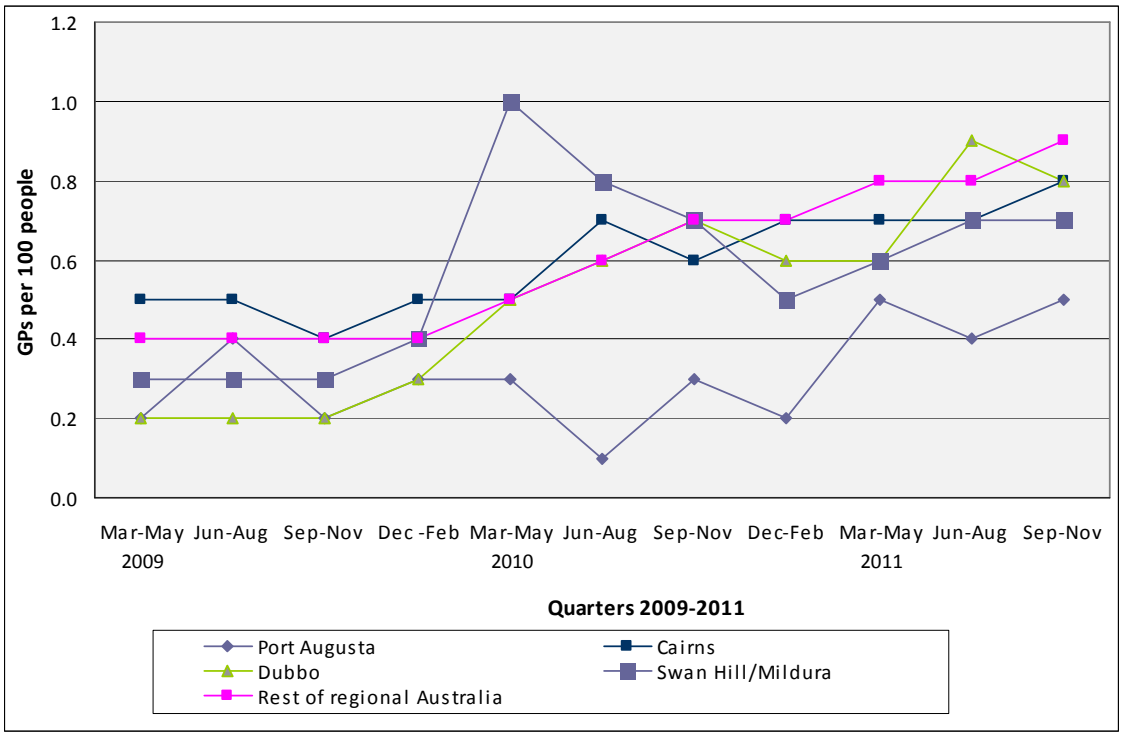


Figure 8.21: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 1 Sentinel Sites, by quarter, March 2009 - November 2011

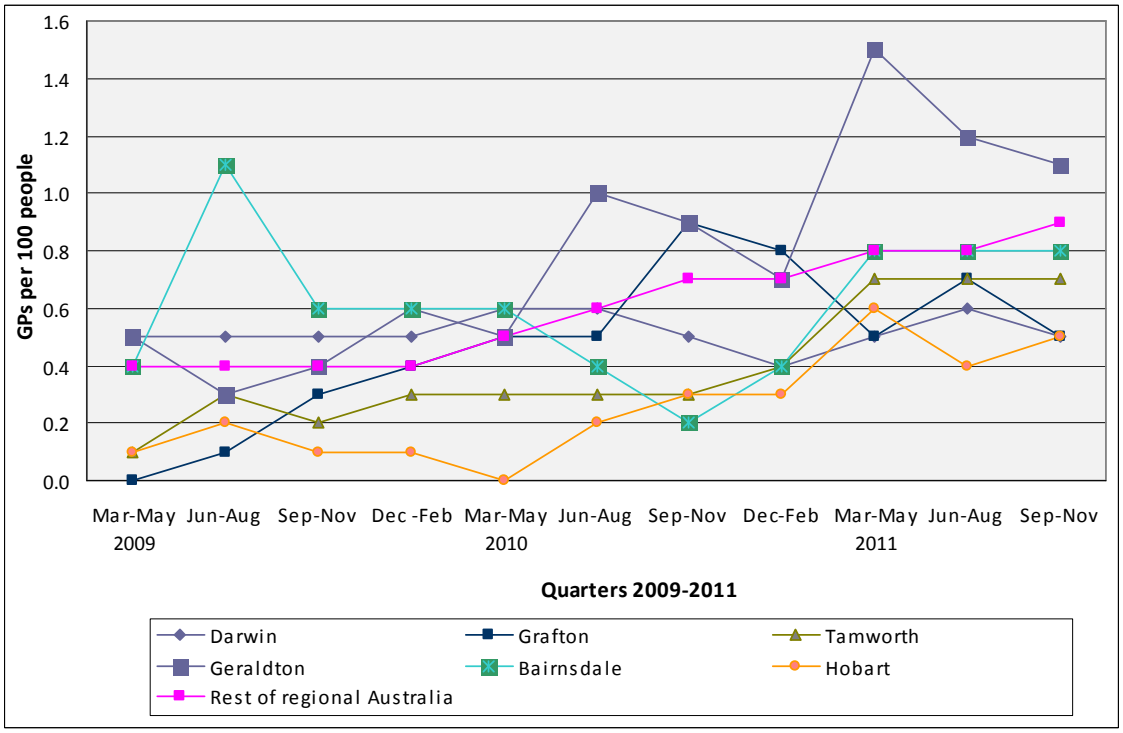


Figure 8.22: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 2 Sentinel Sites, by quarter, March 2009 - November 2011

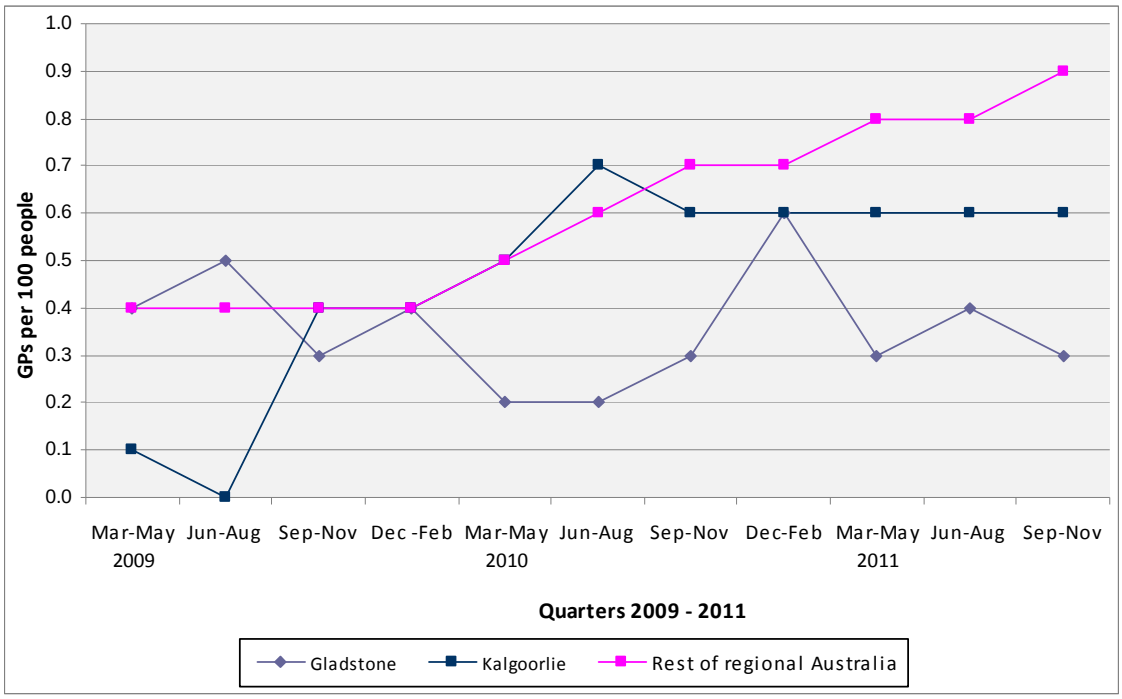


Figure 8.23: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 3 Sentinel Sites, by quarter, March 2009 - November 2011

Trends in the average number of adult health assessments per GPs for specific regional Sentinel Sites

The regional Sentinel Sites tended to show wider variation in the average number of health assessments per GP between quarters than the urban sites (Figures 8.24-8.26). The regional sites that stand out as showing distinctive trends over the period of observation in this report are:

- Dubbo has shown an average of between 10 and about 20 adult health assessments per GP over most of the period of ICDP implementation.
- Cairns has shown an average of between 13 and 18 adult health assessments per GP over the most recent three quarters of the period of observation in this report.
- Tamworth has shown the highest average number of adult health assessments per GP of all sites for most of 2009 and 2010 with relatively lower numbers over the past four quarters (although still considerably higher than most regional sites and the rest of regional Australia).

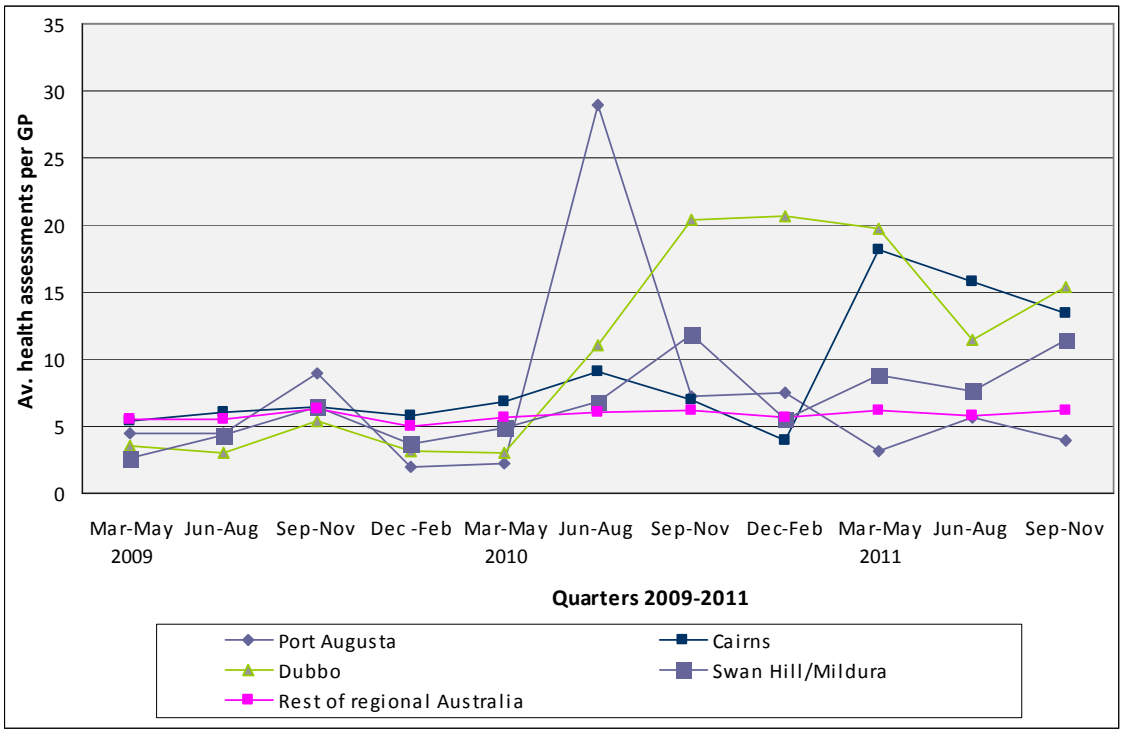


Figure 8.24: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in regional stage 1 Sentinel Sites, by quarter, March 2009 - November 2011

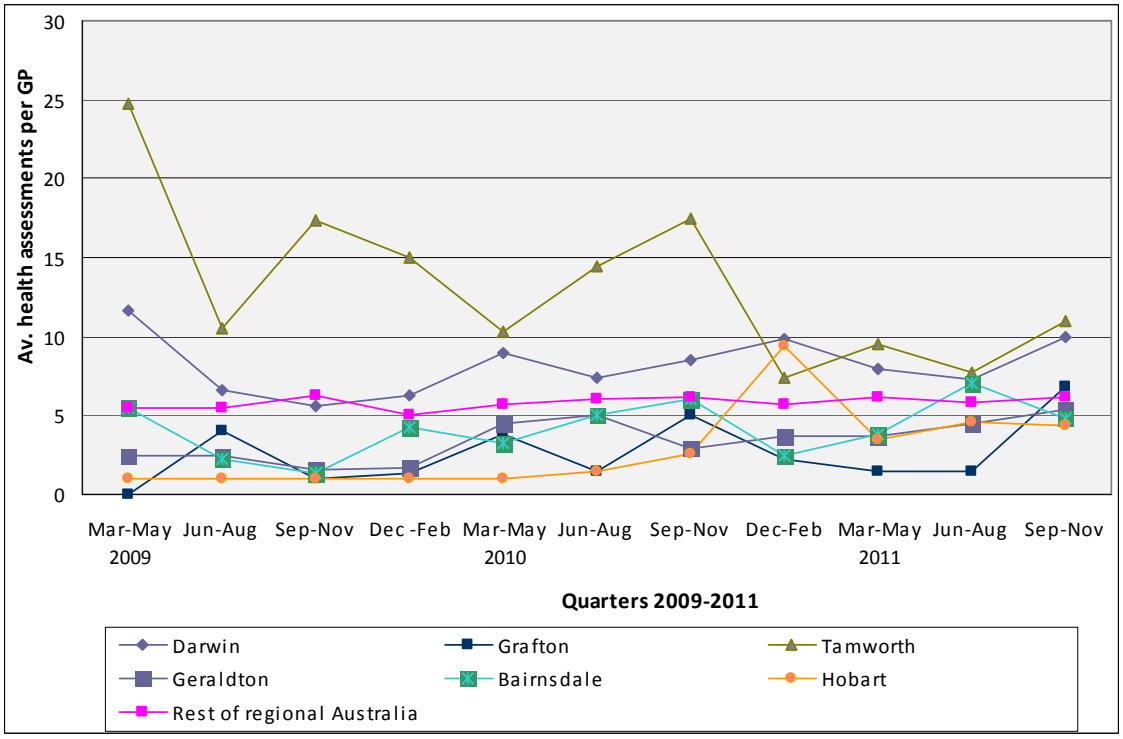


Figure 8.25: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in regional stage 2 Sentinel Sites, by quarter, March 2009 - November 2011

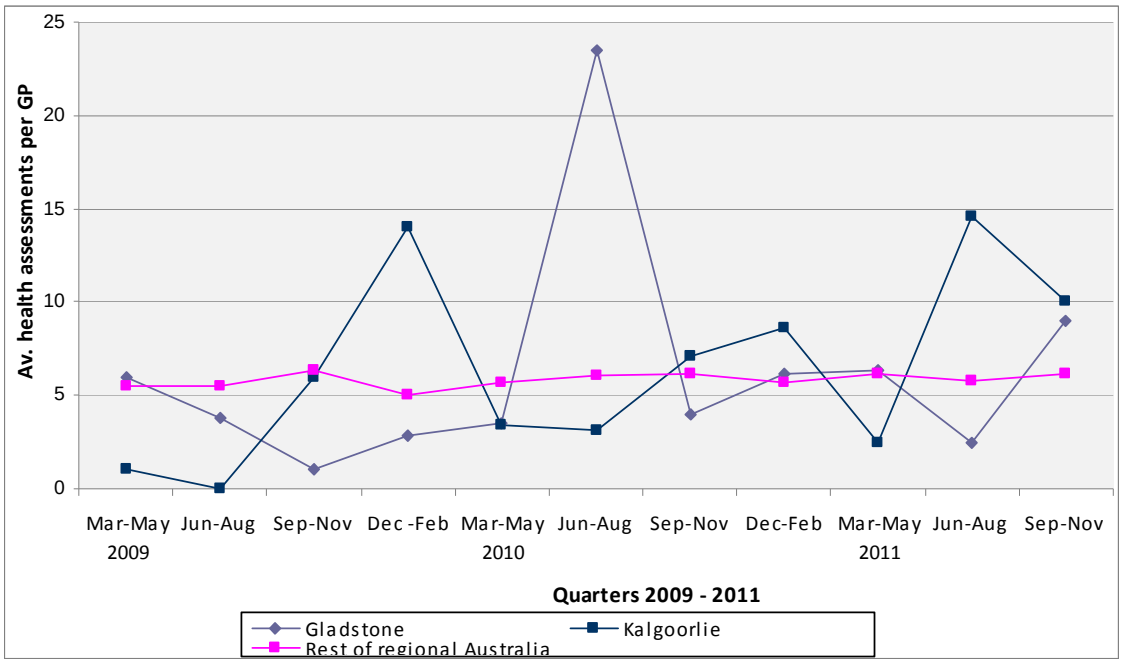


Figure 8.26: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in regional stage 3 Sentinel Sites, by quarter, March 2009 - November 2011

Increased numbers of GPs claiming for adult health assessments and increased number of assessments per GP were key factors underlying the increased rate of adult health assessments that were achieved in regional sites.

REMOTE AREAS

There was wide variability in uptake of adult health assessments in remote Sentinel Sites (Figure 8.27). Derby showed the lowest level of uptake at baseline and greater increase than the other remote sites. Uptake in Derby has been higher than the other remote sites for the most recent two quarters.

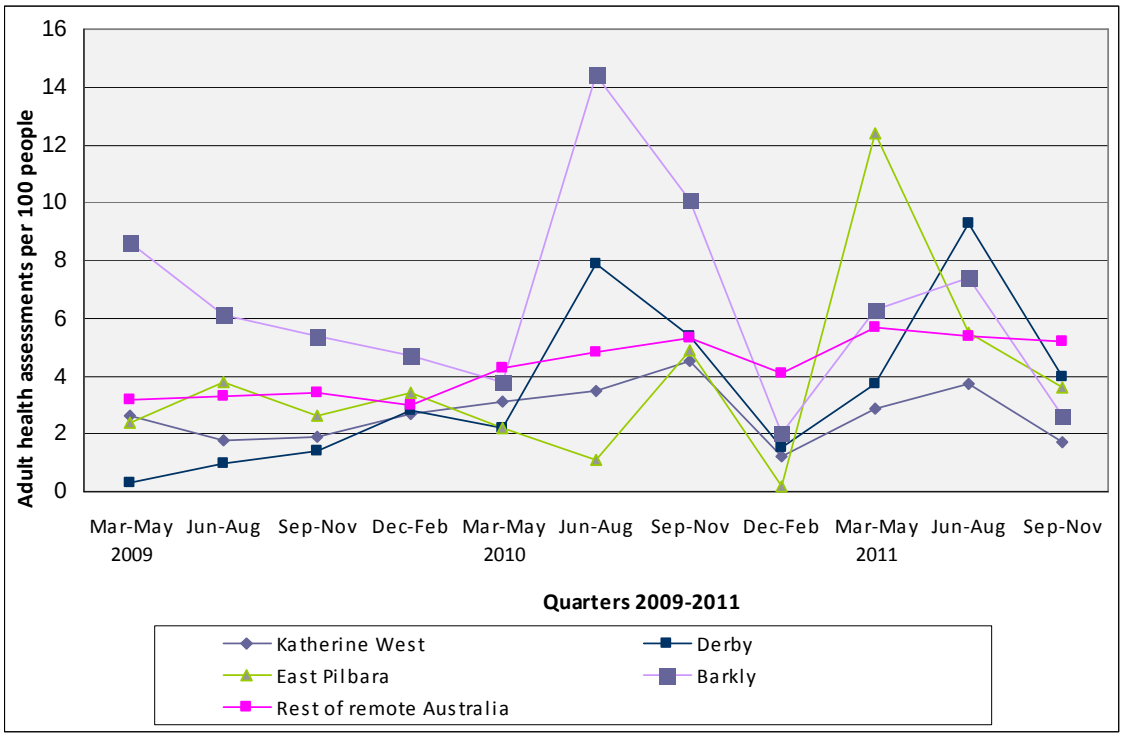


Figure 8.27: Adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in remote Sentinel Sites and the rest of remote Australia, by site and quarter, March 2009 - November 2011

There was very little change in the number of GPs claiming adult health assessments in remote areas. However Barkly had consistently more claiming GPs than the rest of remote Australia (Figure 8.28). The spike in 2010 in assessments completed and in number of GPs claiming for adult health assessments, was partly explained by the influence of intervention teams at the site focusing on undertaking adult health assessments during the NT intervention.

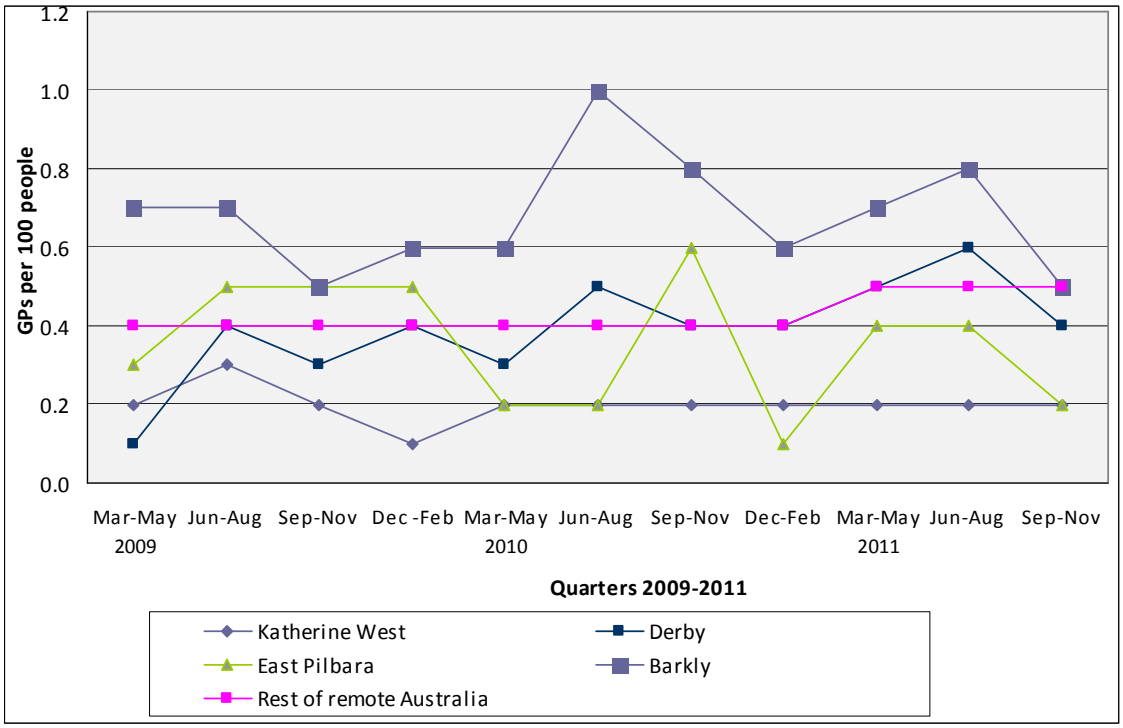


Figure 8.28: Number of General Practitioners who claimed an adult health assessment (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites, by quarter, March 2009 - November 2011

The average number of health assessments conducted per GP also showed considerable fluctuation in all of the remote sites (Figure 8.29).

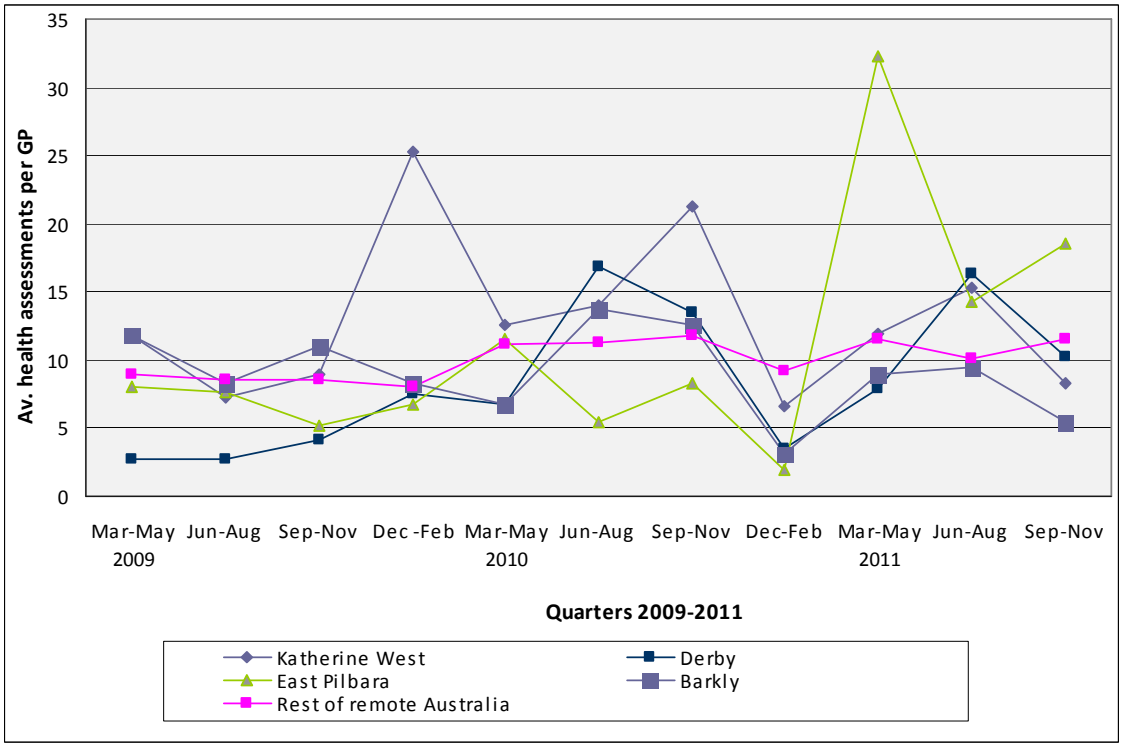


Figure 8.29: Average number of adult health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) claimed per General Practitioner in remote Sentinel Sites, by quarter, March 2009 - November 2011

Barriers to increasing the number of adult health assessments in remote sites that were identified in interviews with key informants in the sites, predominantly related to staffing constraints (lack of staff, high turnover of staff and high use of locums). New staff needed to be orientated to working in a remote setting, using a different patient information system and the basics of the Medicare system, hence the details of implementing and correctly billing for items such as adult health assessments were not high priority for many services facing these challenges. The influence of extreme weather conditions in determining trends, during December-February each year was particularly noted by remote centre staff. During this period staffing constraints were acutely felt, there was a greater use of locums and/or minimal staffing whilst staff take leave.

Events such as the NT intervention were also noted affecting the patterns of service delivery in some of the remote sites. For example, interviewees in Barkly indicated that the spikes in the adult health assessments in the March 2009 - May 2009 and June 2010 - August 2010 coincide with the NT intervention teams at the site focusing on undertaking health assessments (Figure 8.27).

Interviewees in the East Pilbara site indicated that the spike in the March 2011 - May 2011 quarter was due to a nurse at the AHS being dedicated to undertake adult health assessments visiting the clinic. This is reflected in Figure 8.27, indicating an increase in the average number of adult health assessments per GP.

Increases in adult health assessments in remote sites appeared to be driven by changes in the number of health assessments completed per GP. There was no evidence in remote sites of an increased number of claiming GPs. Trends in remote sites were also particularly sensitive to external events such as extreme weather conditions or external interventions.

8.5. Follow-up services by a practice nurse or registered Aboriginal Health Worker

NOTES ON THE INTERPRETATION OF THE MBS ITEM NUMBER 10987 DATA

- The item is claimed by the GP, where a follow-up service is provided by a practice nurse or registered AHW on behalf of the GP for an Aboriginal or Torres Strait Islander person who has received a health assessment (MBS item 715).
- Currently only AHWs in the Northern Territory can become registered and undertake work for this item number on behalf of a GP. In all other states and territories the work for this item number can only be undertaken by practice nurses on behalf of a GP.[99]
- National registration for AHWs is planned for July 2012 after that the MBS items should be more widely available.[100]

[99] DoHA. MBS Online website, <http://www.health.gov.au/internet/mbsonline> (accessed 24 April 2012).
[100] Aboriginal and Torres Strait Islander Health Practice Board - Communiqué 21 March 2012 [website] <http://www.atsihealthpracticeboard.gov.au/News/Communiques.aspx> (accessed 23 April 2012).

OVERALL TRENDS IN RELATION TO IMPLEMENTATION OF THE ICDP

The uptake data for follow-up services by practice nurse or registered AHW (MBS item number 10987) in Sentinel Sites shows:

- The total number of claims per quarter for follow-up services provided by a practice nurse or registered 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 period of ICDP implementation (from March 2010 - May 2010 quarter onwards).
- The number of items claimed in the September 2011 - November 2011 quarter (582) was more than 13 times the average number claimed per quarter during the baseline period (Table 8.2).

In contrast to the Sentinel Site data, the data for the rest of Australia shows that:

- 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 2009 - May 2009) to 749 for the final quarter of the baseline period (December 2009 - February 2010) (Table 8.2).
- The number of items claimed in September 2011 - November 2011 showed nearly a tenfold increase over the average number of claims made in the baseline period.
- The number of claims for follow-up services provided by a practice nurse or registered AHW per 100 Aboriginal and Torres Strait Islander people who had received an adult health assessment was lower in Sentinel Sites than the rest of Australia. This reflects a greater increase in the number of claims for adult health assessments in Sentinel Sites.

In both Sentinel Sites and the rest of Australia there was some evidence of a leveling out of the rate of increase in claims for follow-up items. This occurred from March 2011 in the Sentinel Sites and from June 2011 in the rest of Australia.

The small numbers of claims for follow-up services provided by a practice nurse or AHW in the Sentinel Sites mean more detailed analysis of these data needs to be made with caution.

Table 8.2: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker to Aboriginal and Torres Strait Islander people aged ≥15 years who received an adult health assessment (MBS items 10987), in Sentinel Sites and the rest of Australia, by quarter March 2009 - November 2011

Sentinel Sites/ Rest of Australia	Follow-up items claimed										
	2009				2010				2011		
	Mar - May	Jun - Aug	Sep - Nov	Dec - Feb	Mar - May	Jun - Aug	Sep - Nov	Dec - Feb	Mar - May	Jun - Aug	Sep - Nov
Sentinel Sites	57	72	34	7	161	278	246	258	535	570	582
Rest of Australia	244	338	511	749	1102	1416	1925	2407	3224	4072	4429

TRENDS BY AGE AND GENDER

The general trends were similar for those aged ≥55 years and those aged 15-54, with consistently higher claims per 100 people with adult health assessments for those in the group aged ≥55 years (Figure 8.31).

The general trends were similar for men and women in the rest of Australia, with consistently higher numbers of claims for women (Figure 8.32). However, in the Sentinel Sites, the number of claims for follow-up items for men has been higher than for women for most of the period of the ICDP implementation. While there is greater quarter to quarter variation in the trend for men than women, the general trend for both groups is a steady increase since the start of the ICDP implementation period. The relatively high uptake of follow-up items per 100 adult health assessments among men is likely to be due to the impact of a small number of Health Services in specific Sentinel Sites where there has been a focus on men's health, as reflected in the data for specific Sentinel Sites (not presented here).

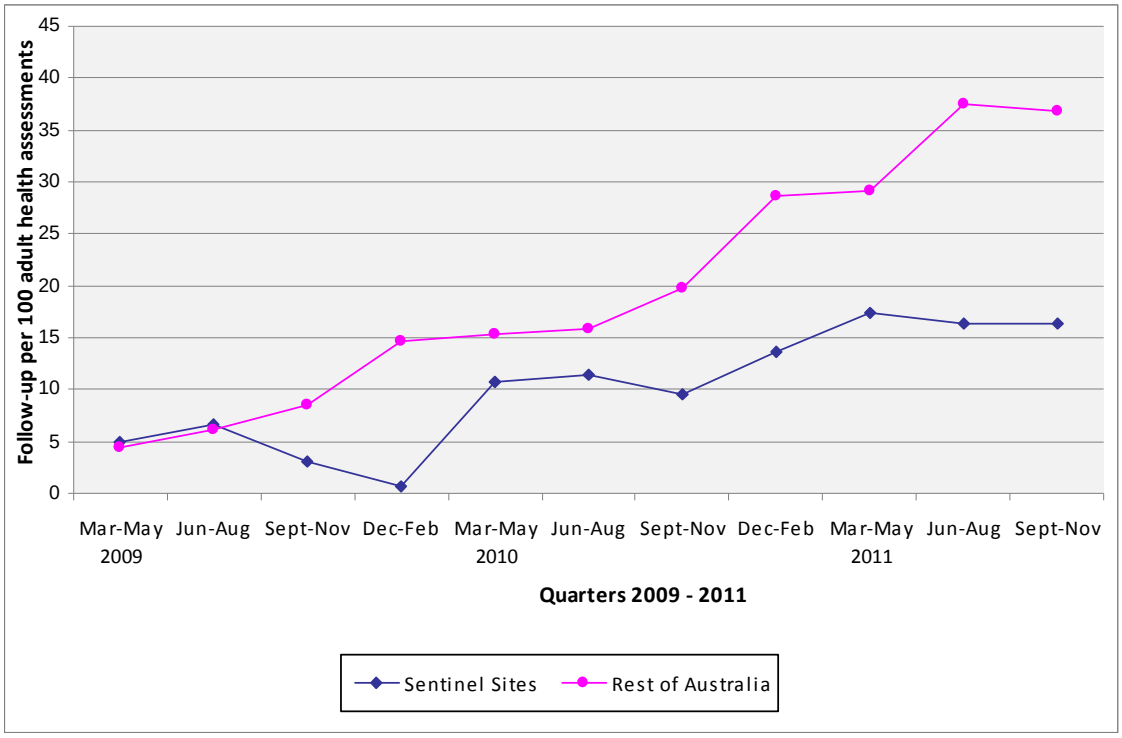


Figure 8.30: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - November 2011

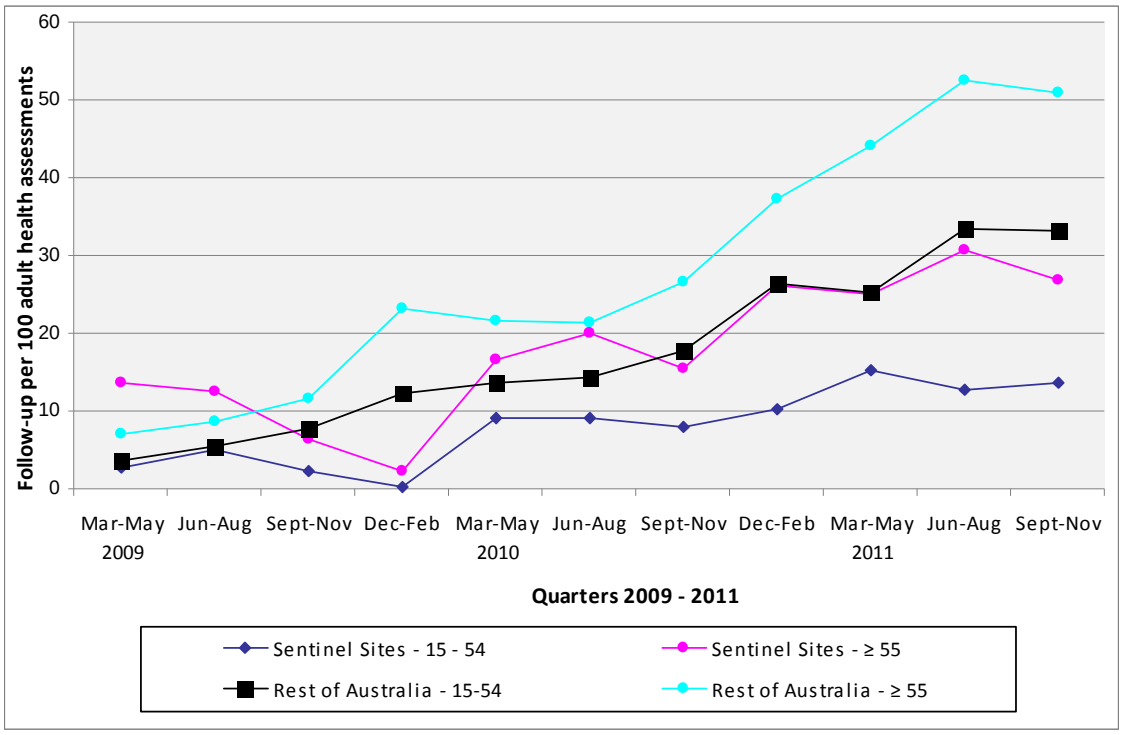


Figure 8.31: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - November 2011

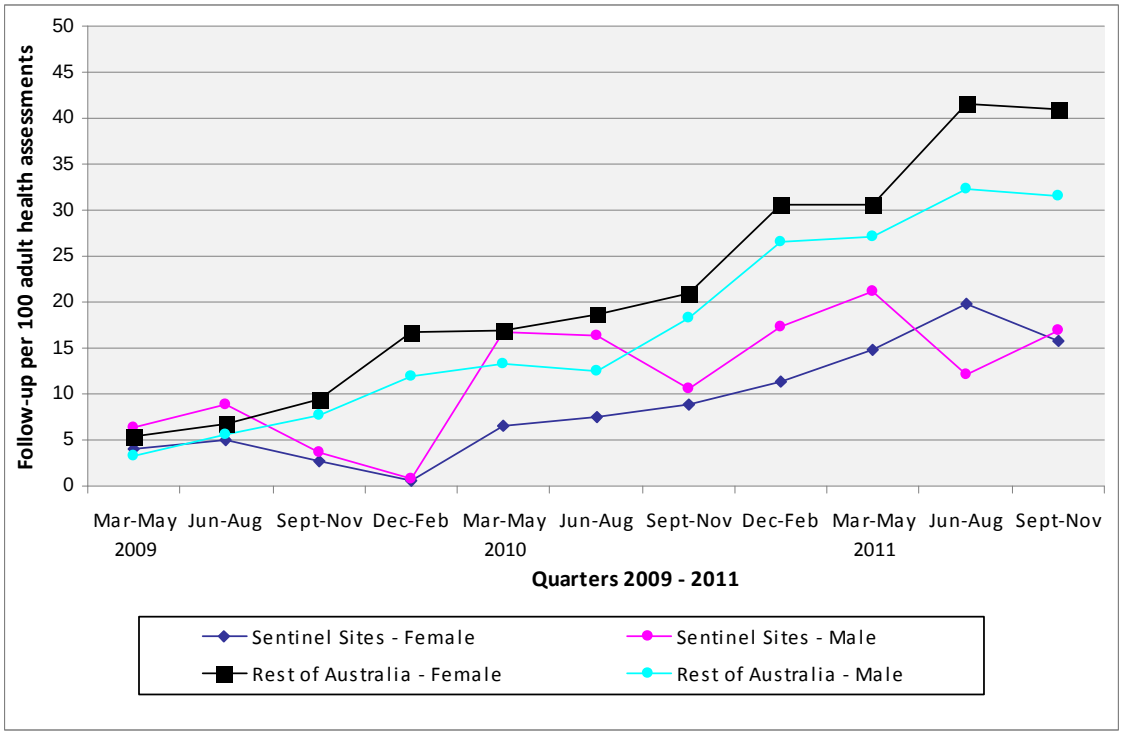


Figure 8.32: Follow-up services provided by a practice nurse or registered Aboriginal Health Worker per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS item 10987) for Sentinel Sites and the rest of Australia, by sex and quarter, March 2009 - November 2011

TRENDS BY GEOGRAPHIC LOCATION

From March 2010 - November 2011 very few claims were made in urban areas for this item (urban Sentinel Sites=227; rest of urban Australia=1446), compared to regional (regional Sentinel Sites=1291; rest of regional Australia=7382) and remote areas (remote Sentinel Sites=1112; rest of remote Australia=9747).

This pattern was apparent throughout the baseline period and the period of the ICDP implementation (Appendix H, Tables H11 and H12). However, urban Sentinel Sites and the rest of urban Australia showed increases in the use of these items from the September 2010 - November 2010 quarter to the September 2011 - November 2011 quarter.

FACTORS CONTRIBUTING TO OBSERVED TRENDS

During this reporting period, interviewees continued to indicate a number of reasons why utilisation and uptake of follow-up item numbers was low. These included:

- ***Lack of awareness of the follow-up item numbers available, particularly the Aboriginal-specific item numbers.*** The Aboriginal-specific item numbers were introduced in 2010. Previously health professionals used the general item numbers. There is in general a low awareness of the availability of these new item numbers and even where GPs are aware, it is difficult to change the habit of using the general item numbers. Informants noted that there was no particular incentive to them to use the Aboriginal-specific numbers.

  'In General Practice Aboriginal patients often only make up a small proportion of patients and so they would be less inclined to get head around Aboriginal specific item numbers when can just charge regular item numbers at no loss of funding to them.' (Feedback from tracking site)

  'Follow-up we are not doing many. It is hard to get RN and AHW to bill. The focus has been on health assessments.' (Interviewee, AHS)

- ***Confusion about eligibility to bill.*** There was confusion about eligibility of AHWs to bill against this number. Only in the NT are Health Services able to bill for services provided by AHWs against the follow-up by nurse or AHW item number. In all other states and territories Health Services can only bill for follow-up services provided by an AHW if the services are provided by the AHW in relation to his/her role as an allied health provider on a Team Care Arrangement and where the service is billed against the allied health follow-up item. There was significant confusion about billing for follow-up services provided by an AHW.
- Emphasis placed on adult health assessments, but no system established to follow up patients.

  'Health checks happen but nothing much happens after that. That's where it ends.' (Interviewee, AHS)

- ***Challenges with getting patients back for follow-up services after a health assessment.*** This included service organisation factors, such as clinical information systems recall and reminder system either not being used or too 'messy' and factors related to difficulties in contacting and finding patients for follow-up. 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.

Vignette - Practical challenges to recalling patients for follow up care

Service X is an AHS in a large remote site in which about half of the population identifies as Aboriginal and Torres Strait Islander. Two of the sixteen Aboriginal languages of the region are widely spoken - many Elders speak up to five languages. Traditional cultural is strong throughout the small, dispersed communities of the site where the AHS provides an outreach service. The Aboriginal population of the region is transient for a variety of reasons - for example, to access services and resources in larger centres, to connect with family, to uphold cultural practices.

Staff at the AHS identified a number of practical challenges to recalling patients for follow- up care. Patient contact details are difficult to update and use. Many people do not have telephones and mobile phones are often shared between family members. There is no postal delivery to some communities. Many people have limited English language and literacy skills.

Patient travel into the AHS or regional hospital for follow-up care is hindered by lack of public transport. Few patients have their own vehicles and the AHS has limited resources for transport, especially between the town and outlying communities. Some journeys take many hours and roads can be poor.

The AHS's patient information system is fully computerised, but at the time of the evaluation interview the patient recall and reminder system was not functioning because patient lists were not current.

In summary, AHS staff have many challenges to overcome in order to provide their clients in outlying communities with adequate follow up care.

SUMMARY OF KEY ISSUES

The key points that emerge from this analysis for MBS item 10987 include:

- The number of claims for follow-up services provided by a practice nurse or AHW was low overall. Some of this apparent lack of follow-up services may have been due to billing to other codes. Health Services indicated lack of awareness of some of the items, habits in billing that were difficult to shift and little incentive to bill against Aboriginal-specific items. In other cases it appeared that follow-up services were emphasised less than the adult health assessments and that this low delivery represented a lack of follow-up services.
- During the period of implementation, these claims have increased in both absolute terms and as a proportion of adult health assessments in the period of the ICDP implementation (March 2010 - May 2010 and onwards) (Figure 8.30, Appendix H, Tables 11 and 12).
- These claims for follow-up services provided by a practice nurse or AHW were largely driven by increases in services in regional and remote areas (Appendix H, Table H12). However, there was an increase in claims for follow-up services in urban areas in the September 2010 - November 2011 quarter.

8.6. Follow-up by allied health professionals

OVERALL TRENDS IN RELATION TO IMPLEMENTATION OF THE ICDP

Table 8.3 shows trends in claims for follow-up by allied health professionals for Sentinel Sites and the rest of Australia.

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 period, except from a minor peak in the March 2010 - May 2010 quarter (Table 8.3). The number of items claimed in the March 2011 - May 2011 quarter was more than twelve 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 H13 and H14) mean caution must be used in analysis of these data.

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 September 2011 - November 2011 quarter (Table 8.3) with the number of items claimed being more than five times the average claimed for the rest of Australia in the baseline period.

Table 8.3: Follow-up allied health services among Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) in Sentinel Sites and the rest of Australia, by quarter March 2009 - November 2011

Sentinel Site/ Rest of Australia	Follow-up items claimed										
	2009				2010				2011		
	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov	Dec-Feb	Mar-May	Jun-Aug	Sep-Nov
Sentinel Sites	33	31	40	47	123	99	104	141	272	390	488
Rest of Australia	130	169	267	354	370	426	787	655	945	930	1207

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 - November 2011 as reported in the section on health assessments above (see Section 8.3).

Claims for follow-up by an allied health professional were generally low. However, the number of claims has increased during the period of implementation of ICDP both in the Sentinel Sites and in the rest of Australia (Figure 8.33). The rate of increase appears to be greater for Sentinel Sites than the rest of Australia from March 2011 - May 2011. There were increases in claims in both Sentinel Sites and the rest of Australia from the September 2010 - November 2010 quarter until the September 2011 - November 2011 with a notably stronger increasing trend for Sentinel Sites than for the rest of Australia.

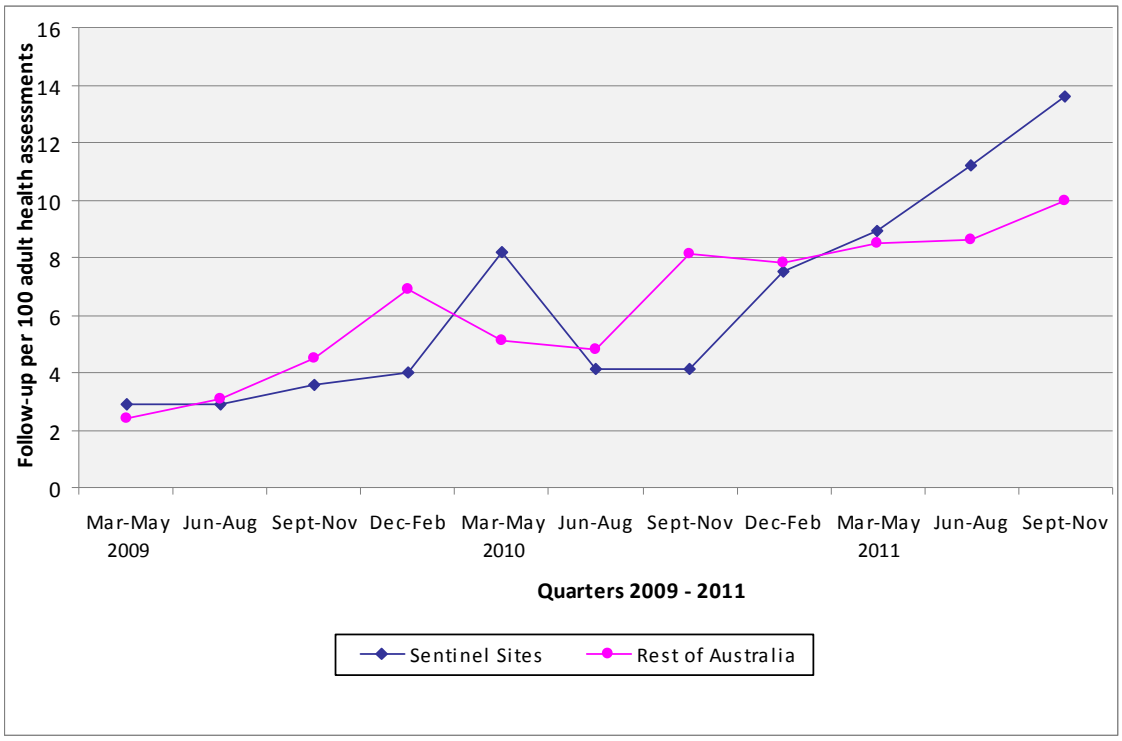


Figure 8.33: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS Items 81300-81360) for Sentinel Sites and the rest of Australia, by quarter, March 2009 - November 2011

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 and for Sentinel Sites increased for people aged 15-54 and for those aged ≥55 years, with the number of claims for services to the older group being about two to three times greater than for the younger group (Figure 8.34).

The trends in the number of MBS items claimed for follow-up by allied health professionals per 100 adult health assessments for the rest of Australia and for Sentinel Sites were similar for males and females, with the number of claims for services to females per 100 people tending to be slightly higher than for males (Figure 8.35).

Data by rurality are presented in the Appendices. Very few follow-up allied health items were claimed in remote areas in both Sentinel Sites and the rest of Australia (Appendix H, Table H14).

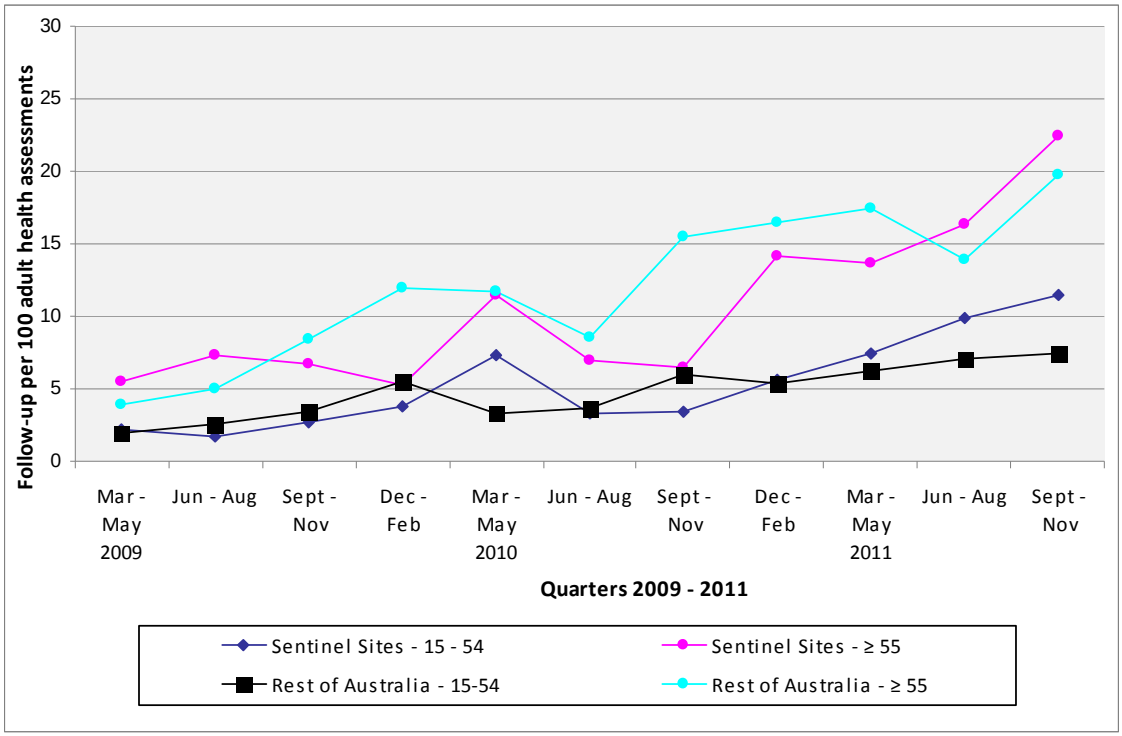


Figure 8.34: Follow-up allied health services per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS Items 81300-81360) for Sentinel Sites and the rest of Australia, by age and quarter, March 2009 - November 2011

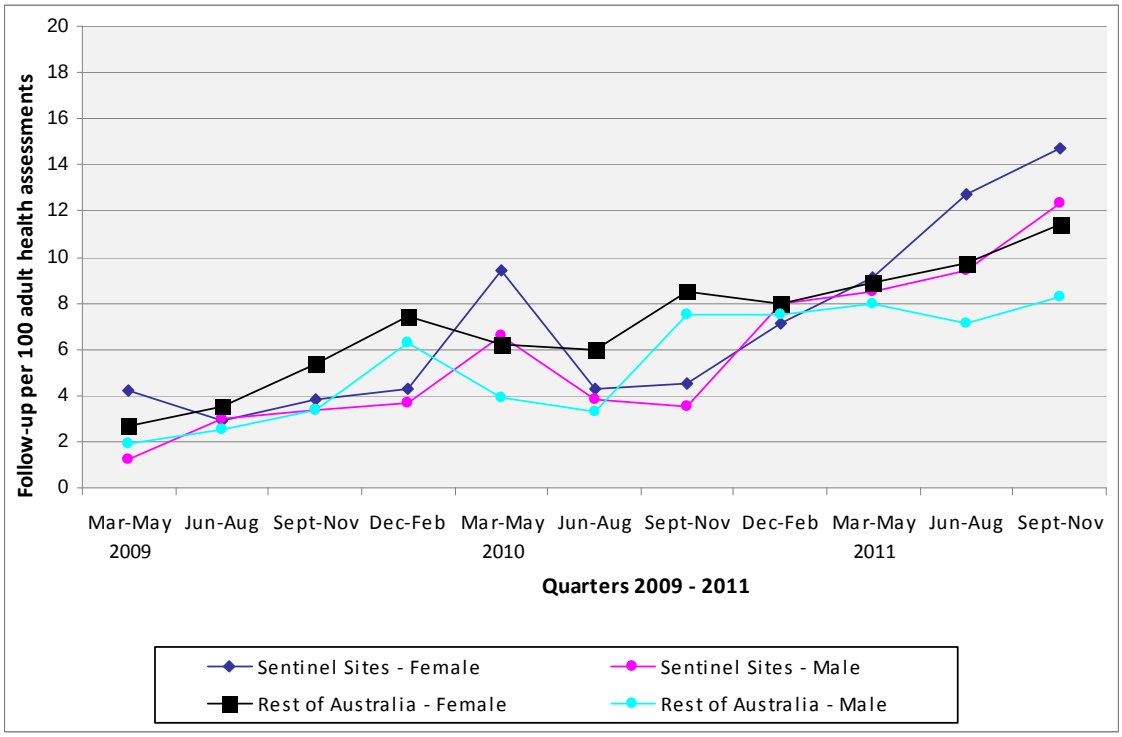


Figure 8.35: Follow-up by allied health professionals per 100 Aboriginal and Torres Strait Islander people aged ≥15 years who have received an adult health assessment (MBS items 81300-81360) for Sentinel Sites and the rest of Australia, by sex and quarter, March 2009 - November 2011

FACTORS CONTRIBUTING TO OBSERVED TRENDS

Interviewees indicated several reasons for the lack of claims for follow-up by allied health professionals. As outlined below, the factors contributing to the low uptake of this item included factors related to billing against these items, even if services were delivered, lack of services and challenges in getting patients to attend for follow-up services. Many of these factors were similar to those identified as influencing uptake of follow-up services by a practice nurse or AHW.

- Some stakeholders indicated that the allied health providers may be billing the regular MBS item numbers for the general population rather than the Aboriginal specific item numbers. This may be occurring due to the low proportion of Aboriginal and Torres Strait Islander patients. There are questions about developing new billing patterns when they can continue to bill as usual.

  'Low claiming of practice nurse and allied health numbers possibly because the item numbers are used that are for general population. Same for allied health … why use Aboriginal specific one … there is no incentive for them to … not paid any extra and so just use mainstream item number. Why create confusion with item numbers?' (Interview, Urban Site, Medicare Local)

- Allied health professionals employed by State health departments, DGPs or AHSs as salaried employees are not always eligible to bill Medicare. Services delivered by these providers are not showing up in the data. There was confusion over whether salaried allied health providers can bill Medicare.
- Some stakeholders observed that private allied health providers are not bulk billing and patients may be faced with a gap payment for allied health services or required to pay the full amount and claim the gap back from Medicare. General Practice staff indicated it was difficult to know which providers would bulk-bill on request and they did not generally have the capacity to notify allied health services beforehand to ensure the patients would be bulk-billed.

  'They have to pay first and then claim that gap … many patients can't afford the upfront payment … tend to utilise own in-house allied health if can and other public system allied health.' (Interview, Urban Site, AHS)

- In some sites the IHPOs and Care Coordinators (CCs) have been trying to establish which practices are bulk-billing and disseminating this information to Health Services though staff do not always access this information for a variety of reasons. This process can be time consuming as each provider needs to be contacted. There is a perception that allied health providers are not necessarily well oriented to claiming for Medicare items.
- A number of sites identified that shortages of allied health professionals to refer to in some areas is affecting use of this measure.
- Interviewees in some areas noted difficulties in getting patients to attend follow-up allied health appointments due to general access issues such as transport, long waiting times for appointments (which can be many months due to shortage of providers) and lack of reminder systems.

8.7. Summary

1. Overall, the utilisation of the MBS adult health assessment items has shown substantial increase from approximately two per 100 to around four to six per 100 people.
    1.1. Increased utilisation has coincided with the period of implementation of the ICDP, particularly with the roll-out of the PIP Indigenous Health Incentive and employment of OWs and IHPOs.
    1.2. Whilst some of the increase may be due to repeat adult health assessments (given the change from bi-annual to annual billing opportunities in 2010), indications are that a substantial part of the overall increase in uptake is due to adult health assessments being done for patients who have not previously received these assessments.
2. Whilst health assessments have increased for both older and younger age groups, levels for older people appear to have reached a plateau at around 9.5 per 100 people, whereas those for younger people have continued to increase. A number of factors could be contributing to this levelling off for older people.
    2.1. PIP registration appears to have provided an impetus for adult health assessments, which means that as PIP registrations reach a saturation point, we would expect assessments to tail off. This explanation fits in with the pattern of the data, as younger people are less likely to register for PIP due to lower rates of chronic disease. Younger people will show a slower but more sustained pattern of uptake.
    2.2. Other factors such as the age structure of population in different geographic locations coupled with different patterns of service provision may also play a role. These are described further in relation to the data disaggregated by rurality below.
3. Urban areas in general show a low number of overall health assessments claimed per 100 people, at less than three per 100 per quarter (or approximately twelve per 100 per annum).
    3.1. To the extent that older people are more likely to receive health assessments in general given their more frequent contact with Health Services, some of this difference may be due to different age structure of the population in urban compared to regional areas.
    3.2. Lower uptake in urban areas may also be related to different patterns of primary health care service provision in urban areas, with possibly a greater role played by private GPs in provision of care in urban settings; GPs may have less of a preventive health focus than AHSs.
4. For urban areas, the sites that achieved high number of adult health assessments were characterised by high numbers of GPs claiming adult health assessments and, to a lesser extent, high numbers of health assessments per GP provider. Additional factors influencing uptake in urban areas included having both AHS and private GP involvement in providing adult health assessments and staff with a particular focus on provision of adult health assessments.
5. Regional sites showed strong increases in number of adult health assessments, reaching six to seven assessments per 100 people in the September 2011 - November 2011 quarter.

6. In regional sites, both increased numbers of GPs claiming for adult health assessments and increased number of assessments per GP were key factors underlying the increased rates of adult health assessment achieved in some sites.

7. There was a wide variability in uptake of adult health assessments in remote Sentinel Sites. Where increases were observed in remote sites they appeared to be driven by changes in the number of health assessments completed per GP. There was no evidence in remote sites of an increased number of claiming GPs. A number of barriers were identified in relation to increasing uptake in remote sites.

    7.1. Barriers predominantly related to staffing constraints (e.g. lack of staff, high turnover of staff and high use of locums).

    7.2. Uptake in remote sites also appeared to be particularly sensitive to external events, such as extreme weather conditions/holiday periods (when staff capacity changed) and externally driven interventions such as the NT intervention.

8. Follow-up after adult health assessment remains a cause for concern. The number of claims for follow-up services provided by a practice nurse or AHW was low overall, although there is evidence of increase during implementation of ICDP.

    8.1. Some of this general lack of follow-up services may have been due to billing to other codes. These codes were introduced quite recently. Health Services indicated lack of awareness of some of the items; habits in billing that were difficult to shift and little incentive to bill against Aboriginal-specific items rather than general items.

    8.2. In other cases it appeared that follow-up services were emphasised less than adult health assessments and that lack of follow-up was considered a significant issue impacting on care quality.

    8.3. The overall increase in claims for follow-up services provided by a practice nurse or AHW was largely driven by increases in services in regional and remote areas with some more recent increase in urban areas.

9. The number of claims for follow-up by allied health professionals showed similar low uptake as described above for follow-up by a practice nurse or registered AHW. Similar factors influencing uptake were identified as described above. An additional factor appeared to be lack of transparency around whether or not providers were going to bulk-bill, acting as a disincentive to referral. In addition, there was a lack of allied health professionals to refer to in some areas.

10. Overall, this analysis indicates that in order to achieve high population coverage of health assessments:

    10.1. In urban areas, it is necessary to have large numbers of GPs doing at least a moderate number of health assessments. It will be difficult to achieve high population coverage through having a limited number of GPs undertaking health assessments even if these GPs do relatively large numbers of health assessments each.

    10.2. In regional areas, (where there tends to be a lower number of GPs per 100 Aboriginal and Torres Strait Islander people than in urban areas) it is necessary to have a high proportion of GPs each doing a high number of health assessments.

10.3. In remote sites, (where there are particular constraints on the availability of GPs) it is also necessary for available GPs to undertake large numbers of adult health assessments; the major limitation on achieving population coverage is the restricted availability of GPs for this purpose.

9. SUPPORTING PRIMARY CARE PROVIDERS TO COORDINATE CHRONIC DISEASE MANAGEMENT (*MEASURE B3 PART A*)

9.1. Description of measure

The Australian Government is providing payments through the Practice Incentives Program (PIP) Indigenous Health Incentive to support accredited General Practices and AHSs to provide better health care for Aboriginal and Torres Strait Islander people, including best practice and 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.[101]

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 fifteen 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).[102]
  - 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.[103] Majority of care refers to the provision of the majority of eligible MBS services, with a minimum of five eligible MBS services expected through the calendar year. Items such as commonly used GP attendance items and Chronic Disease Management items are included. [104]

[101] DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf> (accessed 5 April 2012).
[102] DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010, <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/indigenous-health-incentive-guidelines.pdf> (accessed 5 April 2012).
[103] DoHA, Supporting Primary Care Providers to Coordinate Chronic Disease Management – Fact sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf> (accessed 5 April 2012).
[104] DoHA, Practice Incentives Program Indigenous Health Incentive Guidelines – September 2010, <http://www.medicareaustralia.gov.au/provider/incentives/pip/files/indigenous-health-incentive-guidelines.pdf> (accessed 5 April 2012).

9.2. Program logic

As specified in the National Framework the following outcomes hierarchies in relation to measure B3 Part A, and relevant to the current stage of implementation, include:

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 twelve 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.

9.3. State of implementation – national context

The following information was provided by DoHA in February 2012 at a national level (relevant to SSE):[105,106,107]

- PIP News Updates are sent to Health Services quarterly with their payment advice statements as a key method of communication.
- The November 2011 PIP News Update presented the following statistics with information on improving uptake:
  - Around 43 % of Health Services that have signed-up to the PIP Indigenous Health Incentive had not registered any patients.
  - Thirty-nine per cent of patients registered in 2010 were re-registered in 2011.
  - Five per cent of eligible patients were registered in 2010.

[105] DoHA, B3a report, 14 February 2012.
[106] Practice Incentives Program [website], <http://www.medicareaustralia.gov.au/provider/incentives/pip/news-archive.jsp> (accessed 31 May 2012).
[107] DoHA, B3a update, 29 February 2012.

- The February 2012 PIP News Update reiterated the process for Health Service sign-up, patient registration, annual patient re-registration and Tier 1 outcomes payments.
- The current version of the PIP Indigenous Health Incentive Multiple Registration Form was uploaded to the PIP website on 3 August 2011 (although it has been available since mid to late 2010). The form was created to assist Health Services to register a number of patients on one form particularly in the re-registration process. This information was also included in the November 2011 PIP News Update. In addition the Medicare Liaison Officers were advised the form was available for use and advised Health Services on their routine visits.
- The deadline for Health Services to meet the cultural awareness training requirement for two staff after twelve months sign-up was 10 April 2012. SBO advised members, recounted from the PIP Indigenous Health Incentive section of DoHA that DoHA was aware some Health Services had not completed the training due to circumstances outside their control or it had taken longer than they expected to finish the course. In this case a Health Service should make a note and keep it on file as to why the training did not occur. Similarly, for the training yet to be completed and what the Health Service is planning to do to complete accredited training even if there is going to be some delay due to the preference for face to face training. This documentation will be accepted should the Health Service be audited against the obligations of signing on to the PIP Indigenous Health Incentive.[108]

9.4. Findings from the Sentinel Sites

NOTES ON COLLECTION, ANALYSIS AND INTERPRETATION OF DATA

Stakeholders in eight case study and two enhanced tracking sites were interviewed about their awareness and perceptions of the PIP Indigenous Health Incentive. Additional information was provided by stakeholders during feedback visits at three tracking sites.

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 focus groups held in eight case study sites.

The administrative data presented in this report is for a period until November 2011, the timing of the interviews (February 2012 - May 2012) and of when PIP Indigenous Health Incentive administrative data becomes available to the SSE team. This means that the data that interviewers have available for discussion with key informants at each site relate to a period of up to 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 until May 2011). 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.

[108] General Practice NSW, PIP Indigenous Health Incentive e-communication, 13 April 2012.

In considering the data presented below on the PIP Indigenous Health Incentive please note the following:

- PIP Indigenous Health Incentive data provided by the DoHA are presented for the period March 2010 - November 2011.
- The focus of the analysis is on the uptake of this measure for Aboriginal and Torres Strait Islander people aged ≥15 years in the Sentinel Site compared to the rest of Australia.
- The analysis is a cumulative analysis over the course of the year for which people are registered, which means that the data for each quarter shows the total number of registered people at the end of the quarter (not the number of people who have been newly registered in that quarter).
- People are required to register each year so that registrations only cumulate annually where annual is defined as a period that covers the twelve months prior to December. Hence, for year 2010, the numbers of people signed up for the PIP Indigenous Health Incentive were cumulated up to the end of November and, for the year 2011, numbers were cumulated from December 2010 up to end of November 2011.
- For AHSs or General Practices that have a head office and branches in different locations, an anomaly has been identified when interpreting PIP data at the site level. If only the head office is registered for the PIP incentive, and is outside the site, then the branch data will not be included within the site data extraction as it will have been attributed to the head office. This effect can occur in reverse for those organisations with the head office in the site and branches outside the site. Caution should be exercised when interpreting the site data in respect to this issue. In the case of the head office outside the site, the PIP data presented for specific sites is likely to reflect a lower level of PIP Indigenous Health Incentive activity than is actually occurring. The size of the effect will depend on the level of activity of the clinic in relation to activity for all other services in the site.
    - For this report the data presented for the site of Elizabeth is affected by the 'branch office' issue. The site data do not include the AHS PIP Indigenous Health Incentive uptake for registrations or payments. Other sites that potentially may be affected are Brisbane South (which includes a branch of the ATSICHS organisation that may or may not be included), and North Lakes/Caboolture (which has a branch of the IUIH that may or may not be included in the data).
    - The sites of Port Augusta and Swan Hill/Mildura may be affected by the reverse situation, because both have head offices inside the sites and smaller clinics outside the site.
    - These effects could also be occurring in larger corporate General Practices with different branches.

AWARENESS OF THE MEASURE

There is a high level of awareness of the PIP Indigenous Health Incentive amongst key informants. Awareness has been steadily increasing over reporting periods, with 99% (77/78) of interviewees in the current reporting period indicating they were aware of the PIP Indigenous Health Incentive (Figure 9.1). Awareness of the incentive amongst key informants in remote sites [94% (15/16)] was only slightly lower than for regional and urban sites (100%).

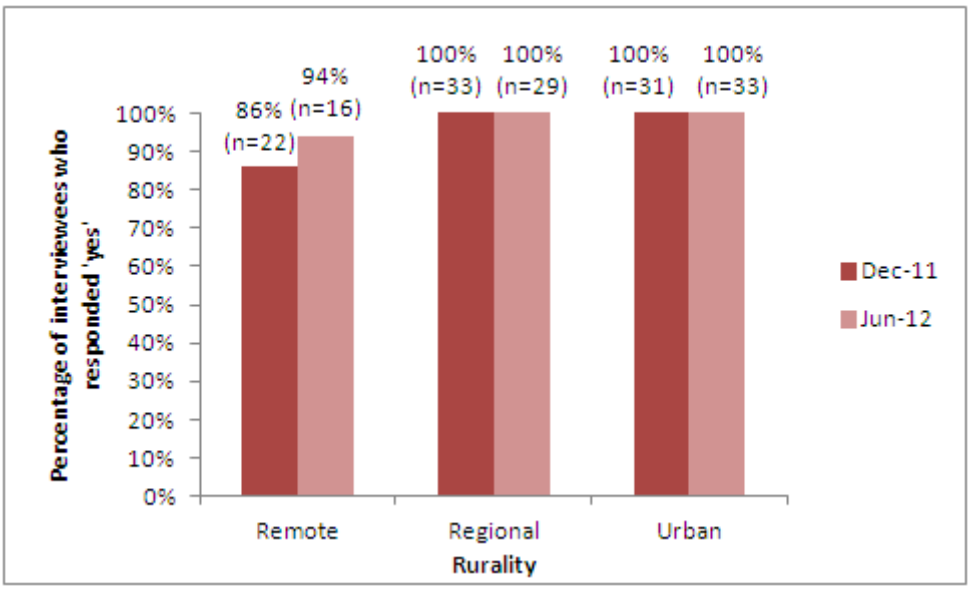


Figure 9.1: Awareness of PIP Indigenous Health Incentive (% who responded 'yes'), overall and by rurality

This high level of awareness may not be universal as private General Practices that have an interest in Aboriginal health were selected to participate in the SSE. Interviewees from service organisations were identified as individuals who would be expected to have an understanding of the ICDP.

Community focus group members had varying levels of awareness of the PIP Indigenous Health Incentive, with some being unaware of the measure, others having some awareness but being uncertain about whether they were registered and some having good awareness and speaking about receiving letters regarding re-registration. Some focus group participants questioned why there needed to be a re-registration process.

A number of interviewees questioned the purpose and intended benefits of the measure. It was commonly reported by interviewees, across both sectors and by people in a variety of positions, that Health Services receive large amounts of information from a variety of sources and they had difficulty processing the information and ensuring it was distributed to all relevant people in the organisation.

> *'Need everything to be simplified. It's a complex package with lots of nuances. GPs don't have time to read through all the promotional material and the finer Medicare details. Materials developed just gather cob webs. Need a face to face presence to discuss and bring to their attention.'* (Feedback from tracking site visit)

INFORMING ORGANISATIONS OF THE PIP INDIGENOUS HEALTH INCENTIVE

Similar to the previous two reporting periods, almost two-thirds [63% (20/32)] of interviewees agreed with the statement that *'stakeholder organisations were clearly informed of the new PIP Indigenous Health Incentive'* while 25% disagreed and 16% responded 'don't know/can't say'. In this reporting period responses to this statement from interviewees in remote sites were less positive (eight out of ten agreeing in previous reporting period compared to four out of eight in the current reporting period), although the small number of interviewees mean these data should be treated with caution. In contrast, interviewees in urban [63% (10/16)] and regional sites (six out of eight) tended to provide more positive responses to the statement. The lower level of agreement in remote sites may be affected by one remote site

having recently commenced registering patients and not feeling that they were well informed about the incentive.

Interviewees identified the following sources as providing information about the PIP Indigenous Health Incentive:

- Medicare Liaison Officers, Medicare Indigenous hotline and PIP Indigenous Health Incentive hotline (AHSs in particular noted these sources).
- State/territory NACCHO affiliates (specific to AHSs). This was not consistent across states/territories with interviewees in some sites reporting they had no contact with the NACCHO affiliate about the PIP Indigenous Health Incentive. In this instance the IHPO did not see it as part of the role to provide information about the PIP Indigenous Health Incentive with the perception this was the role of the Public Health Medical Officer. However, NACCHO affiliates generally indicated that they play an important function in supporting AHSs with provision of information and support for the implementation of the PIP Indigenous Health Incentive.

  'Don't know how services would cope without our support because you are ringing the PIP line and getting all this incorrect information and all these situations that are happening within the services with patients, you won't get that (help) from the PIP line. IHPO provides information to all QLD Aboriginal Health Services.' (Interviewee, NACCHO affiliate)

- Other Health Services, through informal networking and requests for support and information, including communication between private General Practice and the AHS sector.

  '[AHS name] is receiving quite a few calls from GPs to check/confirm the PIP IHI details. AHS, by default, is being used as a resource by GPs.' (Interviewee, AHS)

  'We've spent a lot of time on the phone speaking to other Aboriginal Medical Services to find out how they run their PIP Program and they were in the same boat, didn't really know what they were doing.' (Interviewee, AHS, practice manager)

- The IHPO and the CCs based in the DGP, as reported previously, were identified as important sources of information about the PIP Indigenous Health Incentive through practice visits, resource development and phone support. This source was predominately identified by the private General Practice sector.
- The SBO were identified by DGP staff as providing information about the PIP Indigenous Health Incentive and support through opportunities to attend workshops and distributing information through email lists.
- In a number of interviews the SSE team were noted as the main source of information about the PIP Indigenous Health Incentive.

  'Largely from Menzies, know of coordinators of [NACCHO affiliate name] but never seen or spoken to them. We have had no information from anywhere besides what we have picked up from the evaluation team.' (Interviewee, AHS, Medical Director)

Frustration was expressed across both sectors about information not being consistent across all information sources or even sometimes from the same source. A number of SBOs and NACCHO affiliate identified this as a concern that was being expressed by their members. This

frustration was predominately directed at the hotlines. This is illustrated by the quote presented below:

> *'When you ring the number you get someone new, each time you ring about the same patient you get different information. [Name of CC] says one thing, Medicare says another, it's a pain up the backside, painful. The supports I find contradictory from Medicare, Care Coordinator, help lines … we ring Medicare and they give the wrong information for example Medicare said a year from registration date for re-registration, Medicare also said from the financial year and from 1 January.'*
> (Interviewee, private General Practice, RN)

As reported over the previous two reporting periods, interviewees stressed the importance of continuing awareness raising activities for the PIP Indigenous Health Incentive. In the context of this discussion, interviewees continued to refer to emerging issues regarding re-registration of patients, ways to optimise Tier 1 and Tier 2 payments and ongoing staff turnover within Health Services.

The above comments need to be interpreted in the light of a general perception among Health Service staff that they have been clearly informed of the PIP Indigenous Health Incentive. Specific areas for improvement appear to be in ensuring consistently accurate information is provided and that all relevant staff are engaged.

As noted in the PBS Co-payment (Section 7) a number of interviewees indicated the value of having someone come and discuss the ICDP package as a whole. The SSE team was frequently identified by key stakeholder organisations as playing an important role in this regard. The IHPOs appear to be the only ICDP funded workers who might have a reasonable understanding of the whole of the ICDP, even if they are often focused in their role on a particular aspect of the ICDP and have a large number of services to cover.

HEALTH SERVICES REGISTERING FOR THE PIP INDIGENOUS HEALTH INCENTIVE BY LOCATION

Table 9.1 shows the number of Health Services that received the sign-on payment for the PIP Indigenous Health Incentive. Around 60% of PIP participating Health Services in Sentinel Sites and 55% of PIP participating Health Services in the rest of Australia had registered for the PIP Indigenous Health Incentive by November 2011.

Data provided by DoHA show that more than 40% of those that had signed up had not registered any patients. This indicates that over $1 million has been paid to Health Services that have not yet played any active role in the ICDP.

A higher percentage of general PIP participating Health Services had registered for the PIP Indigenous Health Incentive in regional areas (regional Sentinel Sites = 75%; rest of regional Australia = 69%) than in urban areas (urban Sentinel Sites = 55%; rest of urban Australia = 45%). In remote areas the percentage of general PIP participating Health Services registering for the PIP Indigenous Health Incentive was higher in rest of remote Australia (95%) than in the remote Sentinel Sites (63%).

Table 9.1: Number of Health Services registered for the PIP Indigenous Health Incentive sign-on payment for Sentinel Sites and the rest of Australia by rurality and quarter, March 2010 - November 2011

Sentinel Sites/ Rest of Australia	No. of Health Services registered for the PIP Indigenous Health Incentive sign-on payment							
	Mar-May 2010	Jun-Aug 2010	Sep-Nov 2010	Dec 2010-Feb 2011	Mar-May 2011	Jun-Aug 2011	Sep-Nov 2011	Total
Urban								
Urban Sentinel Sites	89	43	31	33	34	42	31	303
Rest of Urban Australia	373	225	141	100	99	172	97	1207
Regional								
Regional Sentinel Sites	47	19	25	12	14	10	11	138
Rest of Regional Australia	277	165	121	79	76	100	56	874
Remote								
Remote Sentinel Sites	5	<5	<5	<5	<5	<5	<5	7
Rest of Remote Australia	62	19	20	12	5	11	6	135
Total								
Total Sentinel Sites	141	63	57	45	48	52	42	448
Rest of Total Australia	712	409	282	191	180	283	159	2216

Note: <5 means that there were less than five, and for confidentially reasons the data are not presented.

NUMBER OF HEALTH SERVICES PER 1000 ABORIGINAL AND TORRES STRAIGHT ISLANDER PEOPLE

Overall around six 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 seven Health Services per 1000 Aboriginal and Torres Strait Islander people in the rest of Australia (Figure 9.2).

The total number of Health Services (Aboriginal Health Services and private General Practices) receiving the sign-on payment for the PIP Indigenous Health Incentive per 1000 Aboriginal and Torres Strait Islander people was higher in urban areas than regional areas, and higher in regional areas than in remote areas (Figure 9.2).

- In urban areas, about twelve Health Services per 1000 Aboriginal and Torres Strait Islander people received the sign-on payment in Sentinel Sites and about fifteen Health Services per 1000 people received the sign-on payment in the rest of urban Australia.
- In regional areas, about five Health Services per 1000 people received the sign-on payment in Sentinel Sites and about nine Health Services per 1000 received the sign-on payment in the rest of regional Australia.
- In remote areas there was approximately one Health Service registered per 1000 people that received the sign-on payment in Sentinel Sites and two 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 a larger number in regional compared to remote locations.

It is also clear that the number of Health Services registered per 1000 people differs between Sentinel Sites and the rest of Australia. This is most marked in regional and remote locations, where the number of services per 1000 people in the rest of regional and remote Australia is about twice that in Sentinel Sites. The magnitude of the difference between the rest of Australia and Sentinel Sites is less marked in urban areas.

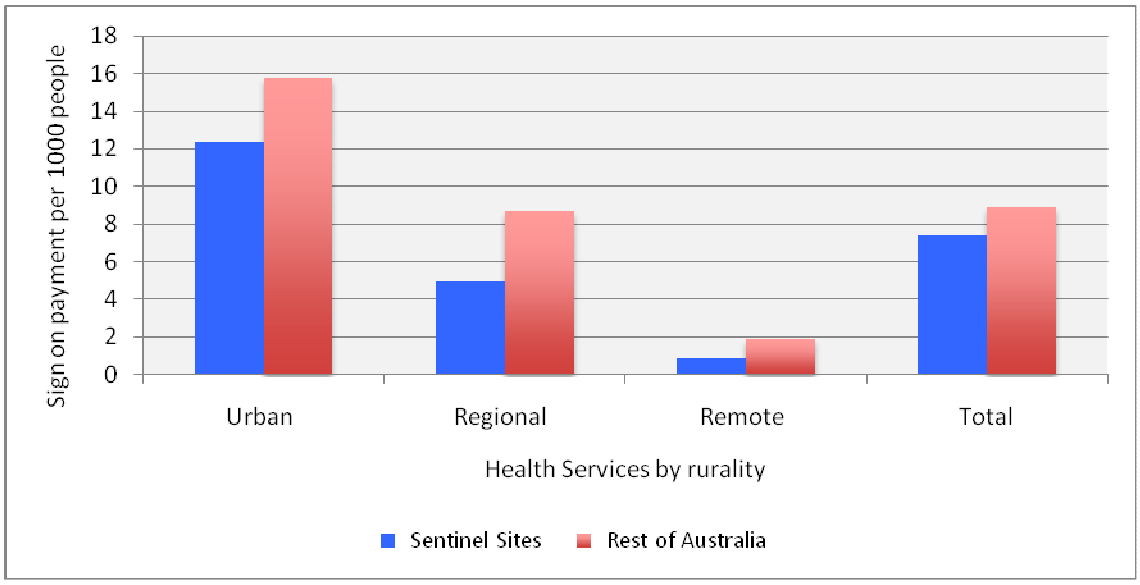


Figure 9.2: Number of Health Services receiving the PIP Indigenous Health Incentive sign-on payment 1000 Aboriginal and Torres Strait Islander people aged ≥15 years in Sentinel Sites and the rest of Australia, by rurality November 2011

TIMING OF HEALTH SERVICES REGISTERING FOR THE PIP INDIGENOUS HEALTH INCENTIVE

Figure 9.3 shows a relatively steady increase in the number of new Health Service registrations from May 2010 through to end of November 2011.

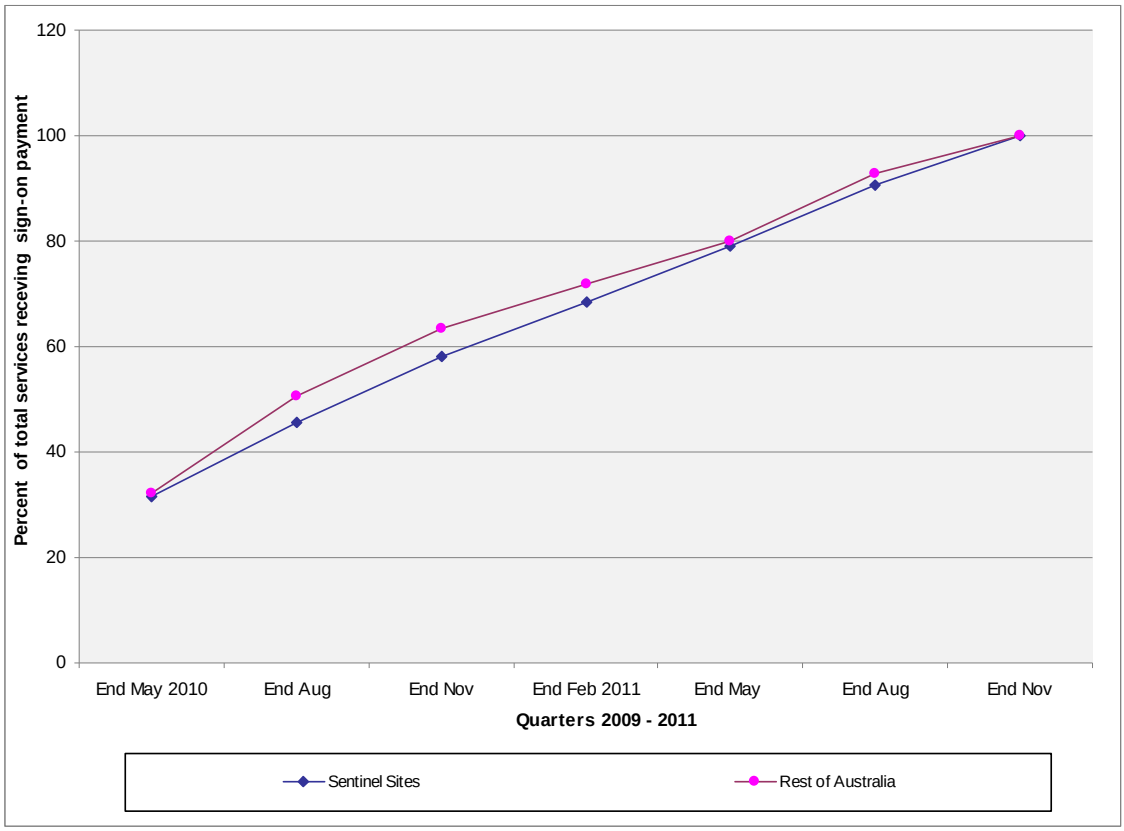


Figure 9.3: Health Services that have received the PIP Indigenous Health Incentive sign-on payment (as a percentage of the total number that received the sign-on payment during the period covered by this report) for Sentinel Sites and the rest of Australia, by quarter.

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 access to an AHS is more limited than in the Sentinel Sites.

PERCEPTIONS OF ADMINISTRATIVE BURDEN

Over the duration of the evaluation between 40 and 60% of interviewees have 'strongly or partly agreed' with the statement *'the PIP Indigenous Health Incentive has caused a large administrative workload'* (Table 9.2) with no clear increasing or declining trend. Patterns were generally similar across remote, regional and urban sites, but with wider variation due to small numbers.

In this reporting period interviewees have reported that the re-registration processes are contributing to the administrative workload.

Table 9.2: Trends in perceptions of the new PIP Indigenous Health Incentive as causing a large administrative workload (% who responded 'strongly agree' or 'partly agree'), overall and by rurality

	Rurality	December 2010	June 2011	December 2011	June 2012
The PIP Indigenous Health Incentive has caused a large administrative workload. MS, CS, PM[a]	Overall	59% (n=34)	42% (n=74)	45% (n=83)	55% (n=77)
	Remote	57% (n=7)	67% (n=12)	37% (n=19)	53% (n=15)
	Regional	57% (n=14)	29% (n=38)	42% (n=33)	45% (n=29)
	Urban	62% (n=13)	50% (n=24)	52% (n=31)	64% (n=33)

[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 numerator are the respondents who indicated 'don't know/can't say'.

As previously reported, about half of clinicians [48% (14/29)] interviewed agreed that the PIP Indigenous Health Incentive has caused a large administrative burden. Similar to last reporting period about a third (8/29) of clinicians also indicated that they 'don't know/can't say'. This is in sharp contrast to practice managers [67% (10/15)] who in this reporting period indicated that it had caused a large administrative burden in comparison to 35% (6/17) in the previous reporting period. Clinicians interviewed continued to indicate that the administrative burden falls on reception staff and practice managers, and that it was not an administrative burden for clinicians. Interviewees indicated that it was practice managers generally who were undertaking the paperwork and developing systems to manage the registration process for patients.

There has been a marked shift between sectors in perceptions of clinicians and practice managers regarding administrative burden since the previous reporting period (Figure 9.4). In AHSs there has been a decrease in perception of administrative burden [55% (11/20) in the previous period compared to 43% (9/21) in this reporting period] compared to private General Practice where there was an increase [35% (9/26) in the previous reporting period compared to 65% (15/23) in this reporting period].

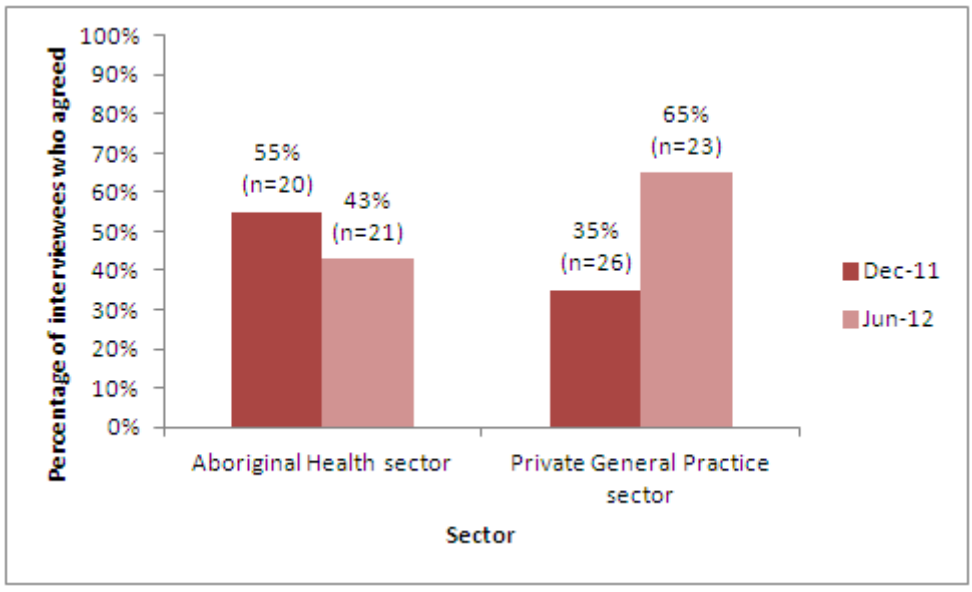


Figure 9.4: Clinicians' and practice managers' response to the statement 'The PIP Indigenous Health Incentive has caused a large administrative workload' (% who responded 'strongly agree' or 'partly agree')

A likely explanation for the difference may be related to a generally much larger number of eligible patients in AHSs compared to private General Practices. With large numbers of eligible patients, AHS have greater incentive to establish systems to manage the sign-up process. In private General Practices with smaller numbers of eligible patients means there is relatively little incentive to develop practice systems. There is a perception that the potential benefit is not worth the effort. However, there were a number of private General Practice interviewees who indicated that as they *'are not dealing with thousands of people this is manageable.'*

We reported previously that there was some evidence of development of systems within the Health Services to manage the registration and re-registration processes. In this reporting period there is further evidence of development of such systems and increasing familiarity with the process.

> *'PIP-IHI has definitely got easier. People are now used to it and it has been embedded into their systems.'* (Interviewee, AHS, CEO)

> *'Initially the paperwork was done by the doctors now the reception staff. Re-registration is an administrative burden on the clinic reception staff.'* (Interviewee, AHS, GP)

Interviewees associated the administrative burden with the paper work involved in registering and checking eligibility of 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. The nature of the administrative burden was as for the previous report.

> *'Too much paperwork, makes a large administrative workload and more burden for the staff. Simple reason is that without calling Medicare there's no way to simply check whether the patients have been registered in any other practice or not. It's difficult without any clear direction of a simple way to check rather than needing to call up every time and wait. Especially if they have registered with other practice and sometimes they need to know the dates is the main issue. It would be nice to just have this process simpler because they have already consented to be registered in the practice. Make it simpler than going through the whole process again. Part of the money from the incentive is therefore being used to assist with this administrative burden.'* (Interviewee, private General Practice, GP)

SYSTEMS BEING ESTABLISHED

A number of issues related to system developments relevant to implementation of the PIP Indigenous Health Incentive were identified in previous SSE reports. Many of the same issues continue to impact on the effective implementation of the PIP Indigenous Health Incentive. These include:

- The lack of efficient information systems that can be used to identify patients for re-registration is a barrier in the re-registration process.

  > *'It takes extra time to find out if someone needs to be re-registered and registering them. Unsure of the current recording system after the reception staff started doing it. Initially the actual hard copies were filed and it was required to flick through the hard copies when the patients have been registered.'* (Interviewee, AHS, GP)

- A number of stakeholder interviewees in Health Services indicated that there is no place on patient information systems to clearly mark if patients are PIP registered.
- Strategies for promoting registration of patients varied between Health Services and continued to include a) registering patients on an ad hoc basis as patients present b) undertaking a 'big push' to promote and undertake registration of patients including in community venues and c) sending out letters asking patients to come in and register.
- Concern continued to be expressed about difficulties for patients and service providers in identifying PIP Indigenous Health Incentive registered Health Services to enable access for care and also for PBS Co-payment prescriptions when people are away from home. There was no evidence of community focus groups participants or other stakeholders being aware of any registers of PIP Indigenous Health Incentive practices.
- Interviewees continued to identify a need for an on–line or telephone system to establish if a patient has been registered at another Health Service. Interviewees continued to express frustration about spending time registering patients to later discover they were already registered with another Health Service.

ORGANISING ACCESS TO THE PIP INDIGENOUS HEALTH INCENTIVE

In this reporting period, over two-thirds [70% (62/89)] 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'* (Table 9.3). About one quarter [26% (23/89)] disagreed with the statement and 4% (4/89) responded that they 'didn't know or couldn't say'. Table 9.3 shows there has been a general increase in agreement with the statement across reporting periods and across ruralities. There is a marked recent increase in agreement in remote and regional sites, but agreement continues to be relatively low in remote sites.

Table 9.3: Trends in perceptions of ease of access to the PIP Indigenous Health Incentive (% who responded 'strongly agree' or 'partly agree'), overall and by rurality

	Rurality	December 2010	June 2011	December 2011	June 2012
Organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy. MS, CS, OW, PM[a]	Overall	46% (n=35)	47% (n=77)	51% (n=91)	70% (n=89)
	Remote	0% (n=7)	8% (n=12)	25% (n=20)	56% (n=18)
	Regional	57% (n=14)	44% (n=39)	44% (n=36)	70% (n=33)
	Urban	57% (n=13)	69% (n=26)	71% (n=35)	76% (n=38)

[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 numerator are the respondents who indicated 'don't know/can't say'.

Clinicians are becoming more positive about the ease of organising access to the PIP Indigenous Health Incentive [59% (17/29) agreed with the statement in Table 9.3 in the previous reporting period compared to 79% (23/29) in this reporting period]. Practice managers also continued to be positive about ease of organising access to the PIP Indigenous Health Incentive [70% (12/17) in the previous reporting period compared to 86% (13/15) in this reporting period].

Figure 9.5 demonstrates that across both reporting periods, both the Aboriginal Health sector and the private General Practice sector clinicians and practice managers are increasingly

positive with ease of access to the PIP Indigenous Health Incentive for Aboriginal and Torres Strait Islander people.

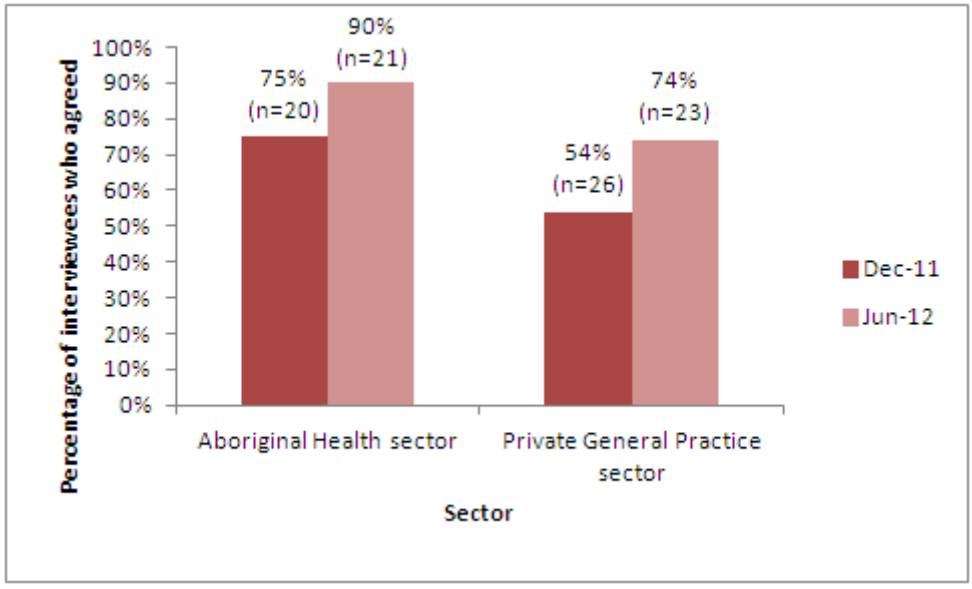


Figure 9.5: Clinicians' and practice managers' response to the statement 'Organising access for Aboriginal and Torres Strait Islander people to the PIP Indigenous Health Incentive has been easy' (% who strongly or partly agreed), by sector

NUMBER OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE REGISTERED FOR THE PIP INDIGENOUS HEALTH INCENTIVE

Figure 9.6 shows the number of people registered for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres Strait Islander people ≥15 years for Sentinel Sites compared to the rest of Australia from May 2010 - November 2011. The 2011 data includes people who were registered for the first time in 2011 and people who were registered in 2010 and re-registered for 2011. The PIP Indigenous Health Incentive requires annual registration and one of the major challenges for the PIP Indigenous Health Incentive is maintaining registration levels in each year. There is concern that once drivers associated with initial registration such as access to PBS Co-payment measure are no longer salient that PIP Indigenous Health Incentive registrations will drop off. The data presented below show that the number of registrations per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 exceeds the number of registrations in 2010 in both the Sentinel Sites (50% increase) and the rest of Australia (45% increase). The data on re-registrations to the PIP Indigenous Health Incentive measure show that a large part of the increase in registrations in 2011 compared to 2010 is due to first time registrations and these are probably driven by interest in gaining access to the PBS Co-payment.

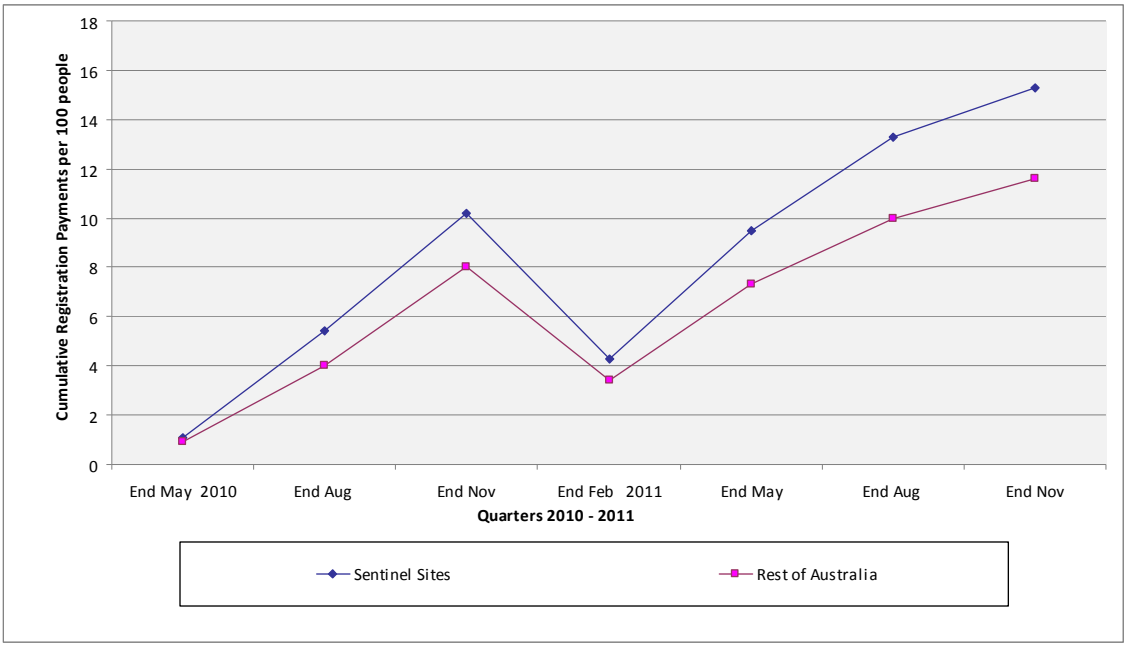


Figure 9.6: Cumulative number of people registering for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for Sentinel Sites and the rest of Australia, by quarter March 2010 - November 2011

TRENDS IN REGISTRATION BY GEOGRAPHIC LOCATION

The trends in registrations per 100 Aboriginal and Torres Strait Islander people varied according to geographic location (Figure 9.7-9.9). Registrations per 100 Aboriginal and Torres Strait Islander people were higher in regional areas and lower in remote areas than urban areas (Appendix I, Tables I1 and I2).

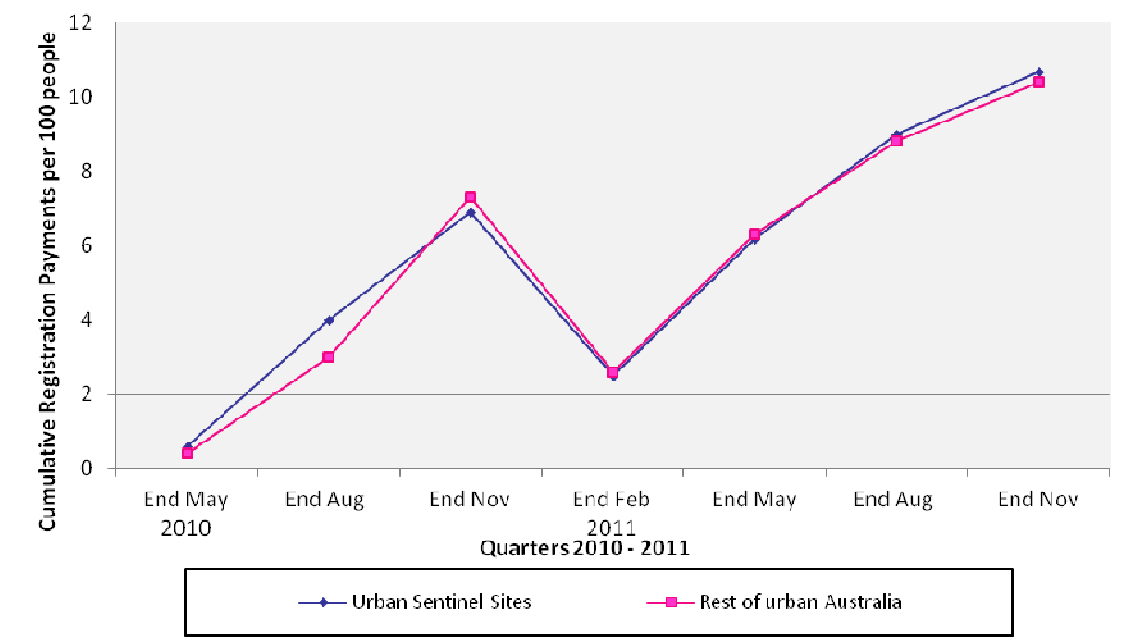


Figure 9.7: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia by quarter March 2010 - November 2011

The increase in number of registrations per 100 Aboriginal and Torres Strait Islander peoples at the end of November 2011 compared to end of November 2010 is evident in both the Sentinel Sites and the rest of Australia (Figure 9.7).

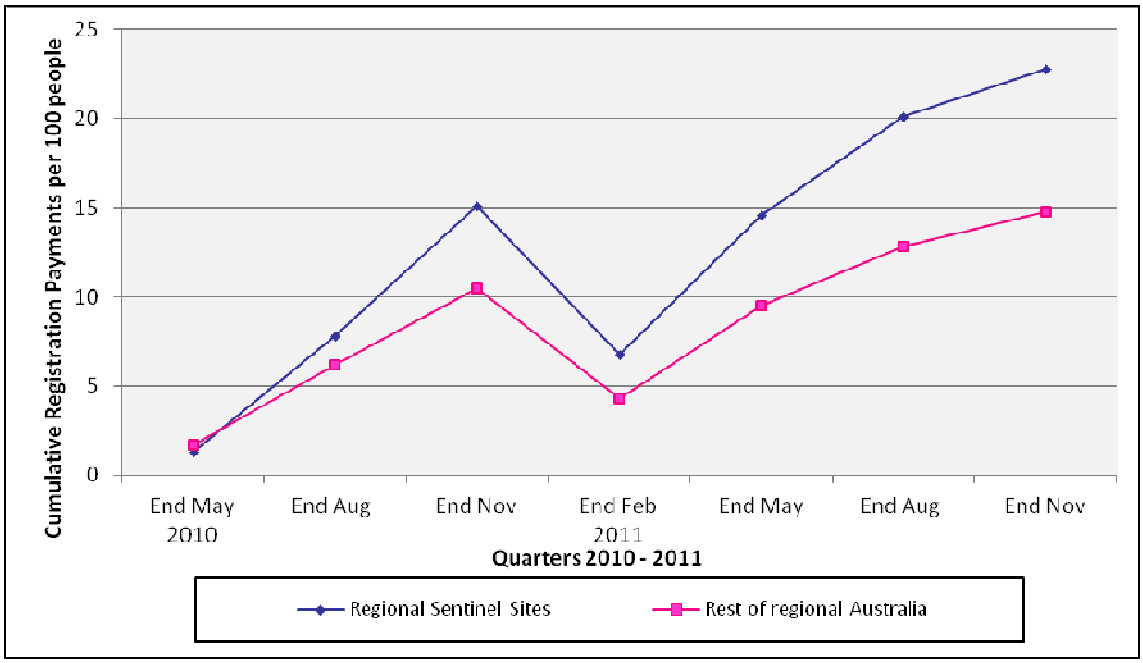


Figure 9.8: Patients registered (PIP Indigenous Health Incentive Patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for regional Sentinel Sites and the rest of regional Australia by March 2010 - November 2011

The trends in regional areas similarly show the number of registrations per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 exceeded the number of registrations in 2010 in both the Sentinel Sites and the rest of regional Australia (Figure 9.8).



Figure 9.9: Patients registered (PIP Indigenous Health Incentive patient Registration Payment) per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia by quarter March 2010 - November 2011

In remote areas the number of registrations per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 showed a relatively large proportional increase over the number of registrations in 2010 in AHSs in Sentinel Sites while there was only a marginal increase in the rest of remote Australia (Figure 9.9).

RE-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 evaluation cycle for which data on re-registration of patients can be reported on. The data on re-registrations presents some complications for analysis, as the available data do not allow for analysis of unique registrations. Therefore, registrations for 2011 included first time registrations and re-registration of people who had been registered in 2010.

Most of the registrations up to November 2011 were first time registrations rather than re-registrations. Re-registration rates were around 31% in Sentinel Sites and 27% in the rest of Australia (Figure 9.10).

Re-registration was higher in Sentinel Sites than the rest of Australia in all areas. This was particularly true of remote Sentinel Sites where over 40% of 2011 registrants had previously registered.

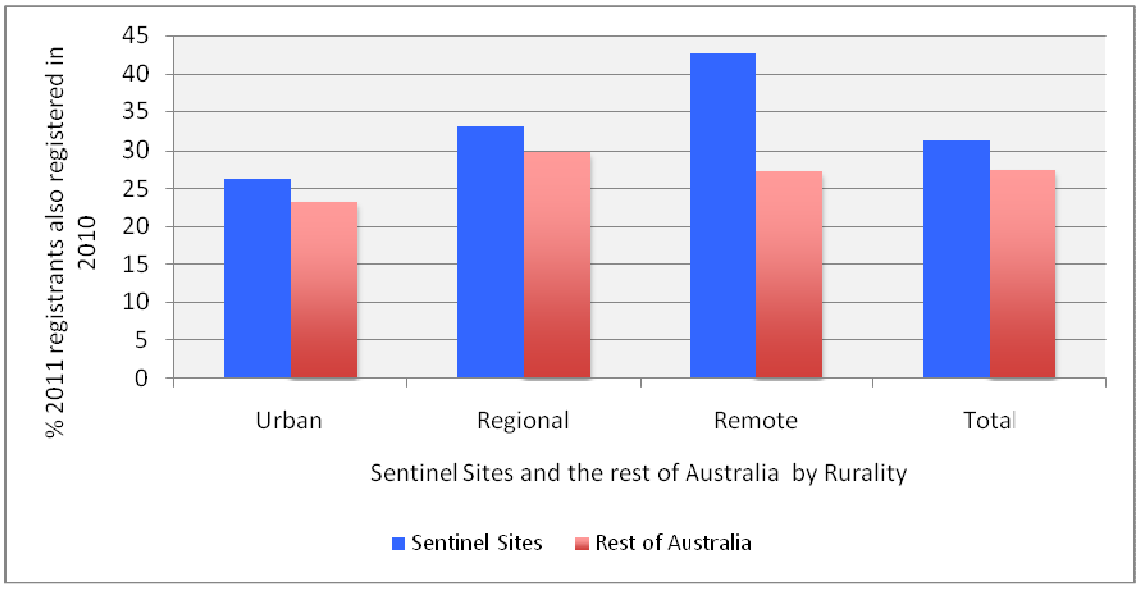


Figure 9.10: Percentage of 2011 registrants (November 2011) who were also registered in 2010, by Sentinel Sites and the rest of Australia and rurality

Urban Sentinel Sites

In urban Sentinel Sites, Brisbane South, Campbelltown and Canberra, the number of registrations per 100 Aboriginal and Torres Strait Islander people was greater than for the rest of urban Australia at the end of November 2010 (Figure 9.11). At the end of November 2011 numbers of registrations per 100 people at Brisbane South, Canberra, Elizabeth and Logan/Woodridge were greater than for the rest of urban Australia. There were particularly large increases in numbers of registrations in Logan/Woodridge and Elizabeth. The number of registrations per 100 people in Campbelltown and Newcastle were similar to those for the rest of urban Australia. The number of registrations per 100 people in Dandenong was particularly

low compared to other urban sites and to the average for the rest of urban Australia over most of the period covered by this report, with little sign of any increase over time. North Lakes/Caboolture also had generally lower numbers of registrations over the period covered by this report, but with a clear increase over time.

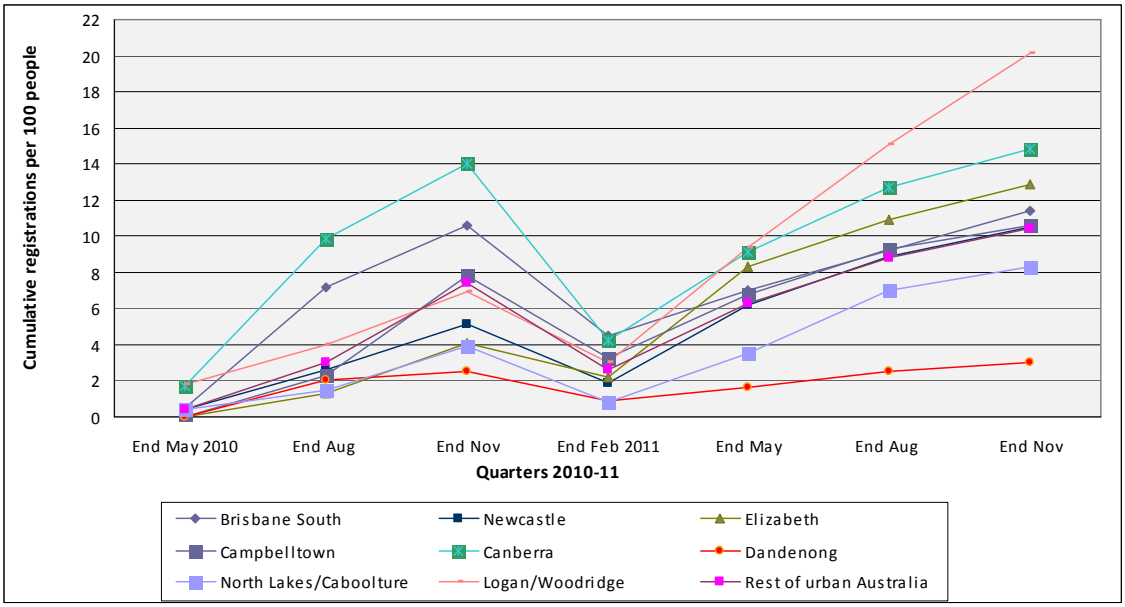


Figure 9.11: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia and quarter, March 2010 - November 2011

The percentage of re-registrations by November 2011 in Brisbane South, Canberra, Campbelltown, Newcastle, North Lakes/Caboolture were higher than for the rest of urban Australia. The percentage of re-registrations by November 2011 was lower than the rest of urban Australia in Elizabeth, Logan/Woodridge and Dandenong (Figure 9.12).

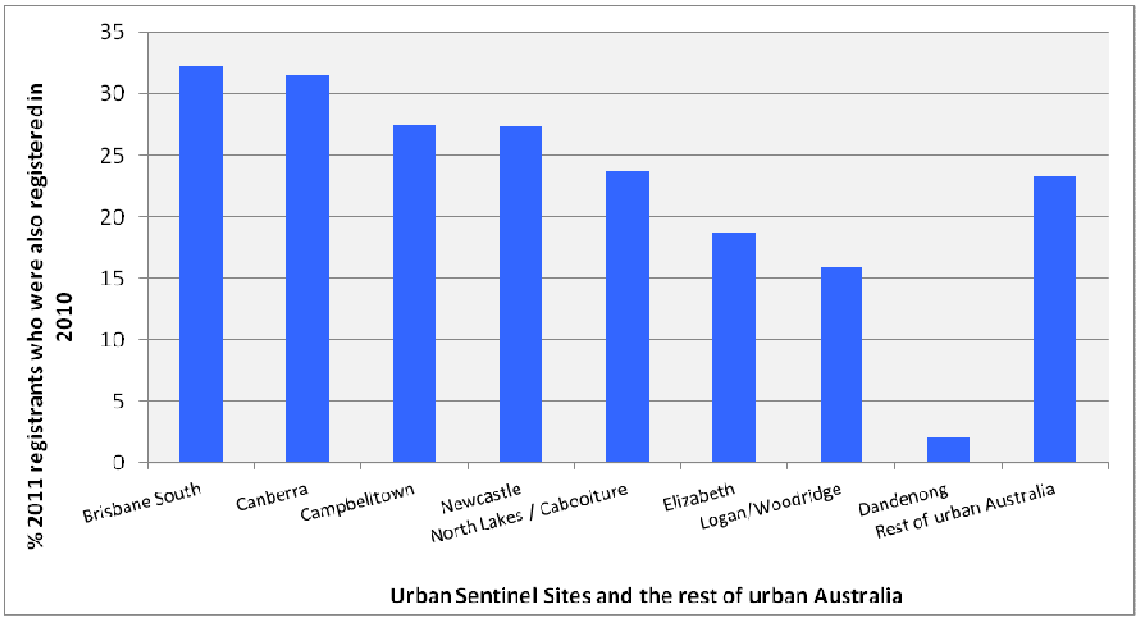


Figure 9.12: Percentage of 2011 registrants (November 2011) who were also registered in 2010, by urban Sentinel Sites and rest of urban Australia

Regional Sentinel Sites

Of the twelve regional Sentinel Sites, eight had higher levels of registration per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 than at the end of November 2010. This is consistent with the pattern for the rest of regional Australia, which showed about a 50% increase in registrations between November 2010 and November 2011 (Figures 9.13-9.16).

There was a particularly marked increase in registrations in Dubbo between November 2010 and November 2011. Cairns and Swan Hill/Mildura had relatively high numbers of registrations in November 2010 and showed notable increases from November 2010 to November 2011.

In contrast, the number of registrations per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 compared to the end of November 2010 in Bairnsdale and Grafton there were half and less than half respectively.

Hobart and Gladstone showed persistently low numbers of registrations over both 2010 and 2011.

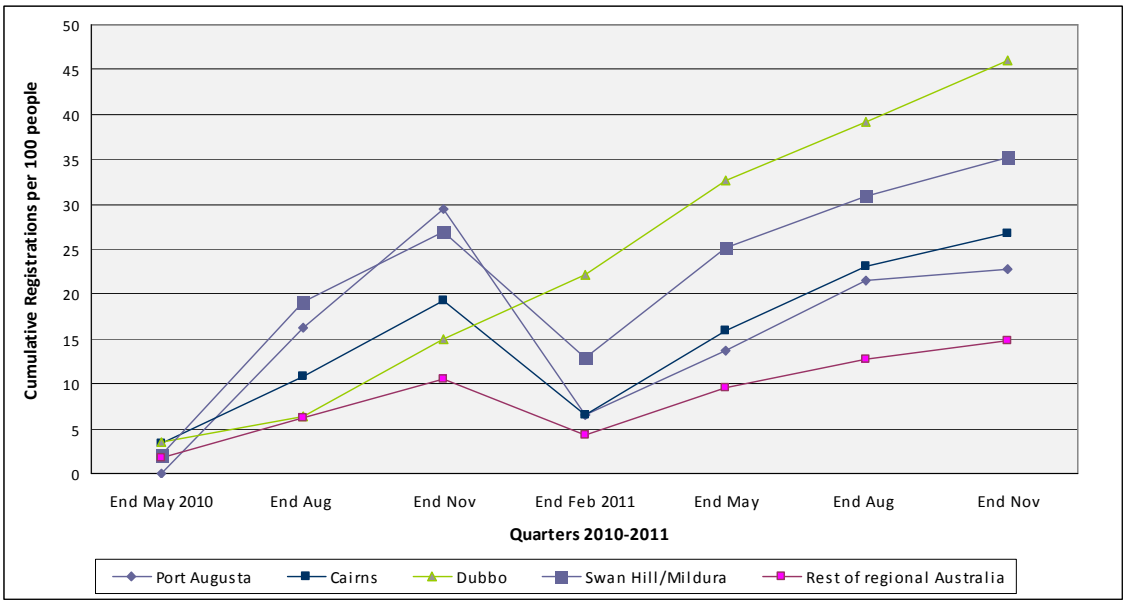


Figure 9.13: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 1 Sentinel Sites and the rest of regional Australia by quarter, March 2010 - November 2011

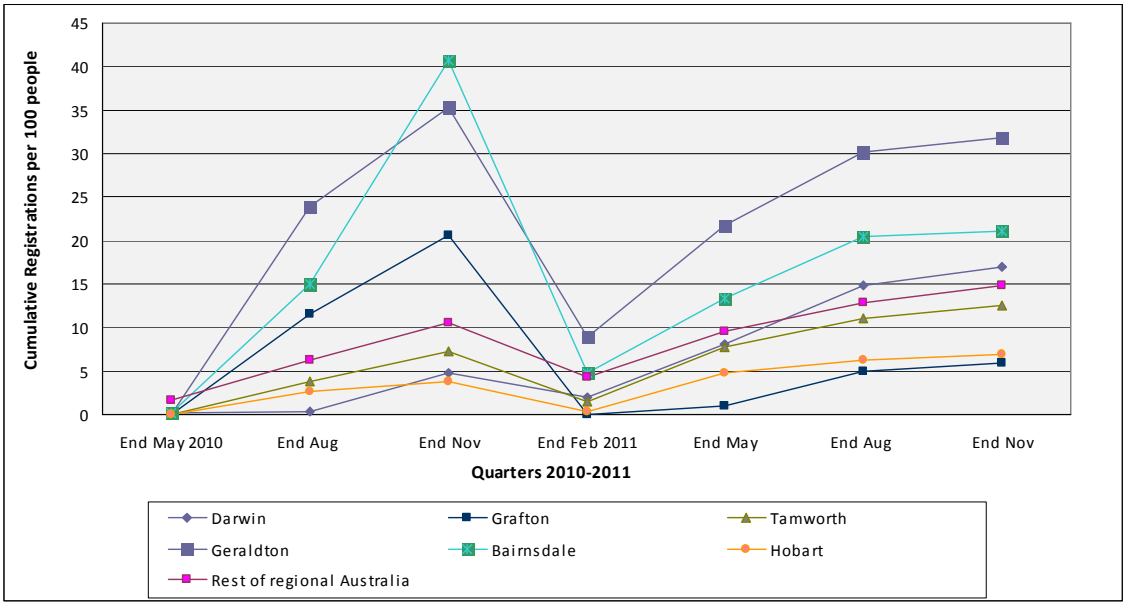


Figure 9.14: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 2 Sentinel Sites and the rest of regional Australia, by quarter, March 2010 - November 2011

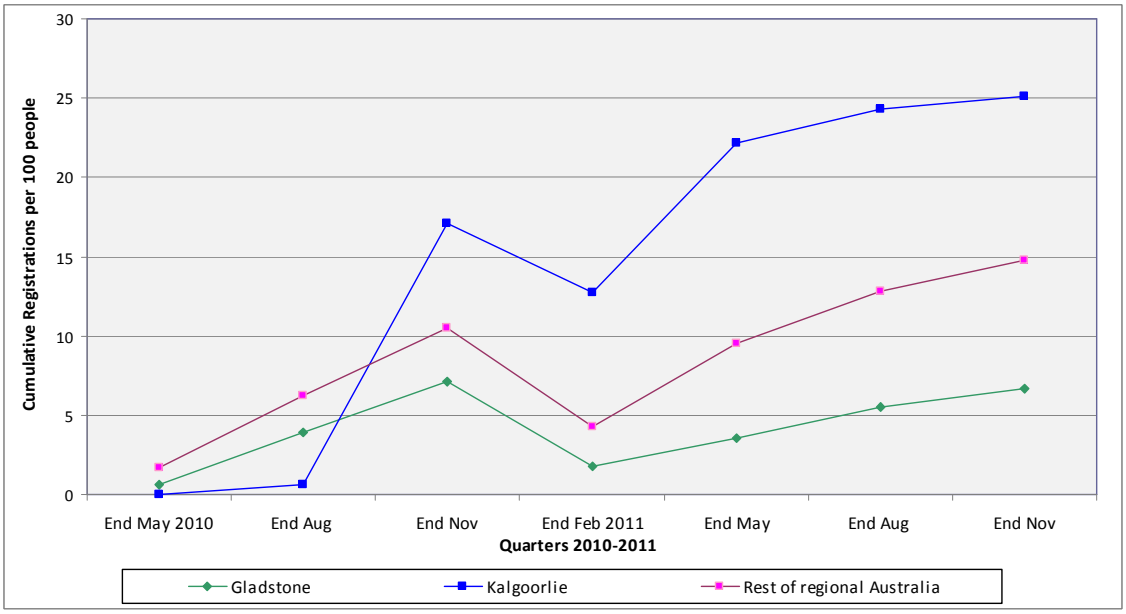


Figure 9.15: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for regional stage 3 Sentinel Sites and the rest of regional Australia by quarter, March 2010 - November 2011

The percentage of re-registrations by November 2011 was above 40% in Port Augusta, Bairnsdale, Geraldton and Hobart. In Cairns, Grafton and Tamworth re-registration by November 2011 was between 30-40% of all 2011 registrants and was higher than for the rest of regional Australia. Re-registration was similar to rest of regional Australia in Kalgoorlie and Swan Hill/Mildura at around 30%. It was lower than the rest of regional Australia in Gladstone, Dubbo and Darwin (Figure 9.16).

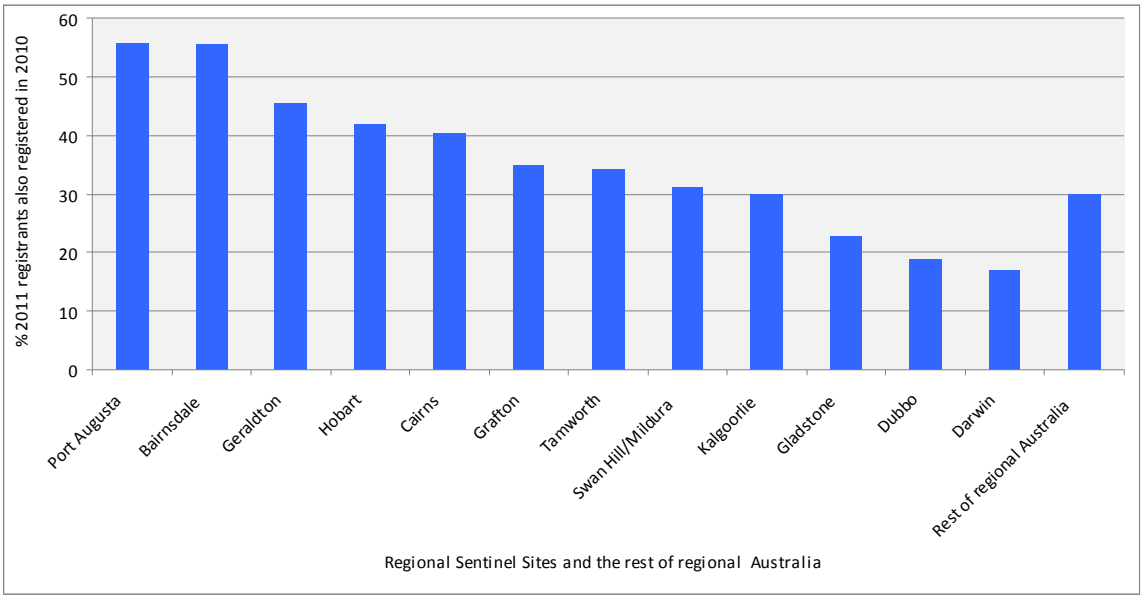


Figure 9.16: Percentage of 2011 registrants (November 2011) who were also registered in 2010, by regional Sentinel Sites and rest of regional Australia.

Remote Sentinel Sites

In remote areas, levels of registration were driven by a relatively small number of Health Services. Of the four remote Sentinel Sites, two (East Pilbara and Barkly) had higher levels of registration per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 than at the end of November 2010. The pattern for the rest of remote Australia (Figure 9.17) also showed an increase in registrations at the end of November 2011 compared to the end of November 2010 (about 30% increase). In contrast, in Derby there were fewer registrations per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 than there were at the end of November 2010.

No registrations were recorded 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. In this reporting period Katherine West had commenced processing PIP Indigenous Health Incentive registrations, but these are not yet evident in the data.

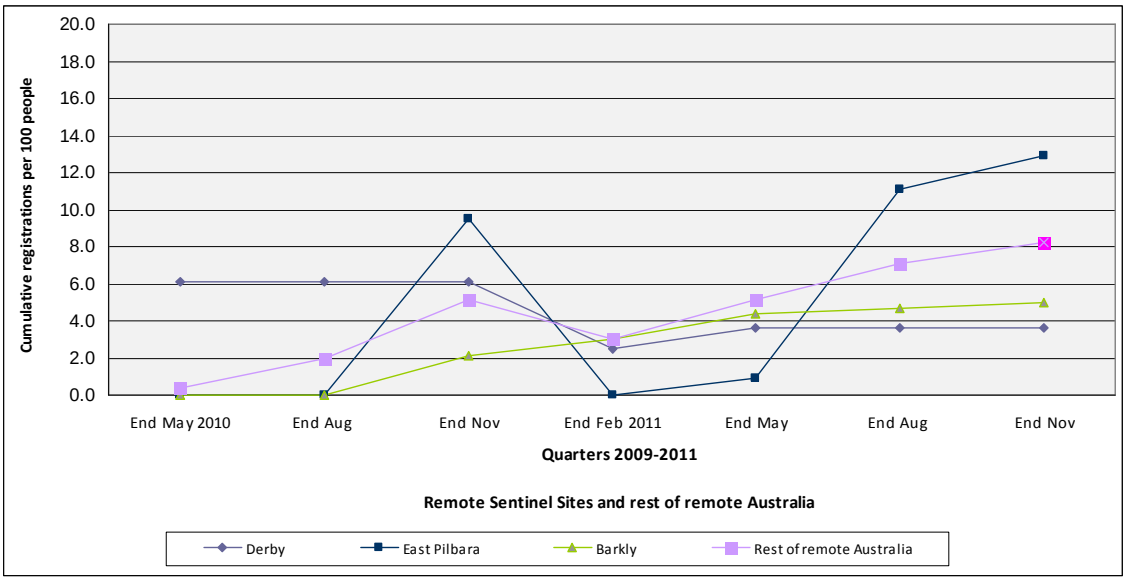


Figure 9.17: Patients registered (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia by quarter, March 2010 - November 2011

The percentage of re-registrations by November 2011 was very high in Derby and the East Pilbara compared to the rest of remote Australia. No re-registrations were noted in Barkly (Figure 9.18).

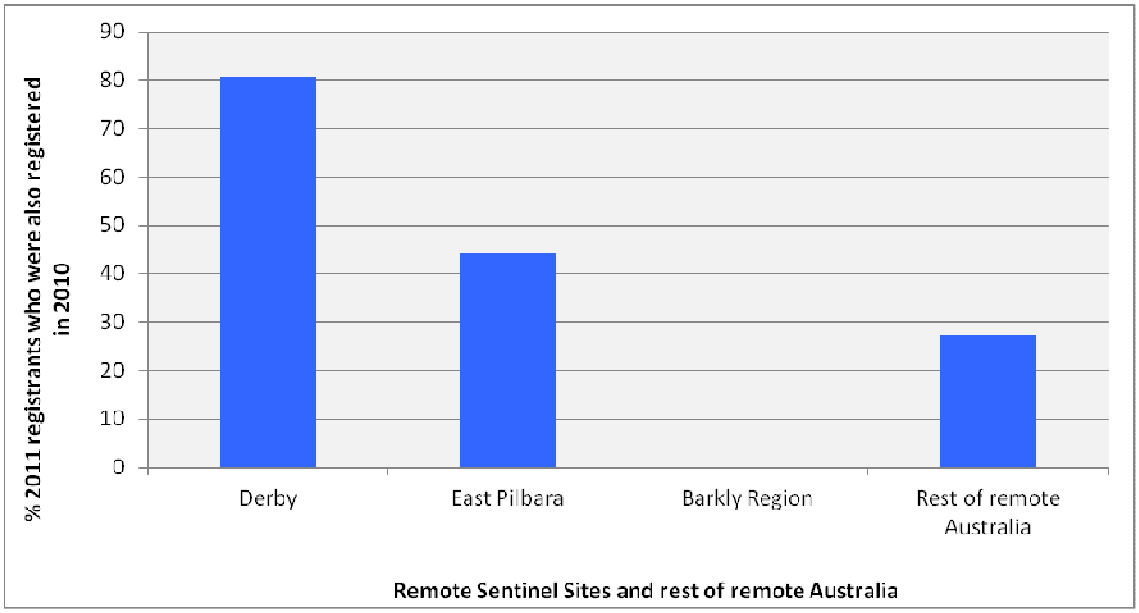


Figure 9.18: Percentage of 2011 registrants (November 2011) who were also registered in 2010, by remote Sentinel Sites and rest of remote Australia

RELATIONSHIP BETWEEN PIP INDIGENOUS HEALTH INCENTIVE REGISTRATION AND PBS CO-PAYMENT REGISTRATION

Table 9.4 shows that there were almost as many people registered for the PBS Co-payment as there were for the PIP Indigenous Health Incentive, except in remote Sentinel Sites where there were about a third of the number of people registered for the PBS Co-payment as there were registered for the PIP Indigenous Health Incentive. This appears largely due to low numbers of PBS Co-payment registrations in East Pilbara and Derby.

Table 9.4: Registration for the PBS Co-payment among PIP Indigenous Health Incentive registrants in 2010 for Sentinel Sites and the rest of Australia, by rurality, age and sex

Sentinel Sites and the rest of Australia		**PBS and PIP registrants by age and sex**				
		Female		**Male**		**Total**
		15-54 years	**55+ years**	**15-54 years**	**55+ years**	
Urban						
Urban Sentinel Sites	PBS registrants	1574	594	1032	370	3570
	PIP Indigenous Health Incentive registrants	1597	606	1040	374	3617
	No. of PBS registrants as a % of PIP registrants	98.56	98.02	99.23	98.93	98.70
Rest of urban Australia	PBS registrants	5148	1884	3452	1252	11 736
	PIP Indigenous Health Incentive registrants	5197	1906	3483	1263	11 849

	No. of PBS registrants as a % of PIP registrants	99.06	98.85	99.11	99.13	99.05
Regional						
Regional Sentinel Sites	PBS registrants	3494	1453	2565	1072	8584
	PIP Indigenous Health Incentive registrants	3518	1469	2580	1080	8647
	No. of PBS registrants as a % of PIP registrants	99.32	98.91	99.42	99.26	99.27
Rest of regional Australia	PBS registrants	8216	3539	6221	2595	20 571
	PIP Indigenous Health Incentive registrants	8320	3586	6300	2624	20 830
	No. of PBS registrants as a % of PIP registrants	98.75	98.69	98.75	98.89	98.76
Remote						
Remote Sentinel Sites	PBS registrants	66	51	34	17	168
	PIP Indigenous Health Incentive registrants	179	134	96	60	469
	No. of PBS registrants as a % of PIP registrants	36.87	38.06	35.42	28.33	35.82
Rest of remote Australia	PBS registrants	2807	1380	1970	1071	7228
	PIP Indigenous Health Incentive registrants	3004	1457	2083	1143	7687
	No. of PBS registrants as a % of PIP registrants	93.44	94.72	94.58	93.7	94.03

ELIGIBILITY CRITERIA FOR THE PIP INDIGENOUS HEALTH INCENTIVE

As reported in previous reporting periods, there was a good level of understanding of the PIP Indigenous Health Incentive eligibility criteria amongst stakeholders with 81% (62/77) of interviewees agreeing with the statement '*patient eligibility criteria for PIP Indigenous Health Incentive are workable in practice'* [compared to 73% (61/83) in the previous reporting period].

There was a high level of agreement to this statement from clinicians and practice managers in both private General Practice [87% (20/23)] and AHSs [90% (19/21)] (Figure 9.19). This pattern is contrary to most other responses to statements where managers are generally more positive. We are not clear as to why this appears to be the reverse situation in relation to this statement.

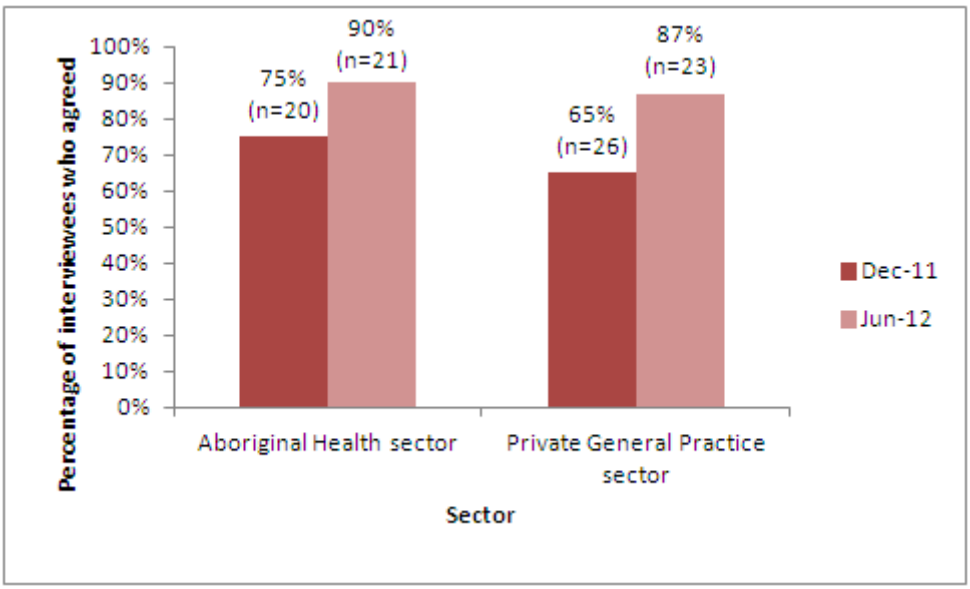


Figure 9.19: Clinicians' and practice managers' response to the statement 'Patient eligibility criteria for the PIP Indigenous Health Incentive are workable in practice' (% who responded 'strongly agree' or 'partly agree') by sector

Concerns raised about the eligibility criteria for the PIP Indigenous Health Incentive in this reporting period were similar to the previous reporting period and include:

- Concern about being unable to register patients with a chronic disease who were under 15 years of age

  'Confusion on the requirements is caused with PBS and PIP-IHI. If you have got a ten years old with asthma therefore suffering from the chronic disease they are not eligible for the PIP, they will have to wait another five years to be eligible. Don't really understand the thinking around the age criteria. It does not make sense at all.' (Interviewee, AHS, CEO)

- Confusion about, or lack of understanding of, the difference in eligibility criteria for the PBS Co-payment and the PIP Indigenous Health Incentive
- Small number of interviewees identified difficulty or discomfort in asking about Aboriginal or Torres Strait Islander descent and raised concerns about self-identification of Aboriginal and Torres Strait Islander status.

  'The proof for people whether Indigenous or non-Indigenous is a bit of a complicated issue. Sometimes patient would come and say that they are Indigenous and we have to take the word of the patient that they are Indigenous. Do not know if there are any other ways to confirm this or better way to find it out. It's not like the driver's license or Medicare card it's written there. In the practice it's not too [much] of an issue when they say they know few of the Elders that we know. We think then probably it is ok to record them as Indigenous. In the software we make sure to tick the boxes if Indigenous.' (Interviewee, private General Practice, GP)

  'Some of the patients are white and they come and say I am Aboriginal that makes it difficult to find out.' (Interviewee, private General Practice, GP)

The concerns about identification are relevant to the PIP Indigenous Health Incentive and the PBS Co-payment measure. These issues reflect the ongoing need for cultural awareness training and for Health Service staff to develop skills in enquiring about Indigenous status.

PROVISION OF APPROPRIATE CARE TO PIP REGISTERED PATIENTS

Figure 9.20 shows the number of Tier 1 outcome payments for services provided in 2010 and 2011 per 100 Aboriginal and Torres Strait Islander people aged ≥15 years. Tier 1 payments are made in the quarter following the completion of the required services, that is, to practices that have both developed and reviewed a GPMP or TCA within the calendar year. Only a relatively small number of Tier 1 payments were made per 100 Aboriginal and Torres Strait Islander people over the reporting period. However, the cumulative rate of Tier 1 payments at the end of the most recent three quarters (Tier 1 payments from March 2011 - November 2011) was double that at the end of the first three quarters (Tier 1 payments from June 2010 - February 2011) (1.61 and 0.82 respectively).

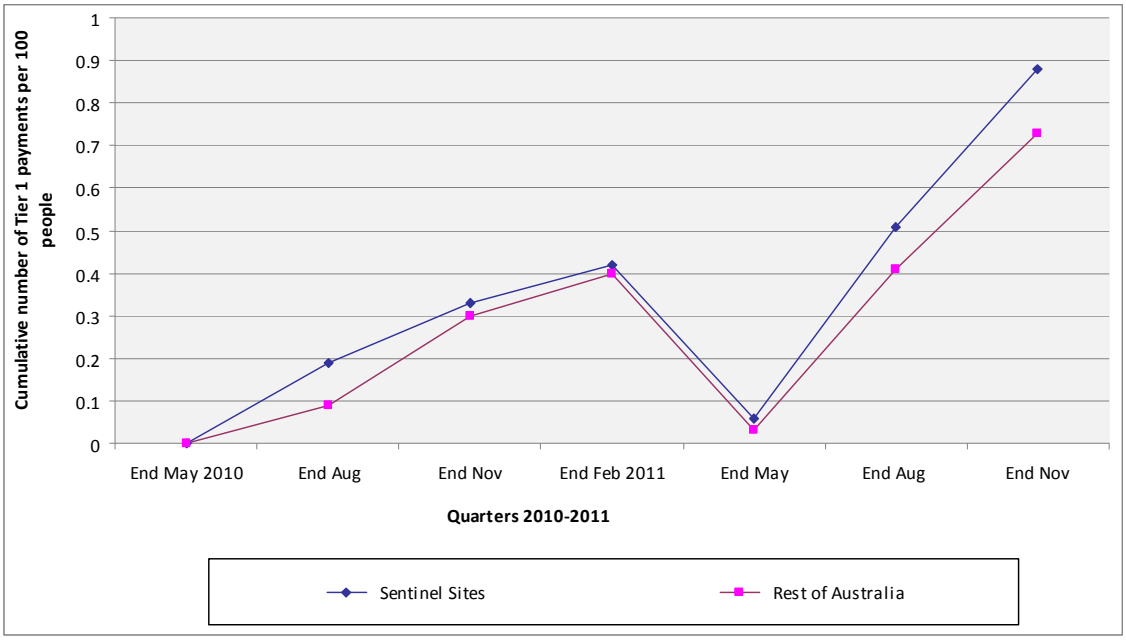


Figure 9.20: Cumulative number of Tier 1 payments per 100 Aboriginal and Torres Strait Islanders aged ≥15 years for Sentinel Sites and the rest of Australia by quarter March 2010 - November 2011

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 low level of Tier 1 payments at the end of May 2011 reflects the start of Tier 1 payments for 2011. Trends in Tier 1 payments must be interpreted with caution. Because the number of payments is relatively low the absolute difference in Tier 1 payments between groups is small.

Numbers of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people at the end of November 2011 compared to the end of November 2010 were around one and a half times greater in both Sentinel Sites and the rest of Australia (Appendix I, Table I3).

The precision of comparisons between Sentinel Sites and the rest of Australia is limited by the possibility that people may register at one service (in or outside a Sentinel Site) and that the Tier 1 payment may be made to another service that is different with respect to location in or outside a Sentinel Site. The extent to which such changes are made is likely to be too small to have a marked effect on the comparisons made in this analysis.

TIER 1 PAYMENTS BY SERVICES BY GEOGRAPHIC LOCATION

Trends in Tier 1 payments varied with rurality (Figures 74-76, Appendix I, Table I5). Graphs by rurality compare Tier 1 payments in the periods from June 2010 - November 2010 with those in the period from June 2011 - November 2011. Comparing the same periods in the two years takes into account seasonal variation. Data are not shown quarterly because of small numbers.

In urban Sentinel Sites there was a more than two-fold increase in the number of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people between the June 2010 - November 2010 and the June 2011 - November 2011 quarters. A similar increase occurred in the rest of urban Australia (Figure 9.21).

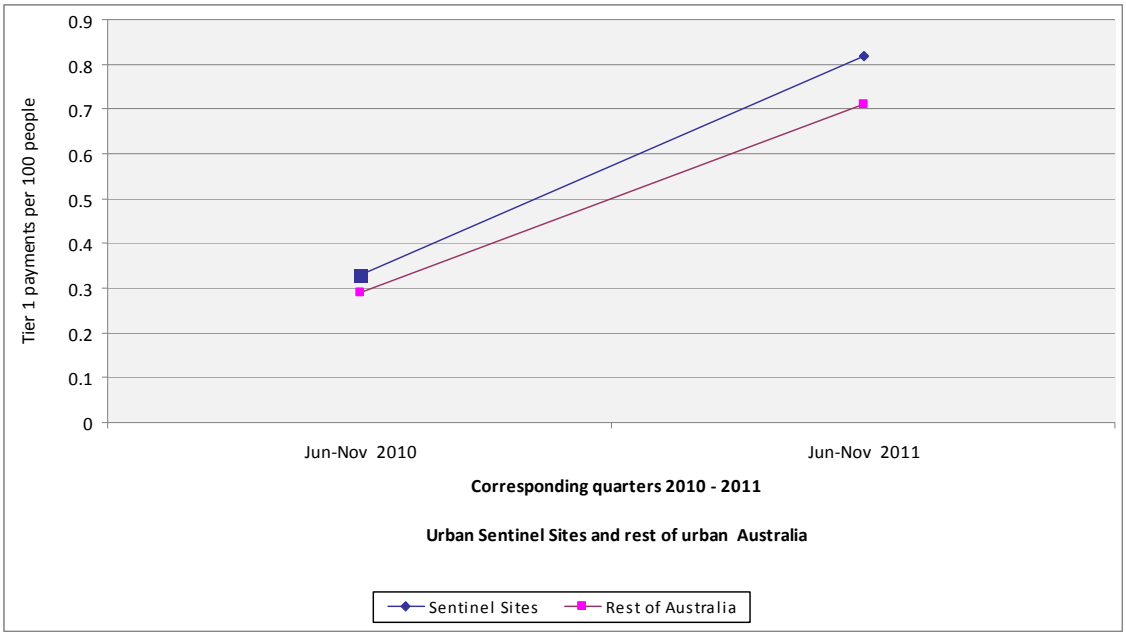


Figure 9.21: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people for urban Sentinel Sites and the rest of urban Australia, June 2010 - November 2010 and June 2011 - November 2011

There was about a three-fold increase in Tier 1 payments per 100 Aboriginal and Torres Strait Islander people in both regional Sentinel Sites and the rest of regional Australia in June 2011 - November 2011 compared to the previous year (Figure 9.22).

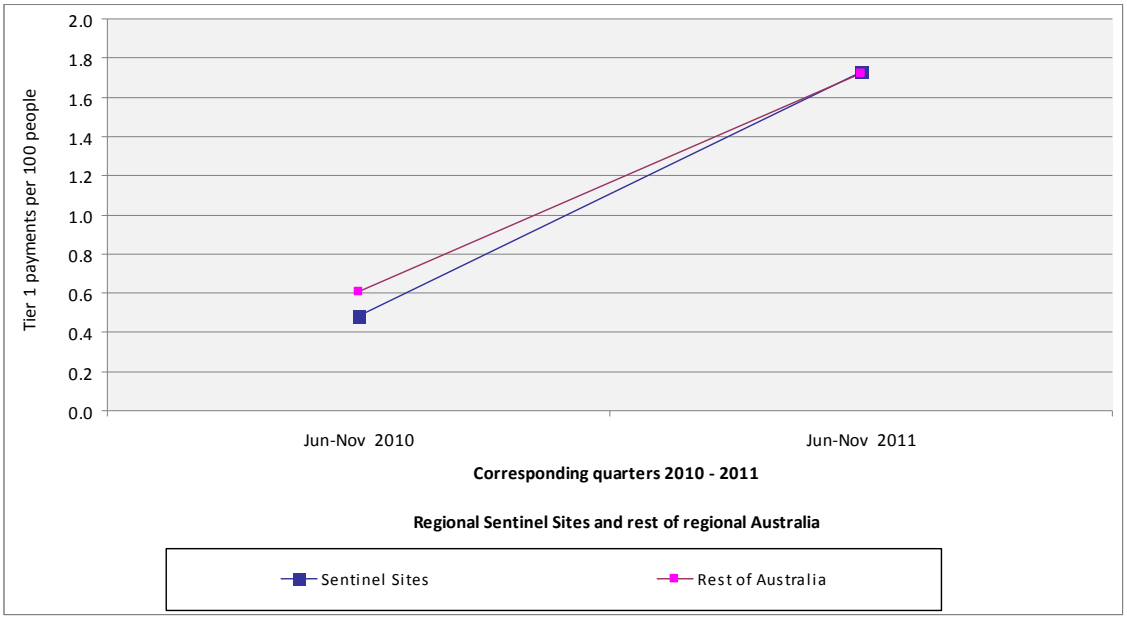


Figure 9.22: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people for regional Sentinel Sites and the rest of regional Australia, June 2010 - November 2010 and June 2011 - November 2011

In remote areas Tier 1 payments per 100 Aboriginal and Torres Strait Islander people did not change in the period from June 2011 - November 2011 compared to June 2010 - November 2010. In the rest of remote Australia there was about a 60% increase in Tier 1 payments per 100 people in June 2011 - November 2011 compared to June 2010 - November 2010 (Figure 9.23).

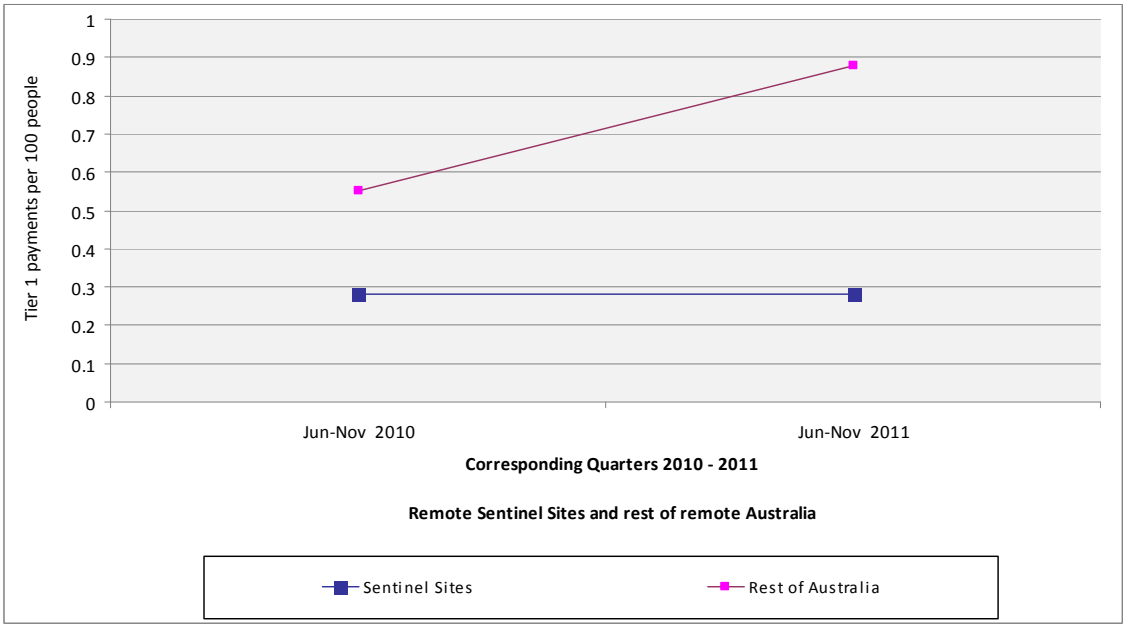


Figure 9.23: Tier 1 payments per 100 Aboriginal and Torres Strait Islander people for remote Sentinel Sites and the rest of remote Australia, June 2010 - November 2010 and June 2011 - November 2011

Urban sites

Levels of Tier 1 payments were low in the first year of the program making it difficult to identify trends at a site level. Among urban Sentinel Sites, Tier 1 payments per 100 Aboriginal and Torres Strait Islander people June 2011 - November 2011 were higher in Brisbane South,

Campbelltown, Elizabeth and North Lakes/Caboolture than in the rest of urban Australia. Numbers of Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were lower than for the rest of urban Australia in all other urban Sentinel Sites. Numbers of Tier 1 payments were particularly low in Dandenong and Canberra, with a ten-fold variation in the numbers in June 2011 - November 2011 between the sites with the highest uptake and those with the lowest uptake. In most urban Sentinel Sites the number of Tier 1 payments per 100 people was higher in June 2011 - November 2011 than June 2010 - November 2010. The only exception was Brisbane South were numbers of Tier 1 payments decreased but were still above average levels in the rest of urban Australia (Figure 9.24).

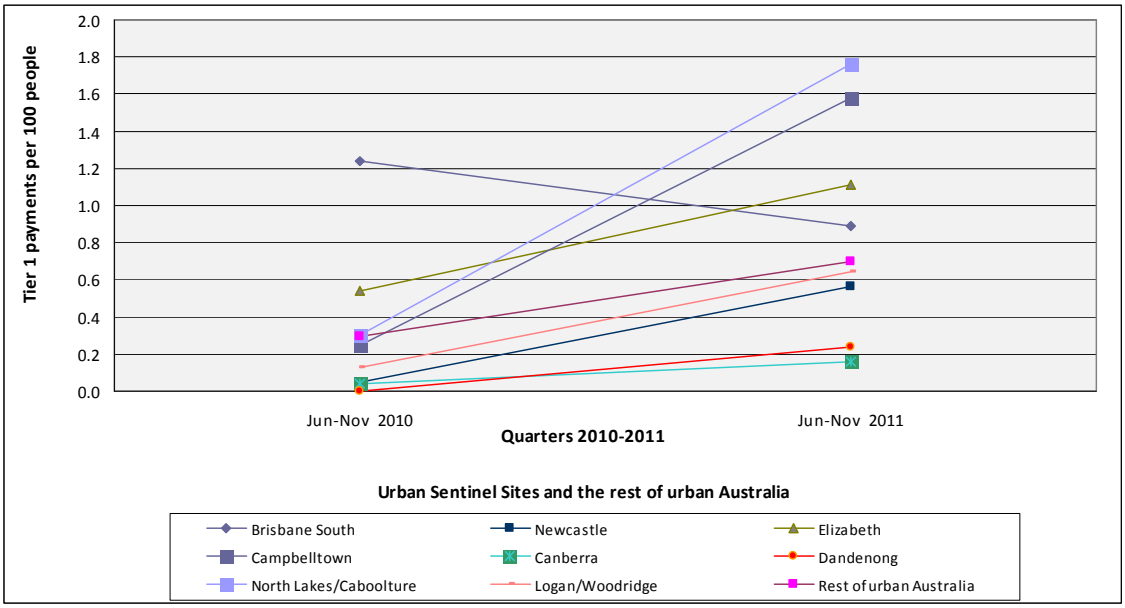


Figure 9.24: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for urban Sentinel Sites and the rest of urban Australia, June 2010 - November 2010 and June 2011 - November 2011

Regional sites

Among regional Sentinel Sites, 2011 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher than the rest of regional Australia in Dubbo and Darwin, similar in Cairns and Geraldton and lower in all other regional Sentinel Sites (Figures 9.25-9.27). Most regional Sentinel Sites showed some increase in Tier 1 payments from June 2010 - November 2010 to June 2011 - November 2011. Bairnsdale and Gladstone had no Tier 1 payments in either time period. There is an even wider variation in the numbers in June 2011 - November 2011 between regional sites than there is for urban sites. Increases between June 2010 - November 2010 and June 2011 - November 2011 were particularly marked in Darwin and Dubbo.

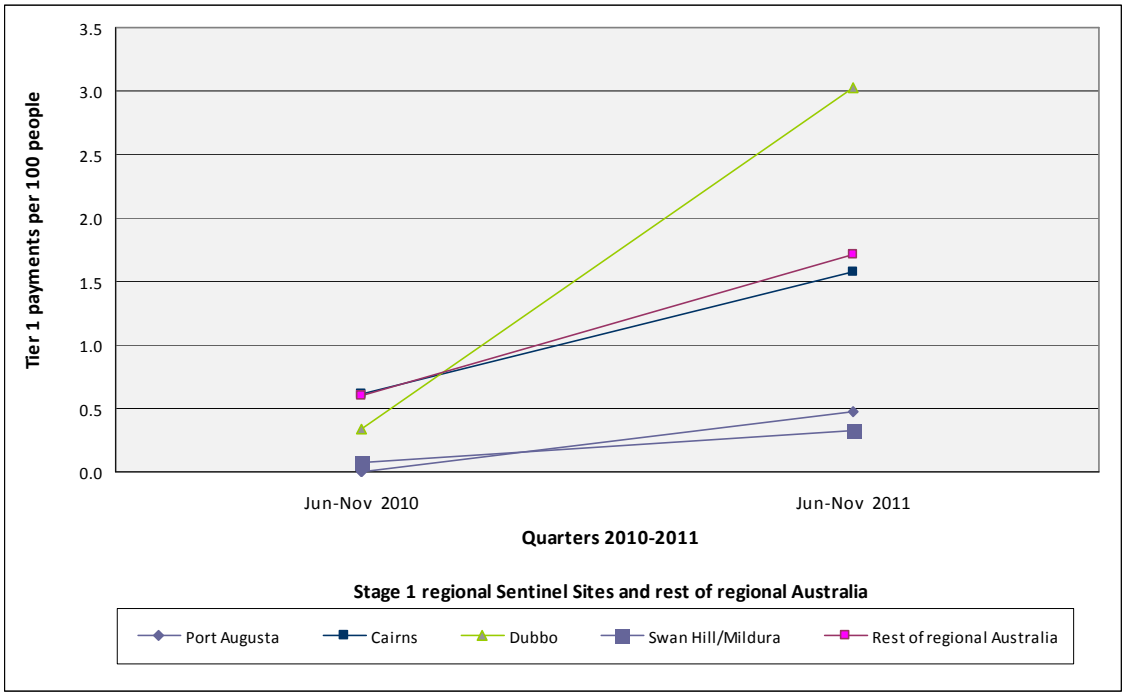


Figure 9.25: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for stage1 regional Sentinel Sites and the rest of regional Australia, June 2010 - November 2010 and June 2011 - November 2011

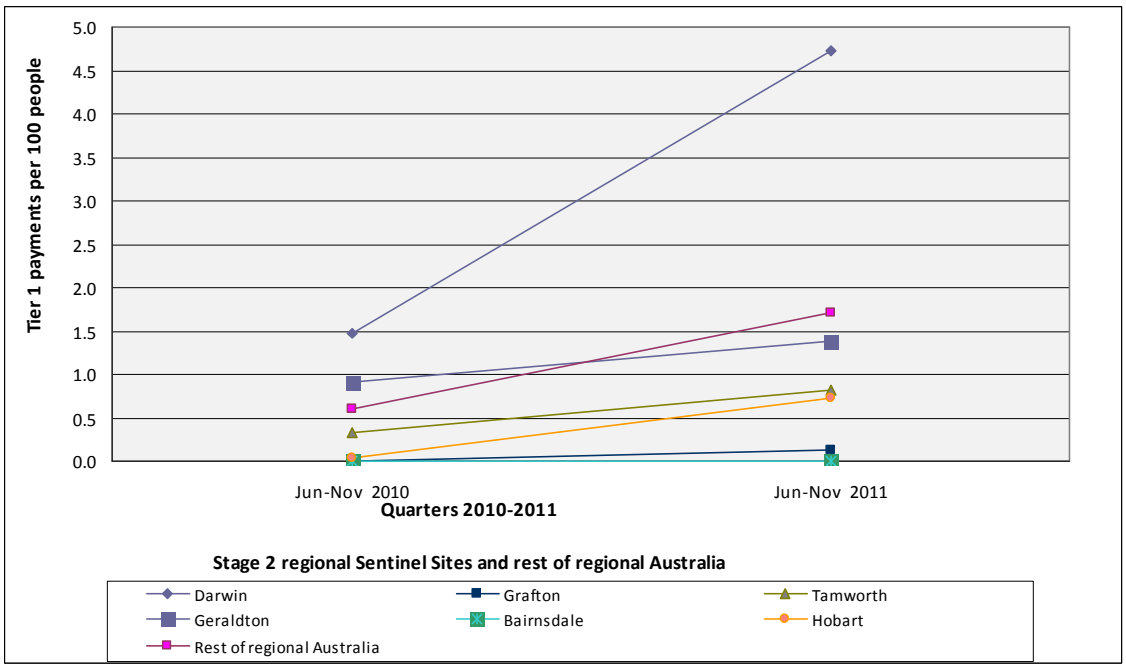


Figure 9.26: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for stage 2 regional Sentinel Sites and the rest of regional Australia, June 2010 - November 2010 and June 2011 - November 2011

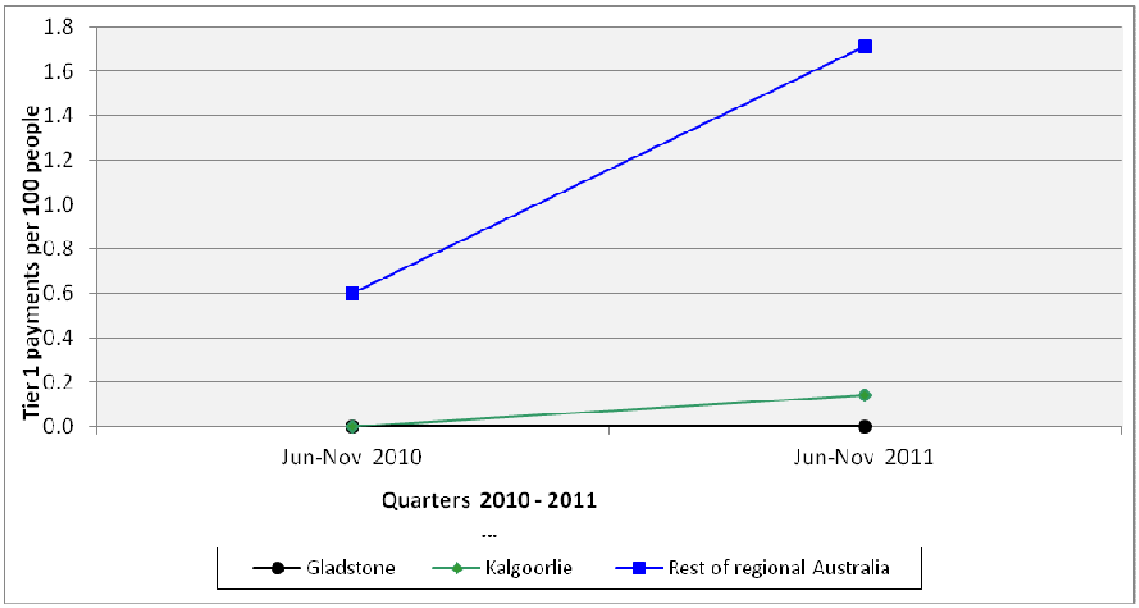


Figure 9.27: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for stage 2 regional Sentinel Sites and the rest of regional Australia, June 2010 - November 2010 and June 2011 - November 2011

Remote sites

Among remote Sentinel Sites, June 2011 - November 2011 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people were higher than the rest of remote Australia in the East Pilbara and lower in Barkly and Derby. Levels of Tier 1 payments per 100 people decreased in Barkly and Derby in June 2011 - November 2011 compared to June 2010 - November 2010 (Figure 9.28).

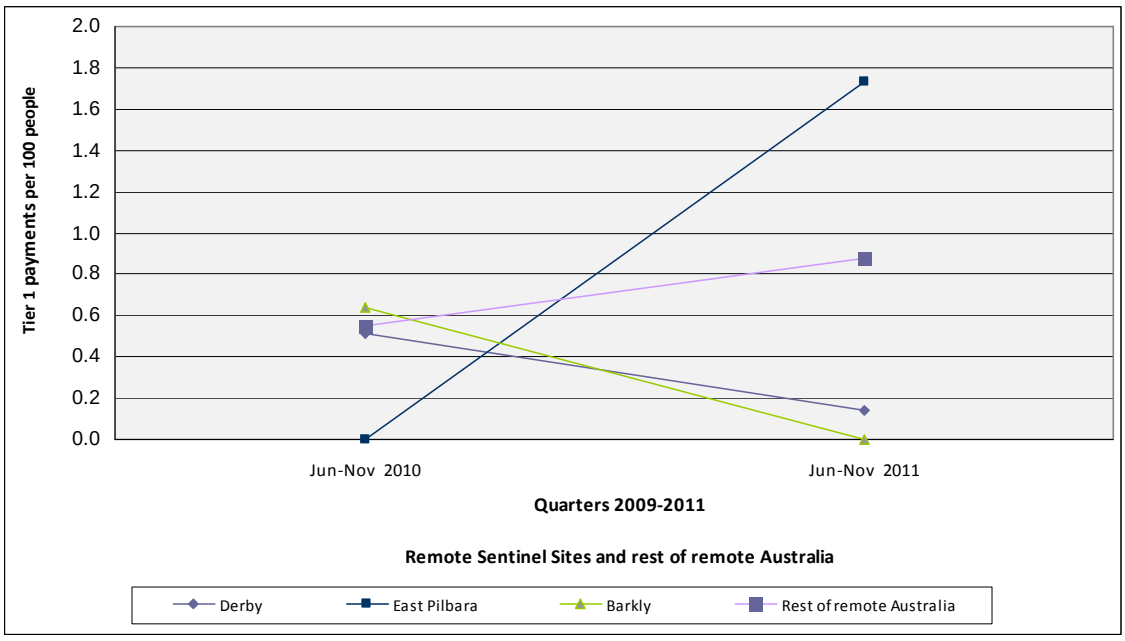


Figure 9.28: Tier 1 payments (PIP Indigenous Health Incentive payment) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years for remote Sentinel Sites and the rest of remote Australia, June 2010 - November 2010 and June 2011 - November 2011

RELATIONSHIP BETWEEN TIER 1 AND TIER 2 PAYMENTS

Figure 9.29 shows the number of PIP Indigenous Health Incentive registrants for whom there were no payments, Tier 1 only, Tier 2 only and both Tier 1 and Tier 2 payments. In general there were no payments for just under a third of PIP Indigenous Health Incentive registrants, almost no Tier 1 only payments, Tier 2 payments for around two-thirds of registrants and the remainder were Tier 1 and Tier 2 payments (Figure 9.29 and Appendix I Tables I5 and I6). In remote areas both Tier 1 and Tier 2 payments were made for a higher proportion of registrants, and there were also a smaller proportion of registrants for whom no payments were made.

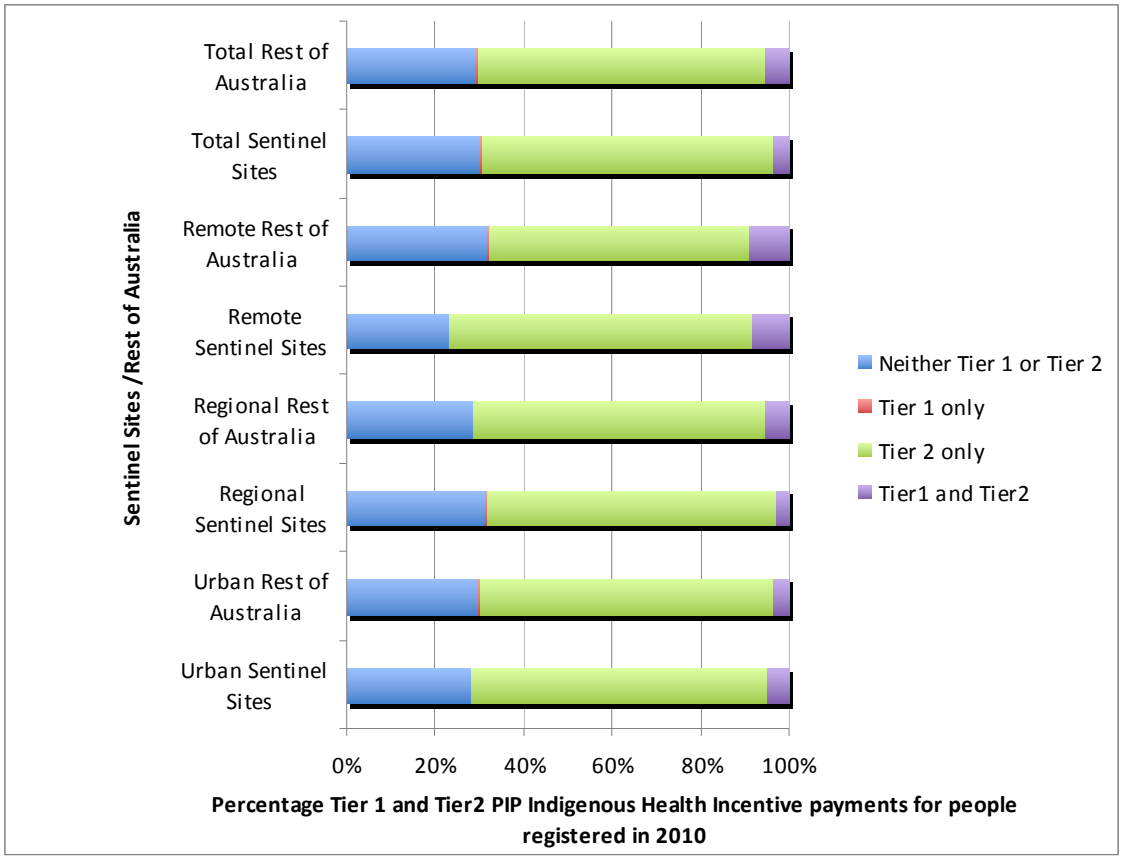


Figure 9.29: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 for Sentinel Sites and the rest of Australia

The percentages of Tier 1 and Tier 2 payments per PIP Indigenous Health Incentive registrant varied between sites. In Campbelltown and Elizabeth the percentage of registrants for whom no payment was made was higher than for the rest of urban Australia. The percentage of Tier 1 and Tier 2 payments was higher in Elizabeth, North Lakes/Caboolture and South Brisbane than the rest of urban Australia. Logan/Woodridge had a higher percentage of Tier 1 only payments than the rest of urban Australia and other urban Sentinel Sites.

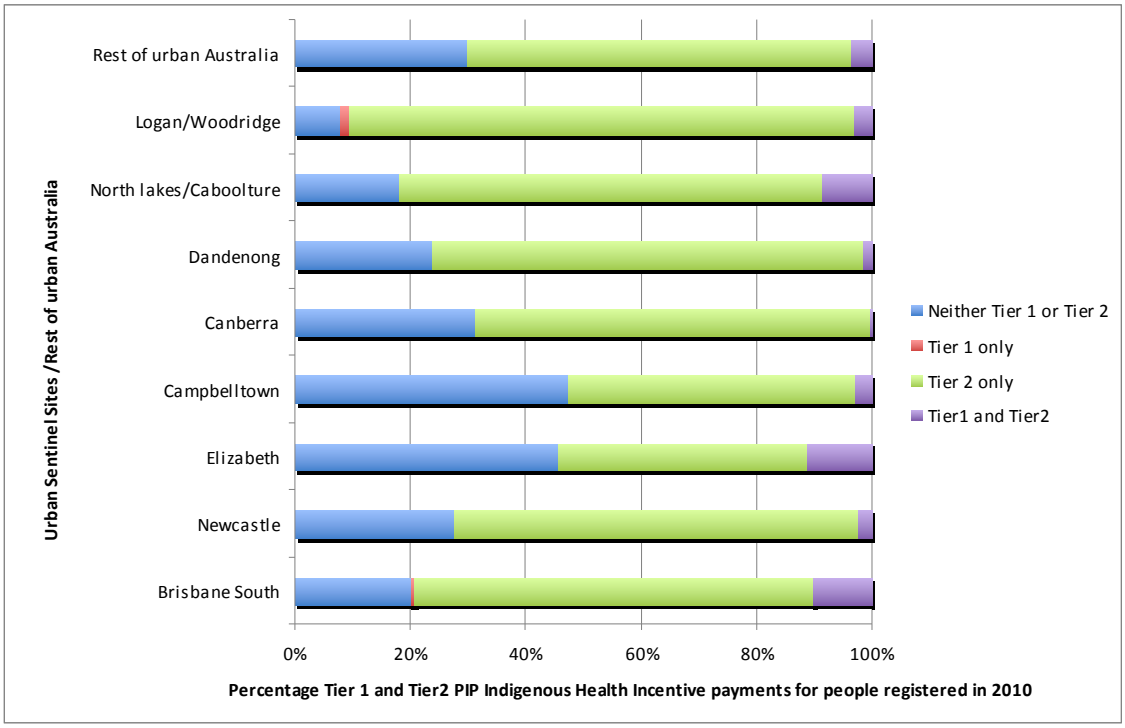


Figure 9.30: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 for urban Sentinel Sites and the urban rest of Australia

There was similar variation in regional sites, with Bairnsdale, Dubbo and Hobart having the percentage of registrants for whom no payment was made. The percentage of Tier 1 and Tier 2 payments was higher in Darwin than for any of the other Sentinel Sites.

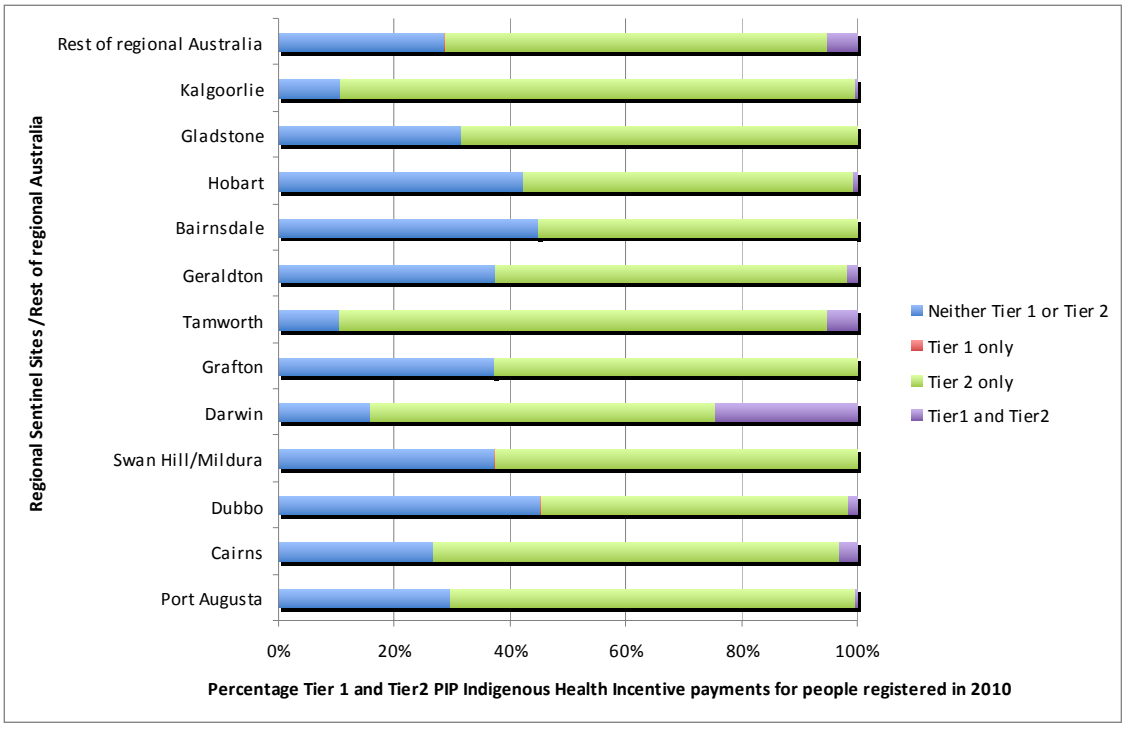


Figure 9.31: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 for regional Sentinel Sites and the rest of regional Australia

There was also significant variation in remote Sentinel Sites. Derby was very similar to the rest of remote Australia. Barkly had much higher levels of payments overall largely due to a higher percentage of both Tier 1 and Tier 2 payments. There were no Tier 1 payments in East Pilbara for people registered in 2010 (as shown in Figure 9.32), however, there was a marked increase in Tier 1 payments in 2011 (as evident in Figure 9.28 above).

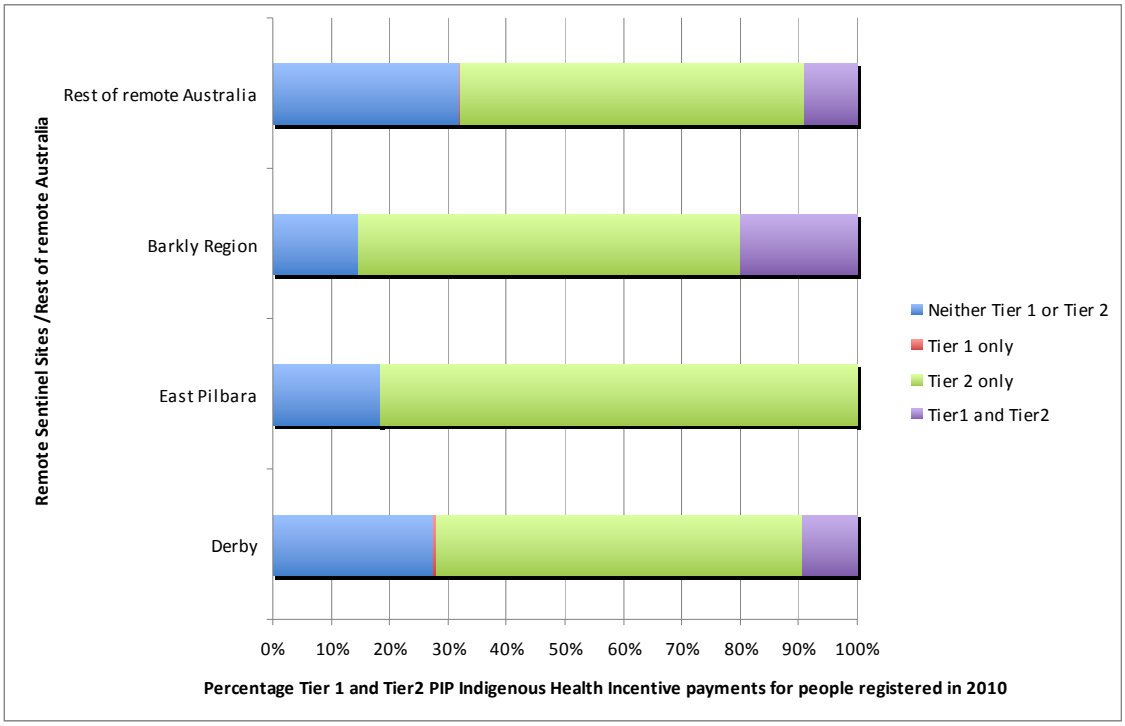


Figure 9.32: Percentage of Tier 1 and Tier 2 payments for people registered for the PIP Indigenous Health Incentive in 2010 for remote Sentinel Sites and the rest of remote Australia

UNDERSTANDING OF REQUIREMENTS TO RECEIVE THE TIERED PIP INDIGENOUS HEALTH INCENTIVE PAYMENTS

There has been a progressive increase 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) to 67% (56/83) to 77% (59/77) in this and the previous two reporting periods].

There continues to be a notable difference between sectors in clinicians and practice managers who agreed with the statement '*Health Services have a clear understanding of what is required to receive the tiered PIP Indigenous Health Incentive payments'* (Figure 9.33). In this reporting period practice managers and clinicians in private General Practices [87% (20/23)] indicated an increase in agreement with the statement, while their counterparts in the Aboriginal Health sector [67% (14/21)] showed a small decrease in agreement.

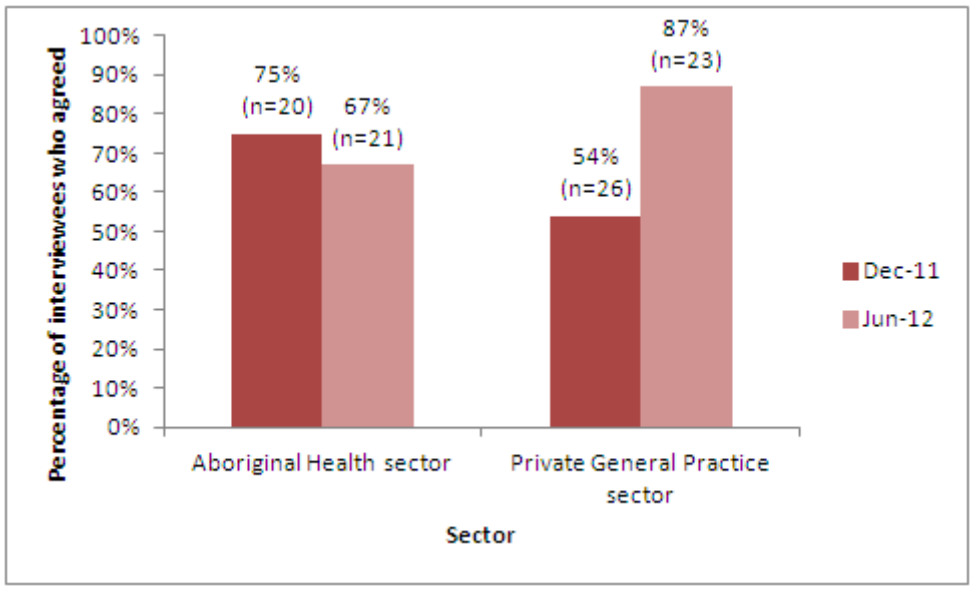


Figure 9.33: Clinicians' and practice managers' responses to the statement: 'Health Services have a clear understanding what is required to receive tiered payments' (% who strongly or partly agreed), by sector and report period

FACTORS INFLUENCING RATES OF TIER 1 AND TIER 2 PAYMENTS

The Medicare data continues to show relatively low numbers of Tier 1 payments. As reported previously, Health Service staff generally report that the introduction of Tier 1 and Tier 2 payments has not influenced the way they run the service or the way that clinicians practice.

> *'The money from the PIP-IHI has been very helpful which was much needed but in itself it does not change in a way the clinicians practice.'* (Interviewee, AHS, GP)

Many private General Practices have small numbers of Aboriginal and Torres Strait Islander patients, and if the Health Service is not already using GPMPs and TCAs, they appear unlikely to change practice in response to an initiative that is relevant to a small proportion of practice population. They do not regard the work involved in reorientating practice systems and staff as being worth the effort.

> *'Due the small proportion of patients practices are not doing reorientation of whole established systems to support Aboriginal patients with PIP. For example they are not going to start doing GPMPs/TCAs if not already doing them just for Aboriginal patients … practices who have these systems in place patients just slot into this.'* (Feedback from tracking site)

Though interviewees are increasingly more aware of the tiered payment arrangements, the data available up to November 2011 shows that any changes made by services have resulted in only a small number of Tier 1 payments being triggered. This may be a reflection of the time taken to get the sort of engagement of Health Service teams that will be required to achieve practice change.

> *'I feel I know a little bit about registration/re-registration and the tiered payment but others don't, because we need to sit down and discuss it and that has not happened yet and requires support to get this happening across the team.'* (Interviewee, private General Practice, GP)

Interviewees continued to indicate that the awareness raising initiatives from DGPs and DoHA have generally focused on signing up patients for the PIP Indigenous Health Incentive with relatively limited focus on what is required to receive the tiered payments. There was little evidence of activity to assist services to enhance delivery of the types of services that would trigger Tier 1 payments for PIP Indigenous Health Incentive registered patients. This may be an important area of focus as the implementation of the ICDP progresses.

There continues to be a lack of understanding of the requirements for Tier 1 and Tier 2 payment to be triggered. The quote below illustrates this confusion even among staff of a peak body that has a key role in informing members about services of these requirements.

> *'When lots of Tier 2 payments are being received, they should be doing something … maybe triggering it from something that's happening in the Tier 1.'* (Interviewee, NACCHO affiliate)

These data highlight the difficulty of developing an adequate understanding among key stakeholders of how the incentive arrangements operate.

However, Health Service staff also described the difficulties involved in recalling patients for follow- up care to meet the requirements of GPMPs and TCAs in a way that would trigger the Tier 1 payment. They highlighted the inadequacies of their recall and reminder systems and with the difficulties of contacting patients for purposes of recall. A number of private General Practices indicated that they were commencing work with the DGP to assist with patient recall.

> *'One of our problems is getting follow-up services provided by a practice nurse done, as hard to get patients to come back. Even if we send letters out they don't always come back, but we are working with the Division on this. One on my other problems is, because I also do the chronic disease care plans, is trying to find time to get everybody in for a review as well. For follow up appointments it's often 4-5 months before patients can be seen … we do have some good proactive patients who do come back and see their GP on a regular basis.'* (Interviewee, private General Practice, nurse)

Some interviewees reported that they were already doing GPMPs and TCAs and that the PIP Indigenous Health Incentive offers nothing extra besides financial incentive to practice.

> *'We also are asking patients to sign for a service that they are already getting.'* (Interviewee, AHS, GP)

Vignette – developing and reviewing GP Management Plans and Team Care Arrangements.

X AHS uses a systematic approach to developing and reviewing GPMPs and TCAs for patients with chronic diseases. A non clinical staff member is employed to go through files on the patient information system to identify those who are due for assessment or follow up for chronic disease management. The Chronic Disease AHW then reviews the relevant patient files to review notes, ensure appropriate documentation is in place and determine the processes to be followed - for example, a health assessment, GPMP and a TCA. The AHW prepares instructions for the GP. Patients and others who need to be involved in consultations are contacted and a one hour appointment is made so that necessary processes can be completed in one booking if possible.

This procedure ensures consultation time is efficiently spent for best patient care. In 2011 Tier 1 payments per 100 Aboriginal and Torres Strait Islander people in this site were the highest of any regional Sentinel Site and higher than the rest of regional Australia.

SERVICE PROVIDER PERSPECTIVES ON FUNDING AVAILABLE THROUGH THE PIP INDIGENOUS HEALTH INCENTIVE

Discussion on the use of funding from the PIP Indigenous Health Incentive was generally consistent with the previous three reporting periods. There remained a general reluctance among interviewees to discuss how they were using the funds obtained through this measure. Most clearly did not know, and those who had some knowledge of the financial management of services generally indicated the funds went into a more general revenue pool. Although some interviewees did identify some new positions or infrastructure or other projects that had been recently initiated, funds from the PIP Indigenous Health Incentive were not clearly associated with funding for specific positions or projects.

Enquiries about how funds generated through the PIP Indigenous Health Incentive revealed a broad lack of understanding of the various measures that make up the ICDP and the different funding arrangements for these measures. For example, while practice manager interviewees in two regional AHSs indicated that allied health services were being funded through the PIP Indigenous Health Incentive, from other information it was clear these services were actually being funded through MSOAP-ICD. In an urban AHS the practice manager indicated that a specialist was funded by funds generated by PIP Indigenous Health Incentive, while other information showed the specialist was actually funded through USOAP.

Interviewees who were willing to provide information on use of PIP Indigenous Health Incentive funds identified a variety of uses, including:

- Use of funds for general operational costs such as wages

  'In August we got $20 000 from PIP IHI registrations this went into our general fund 'operational' for wages.' (Interviewee, AHS, GP)

- Paying for administration staff to sign people up for the PIP Indigenous Health Incentive and also pharmacy such as premium brands of medication.

  'PIP funding being used on pharmacy. It also just covers administrative tasks to get the sign-up done.' (Feedback from enhanced tracking site)

- One private General Practice that was already delivering care through established systems using GPMPs and TCAs (prior to PIP Indigenous Health Incentive) indicated that they were using funding to top up the salary of a nurse to focus on Aboriginal patients within the practice.

> *'We specifically focused over the last six to eight months with the practice's Indigenous patients, especially for patients with a chronic disease, for example, Diabetes Clinics targeting the Indigenous patients. More of a focus and sort of putting in place the GP Management Plan and Team Care Arrangement and making sure that we do the Health Assessments. Also a system for assessing Allied Professional Health helped. This process has taken a fair bit of nurses' time where the PIP-IHI incentive money has been used.'* (Interviewee, private General Practice, GP)

PERCEPTIONS OF FINANCIAL INCENTIVES AND QUALITY OF CARE

The use of funding as an incentive for Health Service participation in the PIP Indigenous Health Incentive in this and subsequent reporting periods continued to receive some critical comment from some stakeholder interviewees. The comments were predominately from a small number of private General Practices' staff, 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. A number of Health Services, in both sectors, indicated that they were already doing the GPMPs and TCAs and the PIP Indigenous Health Incentive was not driving any change in practice.

In this reporting period an increasing number of clinicians also raised concerns about using GPMPs and TCAs as indicators of quality of care. These clinicians felt that they were delivering quality care, and perceived GPMP/TCA to be a paperwork exercise that had no benefit for clinical outcomes.

> *'This is more of an administrative thing rather than clinical outcomes.'* (Interviewee, AHS, GP)

> *'The paperwork for GPMP and TCA stops me doing it. There is a bit of pressure to do the TCA from time to time as it allows access for a patient to allied health services – access drives this for me to do it rather than perceiving it to be adding a layer of quality of care. Income a driver for some GPs to do the GPMPs and TCAs but from my perspective again it doesn't do anything that adds to the quality of care.'* (Interviewee, AHS, GP)

A small number of clinicians in AHSs said that they expected that over time there would be an increase in AHSs doing GPMPs and TCAs as clinic managers and management were

> '*Pushing these care plans as they have their eye on the income to be generated and see the financial benefit.'* (Interviewee, AHS, GP)

Registration of patients for the PIP Indigenous Health Incentive has usually been done in tandem with registration for the PBS Co-payment, and the explanation to patients generally focused on the financial benefits of the PBS Co-payment. A small number of clinicians reflected on how they struggle to explain the benefits of re-registering for the PIP Indigenous Health Incentive.

> *'The CtG is a clear selling point to patients and they love it! PIP harder to sell to patients … this gives us a bit of extra money to coordinate your care … back of my mind is that we should be coordinating their care anyway. For AHS there is a definite*

> *large amount of patients and most AHS see it as funding stream … private GPs not worthwhile as they often have a smaller patient load that are eligible.'* (Interviewee, AHS, GP)

There were a small number of interviewees who offered suggestions about refinement of the payment structure associated with the PIP Indigenous Health Incentive. There was a general perception that the process was focused on the registering patients rather than on improving quality of care. An increasing number of interviewees, predominately clinicians, felt strongly that registration payments should be replaced by payments for care that had been delivered according to specified requirements, and that services should not be benefiting financially from simply signing up patients without delivering care.

> *'At the moment practices are getting paid for filling in paperwork not providing care.'*(Feedback from tracking site visit)

A number of clinicians indicated that financial incentives (such as the PIP Indigenous Health Incentive) provides no direct benefit to salaried GPs and therefore such incentives do not in themselves influence clinician behaviour. Consistent with the international literature, it was suggested that, in order to more strongly influence clinical practice, incentives under the ICDP should be more aligned with the professional values of clinicians (i.e. that there should be more directly related to delivery of high quality care as supported by relevant evidence). Indeed, financial incentives that may be seen to be coercive rather than supportive of and consistent with professionals' perspectives of high quality care have the potential to damage intrinsic motivation.[109]

Specific suggestions included removal of the registration payment for patients and an increase in the funding for Tier 1 payments.

> *'There is currently a $250 registration payment if there is a reduction in this it would make no different to me as a GP as I'm on a salary so no direct effect. If the patient registration was abolished I would propose loading the money into the Tier 1. Suggest directing the Medicare incentives to where they work – incentives into developing long-term relationship with patients, similar to the diabetes cycle of care payments which triggered payment once the service was provided to the patient. Propose having a system of triggering extra payments for GPMP and other funded items such as health assessments.'* (Interviewee, AHS, GP)

The major objection to removal of the patient registration payment would almost certainly be from services for which this has become a significant source of revenue. Concerns over loss of this income could be allayed by increasing the value of other incentives.

Tier 1 payments currently carry the lowest financial value, but probably require the most significant reorientation of clinical practice towards high quality chronic illness care. The small number of Tier 1 payments indicates that few services have been influenced to change their systems in a way that increases delivery of the sort of planned and multi-disciplinary care that is required to trigger a Tier 1 payment. It appears that the financial value of the Tier 1 payment will need to be significantly increased to achieve the change required that this incentive is designed to achieve.

[109] McDonald, R. and M. Roland (2009). "Pay for performance in primary care in England and California: comparison of unintended consequences." The Annals of Family Medicine 7(2): 121-127.

Interviewees argued that the requirements to identify patients as Aboriginal or Torres Strait Islander could be directly linked to the delivery of and claiming for Health Assessments or some of the services required for Tier 1 payments.

Other suggestions were for:

- a payment that is triggered if a 'suite of services are delivered' such as GPMP, TCA, health assessment, follow-up care
- a blended payment of part PIP and part Service Incentive Payment (SIP) so there was some incentive to both the practice and to individual clinicians, depending on the financial model of the practice. It is possible that service organisations could themselves develop internal systems to pass on at least part of the incentive payment to clinicians
- doing away with the requirement for patients to re-register every year for the PIP Indigenous Health Incentive, possibly with a requirement to re-register only if they choose to change to a different service or for the re-registration to be linked automatically to the service that receives the Tier 2 payment.

It was also strongly argued that there needs to be a more fundamental shift in the approach to the financial incentives with direct support and reward for developing systems to support high quality care. This is consistent with lessons from international experience with financial incentives with a shift in focus from 'pay-for-performance' (P4P) to 'investing-for-improvement' (I4I)[110]. '*Financial incentives do have a role to play, particularly for long-term conditions, but only as part of a comprehensive strategy for quality improvement … There is a need to move beyond and away from P4P to focus on 'Investment for Improvement' or I4I.*'[111]

It was felt there was a relative lack of support through the ICDP to enhance local health service system development, and until this was addressed service organisations would be responding to incentives in a piecemeal way rather than building systems to ensure the delivery of high quality clinical care for their service populations. This clinician argued that direct support for Continuous Quality Improvement type approaches would build the potential for achieving the sort of re-orientation of primary care services that is required to provide high quality chronic illness care.

CULTURAL AWARENESS TRAINING FOR PRIVATE GENERAL PRACTICE STAFF

In this reporting period there has been an increase in the number of clinicians and practice managers in private General Practice who agreed to the statement '*Organising access to the required cultural awareness training has been easy to organise*' from 31% (8/26) in the previous reporting period to 68% (15/22) in the current reporting period.

Further to this, 59% (13/22) of clinicians and practice managers in private General Practice agreed that the cultural awareness training resulted in a change to their practice compared to 19% (8/26) in the previous reporting period. Despite this positive trend, about 30% of interviewees responded that they 'don't know/can't say' as they had not yet accessed cultural awareness training.

[110] Campbell, S. M. and T. Eriksson (2011). "Multiple strategies for quality improvement and patient safety—money alone is not the answer, nor is trust. Conclusions of the 6th EQuiP Invitational conference April 2011." European Journal of General Practice 17(4): 238-240.
[111] Ibid.

In the previous 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 the RACGP. In this reporting period there was evidence of a number of DGPs that conducted cultural awareness training days well attended by clinicians. Health service staff perceptions of these training days were mixed, with some discontent, but predominately satisfied.

Interviewees raised a number of issues in relation to the cultural awareness training, including:

- High turnover of staff and the need therefore to keep training staff. Interviewees often stressed the importance of including reception staff in cultural awareness training because of the vital role they play as the first contact for patients with the Health Service.
- Overseas trained doctors were often perceived to hold racist attitudes and lacking awareness of the needs of Aboriginal and Torres Strait Islander patients.
- Frustration that the training was too narrowly focused on identification and how to ask someone if they are Aboriginal and Torres Strait Islander, with an expressed need for more information on how to access services required to support Aboriginal patients.
- The need for social marketing and media campaigns on the importance of identification of Aboriginal and Torres Strait Islander people, and that this should not be left solely up to Health Services (as was felt to be the current situation).

A number of community focus group members noted a change in some private General Practices with the waiting rooms having flags on desks and Aboriginal art works displayed on walls.

> *'There is now Aboriginal art in a lot of the General Practices … not just western art.'*
> (Community focus group)

> *'I've been going there for 20 years and they've only just put up Koori poster.'*
> (Community focus group)

It is encouraging that community focus group participants are experiencing positive changes in private General Practices that appear to be a direct consequence of the ICDP and specifically of the cultural awareness training.

9.5. Summary

1. Awareness of the PIP Indigenous Health Incentive is high among stakeholders and there is a general perception that their organisations have access to a great deal of information about the measure. The SSE team, networking with other services, Medicare Liaison Officers, Medicare and PIP Hotlines, the SBOs, CCs and NACCHO affiliates have emerged as playing an important role in providing information (in addition to IHPOs as reported previously). There was some frustration about inconsistent information being provided, sometimes from the same source (the hotlines).
2. Stakeholders highlight that whilst there is a lot of information available, assistance in engaging with the information is needed to assist in implementing practical processes and activities. The need for ongoing communication and information sharing continued to be highlighted because of various gaps in information, staff turnover and the need to share information on emerging issues with the implementation of the PIP Indigenous Health Incentive, notably re-registration and the requirements to receive tiered payments. There was an expressed need for information on the ICDP as a whole, and whilst IHPOs and other agencies play an important role around communication of information, there is a need to address the current gap in capacity to provide 'whole-of-package' information.
3. Interviewees, particularly clinicians and practice managers, strongly questioned why re-registration was necessary.
4. Community members showed varying levels of awareness, but many were unsure if they were registered. Some community members also questioned the need for re-registration.
5. Community members provided no indication that they had experienced any difference in care as a result of the registration for the PIP Indigenous Health Incentive.
6. Nationally, between 55% and 60% of Health Services participating in general PIP arrangements had registered for the PIP Indigenous Health Incentive by November 2011. More than 40% of these had not registered any patients. This indicates that over $1 million has been paid to Health Services that have not yet played any active role in the ICDP.
7. Concerns about high administrative burden continue to be commonly expressed (for similar reasons as reported previously). However, there has been a marked shift of the concerns between sectors of clinicians and practice managers in particular, with a decrease in the AHS sector and an increase in the private General Practice sector. This appears to be linked to the relative cost-benefit of setting up the systems required to implement the PIP Indigenous Health Incentive. The large number of eligible patients in AHSs makes it more cost and time effective compared to private General Practice where only a small proportion of patients are eligible.
8. There has also been a recent marked increase in perceptions that organising access to the PIP Indigenous Health Incentive has been easy, indicating that systems are becoming more established. However, determining the registration status of patients and lack of systems to support this, continue to cause frustration among Health Service staff. This is partly due to lack of adequately developed clinical information systems and staff being capable to effectively use them, and partly due to lack of a central system to provide information on registration status of patients.

9. There has been an approximately 50% increase in the numbers of people registered for the PIP Indigenous Health Incentive in 2011 compared to 2010. Most of the registrations in 2011 were first time registrations (with about 30% being people who had also been registered in 2010). This suggests that registration for the PBS Co-payment continues to have major influence on registration for the PIP Indigenous Health Incentive, as the initial registration for the PIP Indigenous Health Incentive is done at the same time as registration for the PBS Co-payment.

10. There continues to be wide variation in the number of registrations per 100 Aboriginal and Torres Strait Islander people between specific Sentinel Sites, and this variation is evident in urban, regional and remote locations.

11. While there has been a general increase in Tier 1 payments in the two most recent quarters for which data are available compared to the corresponding period in the previous year, the number of payments continues to be small. The increasing trend is driven by especially marked increases in Tier 1 payments in a few sites, indicating that at least some services in various sites are changing their practices and systems to provide services and to bill Medicare in a way that is consistent with the requirements to trigger Tier 1 payments. Interview data from the sites also show there has been a continuing increase in the stakeholders' perceptions that Health Services have a clear understanding of what is required to receive tiered payments. This is most marked amongst clinicians and practice managers in private General Practice. The effect of the recent increase in understanding may be reflected in more recent administration data as it becomes available. However, it appears that there continues to have been limited attention in Health Services to completing the requirements to trigger Tier 1 payments. Limited capability in the effective use of clinical information systems appears to constrain potential in this regard.

12. The number of Tier 2 payments continues to be much greater than Tier 1 payments in all sites. Tier 1 payments are almost invariably made for patients for whom Tier 2 payments are also made.

13. There is wide variation between sites in the proportion of Aboriginal and Torres Strait Islander people for whom neither Tier 1 nor Tier 2 payments are made, from less than 10% in some sites to almost 50% in others. Only a small part of this five-fold variation between sites is likely to be explained by differences in health status or need for care, with the majority of the variation more likely to be explained by differences in service provision, billing practices, accessibility of services (broadly defined) and patterns of use of health services.

14. The use of funding as an incentive for Health Service participation in the PIP Indigenous Health Incentive, and more generally as a mechanism for influencing practice, continued to be the target of some critical comment. Some private GPs felt they were already delivering a high standard of care and that the incentives would therefore not change their practice. At least one clinician in a community controlled service expressed the view that the approach to care of community controlled services in general is consistent with the style of practice that the incentives aim to promote. There is a view that at least some of the activities (including patient registration and some Medicare items, such as the GPMP and TCA) required to receive payments are simply paperwork and have no benefit to clinical outcomes. There is an increasing perception that registration payments should be replaced by payments for care delivered and services should not be benefiting financially from simply signing up patients without delivering care.

15. It was also argued that there needs to be a more fundamental shift in the approach to the financial incentives, consistent with lessons from international experience with financial incentives, from 'pay-for-performance' to 'investing-for-improvement'. This would require direct support for continuous quality improvement type approaches to re-orient primary care services to provide high quality chronic illness care.

16. There continues to be limited specific data available on how funds from the PIP Indigenous Health Incentive are being used by services. It appears that the funds usually go into a general revenue pool rather than being directed towards specific positions or projects.

17. An increasing proportion of clinicians and practice managers in private General Practice reported that the cultural awareness training had resulted in a change to their practice. Localised approaches (including specifically the contribution of the IHPOs) were particularly valued. It was evident that community focus group participants are experiencing positive changes in private General Practices that appear to be a direct consequence of the ICDP and specifically of the cultural awareness/cultural safety training.

10. SUPPORTING PRIMARY CARE PROVIDERS TO COORDINATE CHRONIC DISEASE MANAGEMENT *(MEASURE B3 PART B)*

10.1. Description of measure

The Care Coordination and Supplementary Services (CCSS) Program intends to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through the following two components:[112]

- Care coordination provided by qualified healthcare workers to Aboriginal and Torres Strait Islander patients with a chronic disease typically AHWs or specialised nurses.[113] Patients must be referred by GPs in General Practices or AHSs participating in the Practice Incentives Program (PIP) Indigenous Health Incentive. In late 2011 the criteria was changed to allow application by SBOs to DoHA for an exemption to this rule for regions, allowing GPs of non-PIP registered practices to refer patients to the service if this was a barrier to appropriate care. [114,115]
- 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.[116]

The CCSS program commenced 1 June 2010 with funding until June 2012.[117] All eight SBOs had funding agreements by June 2011. Each state/territory has received funding that they can utilise to recruit Care Coordinators based on local needs assessments.[118] The SBOs may sub-contract DGP or other organisations such as AHSs to implement the CCSS Program.[119] The CCSS

[112] DoHA, Care Coordination and Supplementary Services Program Guidelines April 2010, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf> (accessed 24 May 2012).

[113] DoHA, Support primary care providers with chronic disease management – factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf> (accessed 19 April 2012).

[114] DoHA, B3b personal communication, 11 January 2012.

[115] DoHA, B3b CCSS generic eligibility letter, 28 February 2012.

[116] DoHA, Support primary care providers with chronic disease management – factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/DHA6136%20B3%20Factsheet.pdf> (accessed 24 May 2012).

[117] Four year funding for CCSS Program is available. The funding agreement with SBOs has been available to June 2012 due to uncertainty of role or existence of SBOs with change to Medicare Locals. Recently there has been an extension for a further 6 months funding to December 2012. DoHA, B3part B personal communication, 22 November 2011.

[118] DoHA, B3b report, 11 January 2012.

[119] DoHA, Care Coordination and Supplementary Services Program Guidelines April 2010, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf> (accessed19 April 2012)

Program will be implemented progressively through a staged approach and will not be available in all locations in the initial years of the program.[120]

10.2. Program logic

As specified in the National Framework the following outcome hierarchies in relation to measure B3 Part B and relevant to the current stage of implementation, include:

Expected outputs for year 1 and beyond:

- Collaborative development of local CCSS arrangements, strengthening linkages between General Practice, AHSs, Divisions, specialist and allied health.
- CCs are trained and established in their roles.
- Assistance is provided by the CCSS in line with measure guidelines.

Early results (years 2-4):

- Indigenous Australians with chronic disease are able to obtain the health services recommended in care plans.
- Appropriate referral to the CCSS becomes normal practice for General Practices.

Medium term results (year 4+):

- Barriers to accessing services necessary in the management of chronic diseases are overcome.
- Increased capacity in local networks of health professionals to provide coordinated care for Indigenous Australians with chronic disease.

10.3. State of implementation – national context

The following information was provided by DoHA in January 2012 on the state of implementation of measure B3 Part B at a national level (relevant to the SSE):[121, 122]

- Funding agreements with host organisations for the CCSS program are in place until 30 June 2012 (in line with funding for SBOs under the DGP Deed for Multi-Program funding). On 19 July 2011, Minister Roxon announced that funding for SBOs in NSW, Queensland, Victoria, Western Australia and South Australia would be extended until 31 December 2012. Funding agreements with SBOs would therefore be extended until 31 December 2012 to enable SBOs to continue transition work with Medicare Locals and the new national body.
- In the case of the ACT, NT and Tasmania, a single Medicare Local will be in place for these jurisdictions from 1 July 2012. Funding for the CCSS program would therefore be

[120] DoHA, Care Coordination and Supplementary Services Program Guidelines April 2010, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf> (accessed 14 April 2012).
[121] DoHA, B3b report July to September 2011, 11 January 2012.
[122] DoHA, B3b personal communication, 11 January 2012.

provided via a schedule to the Medicare Local Deed for Funding for the period from 1 July 2012 to 31 December 2012. A letter has been sent to the SBOs (including the NT SBO) and the ACT and Tasmania Medicare Locals outlining this information and their funding allocations.

- DoHA disseminates information on any changes or major activities for the CCSS Program through written communication to the SBOs. It is then the responsibility of the SBO to forward on any relevant information to their sub-contracted organisations.
- The CCSS program has had changes to the eligibility requirements which will allow referrals to come from non-PIP accredited Health Services. SBOs must apply on a case by case basis for regions where availability of General Practices or AHSs that are eligible for PIP is a barrier to accessing this service.[123] Only one region in QLD had applied for an exemption as of January 2012.[124]
- Individual care coordination positions have funding until the end of June 2012 and it will be up to the SBOs to extend their contracts until Dec 2012.
- Implementation of the CCSS Program was initially slower than anticipated, with 22.1 FTE CCs employed nationally under the program as at 30 June 2011. Services have now commenced in all States and Territories and there has been a significant increase in appointment with 64.3 FTE CCs employed nationally under the program as at 31 December 2011.
- In addition to the Guidelines, DoHA has developed a Frequent Asked Questions document to provide some clarification to services about what is in/out of scope. [125,126] This document is disseminated through the SBOs and Australian General Practice Network in hard copy only. It can be found uploaded on some websites.[127]

Table 10.1 shows the uptake of the CCSS measure by State and Territory. Changes evident between this and the previous reporting period include:

- Commencement of recruitment and service delivery under this measure in SA and Tasmania (from July 2011 - December 2011).
- Substantial overall increase in care coordination services provided in all States and Territories.
- Broadening of the GP referral base, particularly in WA. GP referrals have been slow but are increasing.

As also indicated in the table, a range of services have been funded using supplementary services funding. Local transport was the supplementary service item most extensively purchased and most commonly purchased across host organisations with five of the eight SBOs reporting activity under this service item. Whilst some of the specialist services funded under CCSS overlap with MSOAP and USOAP funding, the caveat for utilisation of the supplementary services funding is that other funding sources need to be exhausted prior to utilisation of this funding stream.

[123] DoHA, B3b CCSS generic eligibility letter, 28 February 2012.
[124] DoHA, B3b personal communication, 11 January 2012.
[125] DoHA, B3b report update, 19 April 2012.
[126] DoHA, B3b personal communication, 11 January 2012.
[127] GPQ [website], <http://www.gpqld.com.au/content/Document/3%20Programs/Aboriginal%20and%20Torres%20Straight%20Islander%20Health/FAQs_111101_CCSS_DoHA.pdf> (accessed 9 May 2012).

Table 10.1: State-based Care Coordination and Supplementary Services program reporting July 2011 - December 2011

SBO funded	No. of CC Services provided; No. of referring GPs	No. of patients receiving CC only	No. of patients receiving both CCs & SS	No. and type of Supplementary Services purchased	
GP NSW	1691; *75*	182	81	71 - Local transport 44 - Other Specialist 31 - Physiotherapy 27 - Other allied health 24 - Cardiologist 21 - Dietitian/nutrition 18 - Exercise Physiologists 14 - Podiatrist 9 - Respiratory physician 6 – Diabetes education	6 – Psychology 4 - Renal Specialist 3 - Radiography 3 - Dental/Oral hygiene 2 - Gynaecology 1 - Mental Health Service 1 - Gastroenterologist 1 - Audiologists 1 – Endocrinology
GP Victoria	492; *32*	232	156	127 - Local transport 6 - Radiographers 5 - Dentist 4 - ENT 3 - Oral Surgeon 2 - Counsellors 2 - Audiologists 2 - General Surgeon	1 - Maxillofacial Surgeon 1 - Neurologist 1 - Chiropodists/ Podiatrists 1 - Cardiologist 1 - Endocrinologist 1 - Orthopaedic Surgeon 1 – Vascular Surgeon
GP Queensland	3044; *39*	172	78	128 - Local transport 25 - Chiropodists/podiatrists 18 - Diabetes Educators 10 - Dietitian/Nutritionists 7 - Dental/Oral hygienists 5 - Other: AHW 5 - Physiotherapists 4 – Ophthalmologists	3 – Counsellors 2 - Other: Pharmacists 1 - Other: weight loss clinic, OT etc. 1 - Cardiologist 1 - Dermatologist 1 - ENT 1 – Neurosurgeon
WA GP Network	469; *235*	408 [a]	65 [a]	165 - Local transport 4 - Other Allied Health 3 - Optometrists 3 - Endocrinologists 3 - Bowen Therapist 3 - Other Specialist 2 - Physiotherapists 2 - Chiropodists/Podiatrists	2 - Ophthalmologists 1 - Dental/Oral hygienists 1 - Speech Pathologist 1 - GP Consult cancellation fee 1 - Cardiologists 1 - Radiographers 1 - Pharmacist 1 – ENT

SBO funded	No. of CC Services provided; No. of referring GPs	No. of patients receiving CC only	No. of patients receiving both CCs & SS	No. and type of Supplementary Services purchased	
GP Network NT	358; *14*	346 – Total number of patients. Unable to determine split. GPNNT working to resolve.		13 - Chiropodists/Podiatrists 13 – Exercise physiologists	1 - Dental/Oral hygienists
ACT Division of General Practice	475; *27*	149	0	123 - Dietitian/nutrition 103 – Group Dietetic	71 – Podiatry
GP Tasmania	25; *7*	19	6	9 - Chiropodists/Podiatrists 5 – Exercise physiologists	2 – Osteopaths 5 – Physiotherapists
GP South Australia	554; *42*	76	25	402 - Local transport 6 - Chemist for medication and or/medication reviews 5 – Urologist	4 - Chiropodists/ Podiatrist 1 - Dental/Oral hygienist 1 – Cardiologist

Sources: DoHA, B3b report July to September 2011, 11 January 2012 and DoHA, B3b report October to December 2011, 28 February 2012.

Note: Numbers do not necessarily total. Data is as provided by DoHA.

[a] Total number of patients receiving only care coordination and those receiving both care coordination and supplementary service combined is greater than the total number of care coordination services provided. This indicates there is an error in the reported data, but the nature of the error is not clear.

10.4. Findings from the Sentinel Sites

NOTES ON DATA SOURCES

Data presented in this section primarily derive from interviews and focus group discussions in case study and enhanced tracking sites and SBOs where CCs have been appointed. The data are primarily qualitative, because program activity data from DoHA are not provided at a site level. The workforce data are provided by DoHA only as recruitment occurs as the fund holders determine the allocation of positions on a needs basis. These data are not aligned with the current evaluation period.

For the period covered by this report, there were CC roles in four case study sites (Tamworth, Katherine West, Campbelltown and Port Augusta). These sites were at various stages of implementation of the CCSS program. CCs and other key informants were interviewed at these sites. Three community focus groups in two of these case study sites were asked about their awareness and perceptions of care coordination between service providers and their perception of changes over the past six months. The CCSS program was also discussed with key informants during evaluation visits to the two enhanced tracking sites of Darwin and Barkly. Stakeholders in North Lakes/Caboolture, Hobart and Dandenong also provided comment on this measure during feedback visits to these three tracking sites.

The early stage of implementation of the CCSS measure in the majority of case study sites means the data available on implementation at site level remains limited.

Data were not obtained from those sites where implementation of the measure had not commenced or work was not focused within the site boundaries. This included three case study sites (East Pilbara, Logan/Woodridge and Brisbane South) which have CCs allocated to an organisation with jurisdictional responsibility for the Sentinel Site. The focus of the positions is on working in locations outside the Sentinel Site boundaries. A further case study site (Bairnsdale) has not been allocated funding for the CCSS program and does not therefore contribute any data on this measure.

COLLABORATIVE DEVELOPMENT OF LOCAL CCSS ARRANGEMENTS

Local implementation is fairly complex, requiring considerable stakeholder engagement and a number of steps in order to deliver services in accordance with measure guidelines. This section describes findings in relation to how the CCSS measure has been implemented at the local level in participating sites. The steps required to achieve program delivery are shown in the Figure 10.1 below. These steps are important, as emerging barriers and enablers to effective implementation can be identified at the various steps.

Implementation activity needs to take into account that the roll-out of the funding for the CCSS has been different to other ICDP funded programs. The CCSS funding was allocated to the SBOs who act as fund holders. Each SBO then either called for expressions of interest or released targeted funding for organisations in each State or Territory. For the expressions of interest DGPs/AHSs were 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.

In light of the multiple steps required to implement the CCSS measure, it is not surprising that the program has not yet achieved substantial impact on service delivery, as these processes take time to implement.

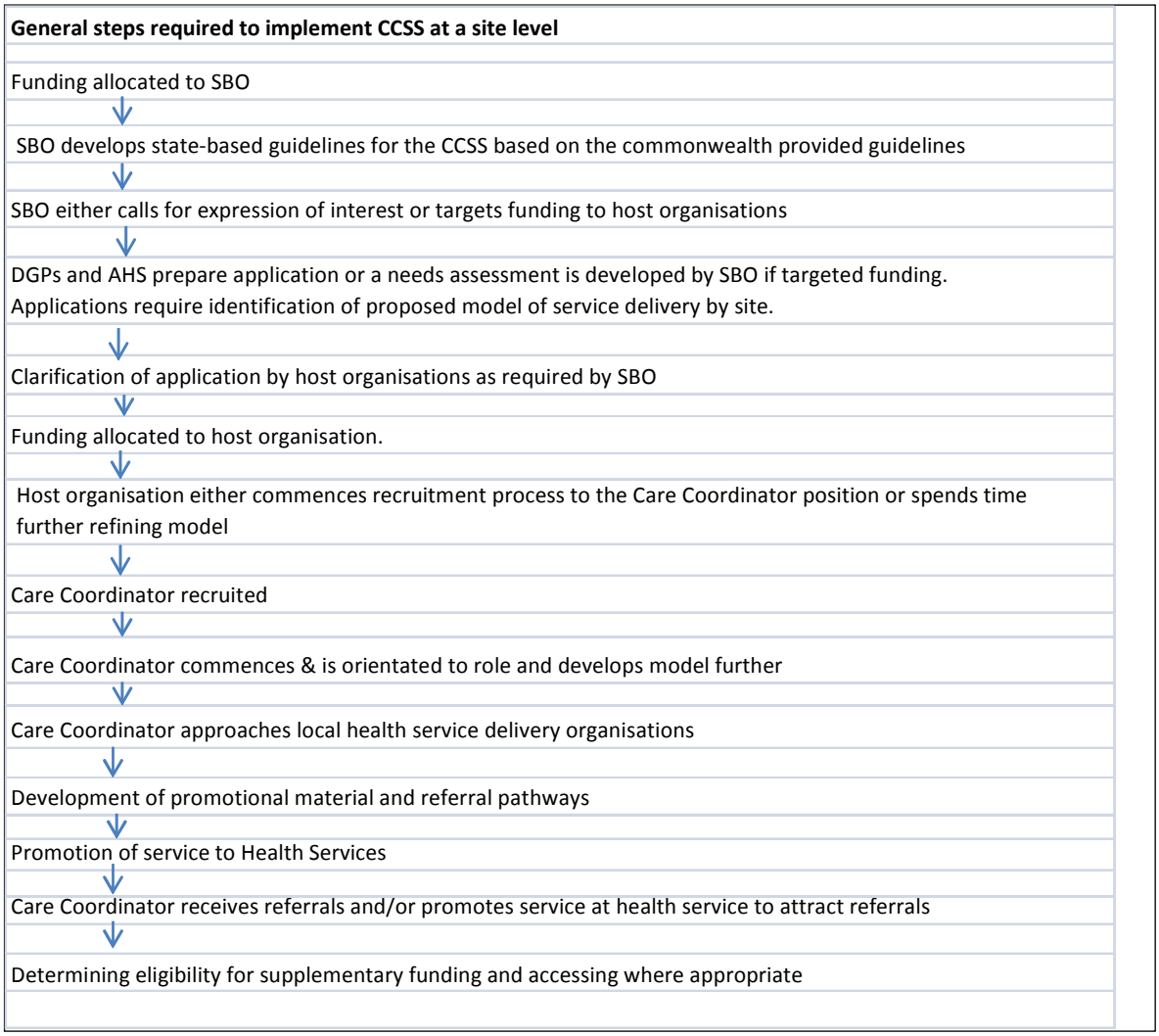


Figure 10.1: Implementation of the Care Coordination and Supplementary Services program

ALLOCATION AND RECRUITMENT FOR CARE COORDINATION POSITIONS

Table 10.2 presents the allocation and recruitment status of CCs at a site level; according to data provided by DoHA as at 31 December 2011 and data gathered by the SSE through evaluation visits and interviews. These data show twenty-one of the twenty-four Sentinel Sites have CC positions allocated to key organisations for the sites. These included sites located in urban areas (n=8), regional (n=10) and remote sites (n=3). Seven of these sites are SSE case study sites. One organisation represents South East Queensland which includes the regions for three urban Sentinel Sites. Only one site receives the care coordination service through this organisation, as a state-based service co-exists.

Allocation of positions varied by FTE status, but no clear pattern was evident with regards to rurality and FTE status. Across the Sentinel Sites, between 0.4 and 3.0 FTE status positions were allocated per site with a median of 1.0 status. Positions in urban sites tended to be 1.0 FTE. Three of the ten regional sites had recruited part-time positions ranging between 0.4-0.8 FTE.

Host organisations for Care Coordinator positions included DGPs (or Medicare Locals) and less commonly AHSs. As indicated, all of the known allocated positions, with the exception of those in Katherine West, Darwin, North Lakes/Caboolture and part of the Hobart allocation

were based in DGPs or more recently, Medicare Locals. Positions in all of the sites were filled, with the exception of Dubbo (where a position has recently become vacant).

Recruitment of Care Coordinators showed considerable progress since the last reporting period. Twelve more CC positions were filled over the most recent reporting period, although one of these positions had become vacant. Nineteen of the twenty-one sites with positions allocated (90%) had successfully recruited to these positions.

Recruitment to positions did not appear to be consistently more or less challenging in urban, regional or remote sites. One urban site (Dandenong) had been trying to recruit to the position for some time without success. The DGP changed the service delivery model as a way of overcoming the difficulty with recruitment. Other urban sites reported no delays. Of the ten regional services with positions allocated, all sites had at least some of their positions filled over the reporting period. As indicated above, one site (Dubbo) had a position that had recently become vacant. Three remote Sentinel Sites had funding for CCs and had filled these positions. Two of these sites will not receive services from the positions due to the distance of the sites from the location where the positions are based. Katherine West had a newly appointed CC.

Table 10.2: Recruitment and retention data for Care Coordinators by Sentinel Site as at 31 December 2011

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/Retention status and Changes since Dec 2011 SSE report
Case study sites					
Port Augusta	Regional	Flinders and Far North Division of General Practice	1.0	1.0	Position remains filled
Campbelltown	Urban	Sydney South West GP Link (formerly Macarthur DGP)	1.0	1.0	Position remains filled
Logan/Woodridge	Urban	Institute for Urban Indigenous Health [a]	4.5 [a]	4.5 [a]	Positions remain filled, not servicing this site. Area covered by State-based Care Coordinators [a]
Brisbane South	Urban	Accoras	1.0	1.0	New position filled since previous report
Tamworth	Regional	North West Slopes DGP	1.0	1.0	Position remains filled [b]
East Pilbara	Remote	Pilbara DGP	1.0	1.0	Position remains filled. Based in Karratha doesn't cover the site [c]
Katherine West	Remote	Katherine West Health Board	1.0	1.0	Position filled recently [d]
Enhanced tracking sites					
Newcastle	Urban	Hunter Urban Medicare Local (formerly GP Access)	1.9	1.9	One position filled since previous report and one new position filled March 2012
Dubbo	Regional	Dubbo Plains DGP	1.0	0	Position filled since previous report. Filled from September 2011 - March 2012, now vacant [b]
Swan Hill/Mildura	Regional	Lower Murray Medicare Local (formerly Mallee Health Care Network and Mallee DGP)	1.0	1.0	Position filled since previous report. Swan Hill township is now not covered by the same Medicare local as Mildura but there is a transition phase. GPV are negotiating with the Loddon-Murray-

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/Retention status and Changes since Dec 2011 SSE report
					Mallee Medicare Local for care coordination arrangement for Swan Hill [e]
Elizabeth	Urban	Adelaide Northern Division of General Practice	1.0	1.0	Position filled since previous report. Recruited December 2011 [f]
Derby	Remote	Boab Health Services (formerly Kimberly DGP)	0.5	0.5	Position filled since previous report. Funded organisation is situated in Broome, role not proposed to cover Derby site [g]
Darwin	Regional	Danila Dilba Health Service	1.0	1.0	Position new since previous report [h]
Tracking sites					
Kalgoorlie	Regional	Goldfields Midwest Medicare Local (formerly Goldfields Esperance GP Network)	0.5	0.5	Position remains filled. Commenced December 2010 [i]
Canberra	Urban	ACT Medicare Local	3.0	3.0	Positions filled December 2011 and January 2012.[j] National Care Coordinator role also based at AGPN, ACT
Geraldton	Regional	Goldfields Midwest Medicare Local (formerly Mid West General Practice Network)	1.0	0.8	Position remains filled. Commenced December 2010 [i]
Grafton	Regional	Mid North Coast Division	1.0	1.0	Position remains filled. Commenced May 2011 [b]
Dandenong	Urban	Dandenong Casey GP Network	1.0	0	Recruitment commenced. Recruitment had not been successful. The service delivery model has been changed and recruitment continues [k]
North Lakes/Caboolture	Urban	Metro North Brisbane Medicare Local/Institute for Urban Indigenous Health[a]	2.0[a]	2.0[a]	New positions since previous report. Positions filled 2011 and January 2012.[l] There were 4 positions recorded to make the 2.0 FTE.
Gladstone	Regional	Capricornia Division of General Practice	1.0	1.0	New position filled this report

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/Retention status and Changes since Dec 2011 SSE report
Hobart	Regional	Tasmanian Medicare Local (South)	0.6	0.6	New position filled recently. Position commencing part time until the workload increases. To start at one GP practice that has a number of eligible patients [m]
		Tasmanian Aboriginal Corporation	0.4	0.4	New position being established in Hobart. TAC has one Care Coordinator also in Launceston (out of the site boundary) [m]

[a] DoHA reports a recruitment of 4.5 FTE for CCs at IUIH to cover the SE Queensland region. Logan/Woodridge and Brisbane South sites are not recipients of this service as a pre-existing state-based service is operational in the region (evaluation visit 27 February, 2012). North Lakes/Caboolture has received 2.0 FTE of that 4.5 recruitment.

[b] GPNSW, personal communication, 16 April 2012.

[c] Evaluation visit update, 19 March, 2012. This position was filled in July 2011 but the data had not been available in the previous reporting round.

[d] GP Network NT, personal communication, 20 March 2012.

[e] GPV, personal communication, 12 April 2012.

[f] DoHA B5B update, personal communication 26 March 2012.

[g] Evaluation visit update, 15 October 2011.

[h] Evaluation visit update, 15 March 2012.

[i] WA General Practice Network, personal communication, 26 March 2012.

[j] ACT Medicare Local, personal communication, 12 April 2012.

[k] Evaluation visit, 21 February 2012.

[l] GPQ, personal communication, April 2012.

[m] Evaluation visit , 27 February 2012.

Note: Bairnsdale, case study site, had applied for funding but is waiting on the establishment of the Medicare Local before progressing (GPV, personal communication, 12 April 2012).
Cairns and Barkly site do not have any ICDP CCs within the boundary.

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, 31 December 2011 unless specified by footnotes.

TRAINING FOR CARE COORDINATORS AND ORIENTATION TO ROLE

CCs that were interviewed in this reporting period had all attended networking workshops facilitated by the SBOs. These networking workshops brought together the CCs with other categories of ICDP funded workers based within DGPs such as OWs and IHPOs. The Regional Tackling Smoking and Healthy Lifestyle teams funded predominately through AHSs did not participate in these workshops.

Whilst CCs valued the networking aspect of these workshops, concerns were expressed regarding the lack of specialised training offered to the CCs as a separate group. CCs' suggestions for specialised training included clinical training on chronic disease management, care coordination or on patient information systems with Health Services.

> *'More practice stuff … computer packages as each practice have different packages such as Communicare, Medical Director, Best Practice, Monet, sphere … I don't have access to a lot of those computer packages.'* (Interviewee, DGP, CC)

As reported previously one CC has attended the Flinders Chronic Disease Self-Management training run by Flinders University as part of measure B4 (Section 11). In this reporting period the CC again highlighted that the training provided at the self-management workshop equipped her with skills to fulfil her role. The CC also attended a quitting smoking workshop.

> *'I attended the self-management training workshop … there was a focus on Aboriginal specific chronic disease … how to deal with Aboriginal patients like no shows. From Flinders University, it was worthwhile, the care plan is better it is holistic, patients set their own goals.'* (Interviewee, DGP, CC)

It was also noted by interviewees that CCs are being placed in or working with private General Practices. There was a perception that the small business nature of private General Practice meant that the presence of the CCs may have little influence on the way the practice is organised. These comments were made in relation to documentation practices recommended in the Flinders training. While the placement of CCs in General Practice was viewed as positive, there was a perception that their potential to change established documentation practices to be more in line with the self-management model would be minimal.

DEVELOPMENT OF LOCAL CARE COORDINATION MODELS

The measure guidelines envisage the development of local care coordination guidelines and models that take local contextual factors into account. A foundation for the local care coordination models is laid through development of work plans/funding submissions that DGPs submit to SBOs as the fund holders. Evidence from Sentinel Sites indicates that this approach and preparatory work are valuable and the guidelines that have been developed by the SBOs are often referred to as being helpful and a good starting point for development of local models.

LINKAGES WITH OTHER ICDP FUNDED POSITIONS

Within the work plans/funding submissions that DGPs submit to their SBOs as the fund holders, 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.

'[The] process of applying gave us time to think through linkages and how to operationalise program.' (Interviewee, DGP, Manager)

Examples of how the various ICDP funded positions are working together at the local site level include:

- OW support in identifying possible patients. In some sites, OWs who are based in DGP play a role in identifying patients who may benefit from care coordination services, for example, at community events or hospitals, and referring these to the CC, who then returns to the GP for an 'official' referral.
- IHPO assistance with access to General Practices and informing of the care coordination service, through established relationship with practice.
- OW assistance with arranging transport services.
- Collaboration between the OW and CC, working at General Practices together.

  'They stay for two hours, the Outreach Worker sits on the reception desk, the Care Coordinator sits in an allocated room at the rear. The Outreach Worker engages with people walking in the door and practice staff, the Care Coordinator works on referrals for case management and with practice staff to identify potential referrals.' (Interviewee, private General Practice, GP)

- Assistance with reporting by the IHPO, easing some of the administrative burden from CCs.

  'I get quite a lot of clerical support from the IHPO. The IHPO helps out with a lot of clerical stuff she is pretty good about that so that has been useful because I have a clinical background. The finance team at the Division have also been absolutely fantastic because a lot of the CCSS programs are required to deal with funds and establish pathways for invoicing.' (Interviewee, DGP, CC)

Vignette – OWs and CCs work together, bringing local knowledge that can enable access to services

A community member in a regional site recounted the outcome of a home visit from the DGP based OW and Care Coordinator.

A family's GP had referred a family member to a private specialist imaging service in a town 75 kms away. However, no transport was available and the patient was faced with the prospect of missing the appointment. The OW and Care Coordinator were aware of the family's circumstances and knew the service was available at the town's public hospital. The referring GP was contacted and the referral was changed to be done locally. The OW was able to supply a taxi voucher to assist the family with transport to have the procedure done at the local hospital.

Although on the whole there were positive instances of linkages with other ICDP initiatives, as described above, there was no evidence from the case study site interviews of the CCs working with the Tackling Smoking and Healthy Lifestyle teams funded under the ICDP. This may be partly due to there being different host organisations for these teams (the latter teams usually being in AHSs and the former in DGP), and the need to still develop effective inter-sectoral

working relationships. The Tackling Smoking and Healthy Lifestyle teams are not included for example in the networking workshops held as part of CC orientation, whereas other categories of ICDP workforce are included. In one regional site informants felt that roles between OW, CC and IHPO needed further clarification, and that a lack of clear role definition was impacting on ability to work as a team. OWs as entry-level workers are not necessarily equipped to provide accurate advice and the legal and social ramifications of this continue to be expressed as a concern by DGP staff. The DGPs often noted they 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 CCs join the teams.

LINKAGES WITH OTHER SERVICE PROVIDERS

Interviewees often commented that the CC program is a new type of program and that it has taken time to develop guidelines that are locally relevant. There continues to be evidence of the CCs spending considerable time developing local collaborative arrangements for the CCSS program. This activity includes:

- Identifying visiting and existing services and stakeholders in the region to ensure there is no duplication of service development.
- Identifying and linking with existing state-funded care coordination programs where appropriate, such as Connecting Care in NSW. The supplementary services guidelines indicate that prior to use of the SS funding all other applicable funding sources must be exhausted. CCs are spending time exploring what these other avenues of funding are and how to access them.
- Approaching health service providers (such as specialists and allied health professionals) about participating. This is often through establishing arrangements whereby services agree to either bulk-bill patients referred or agree on a process for paying the 'gap' fee through supplementary services.

  > *'Today I have had a patient referred to access two specialists services but I haven't actually had any contact with them. So these two services I will have to go down and talk to and try to establish a relationship with them. That's why it is time consuming at this stage.'* (Interviewee, DGP, CC)

- Establishing referral pathways once a patient is referred into the care coordination service.
- Establishment of documentation such as referral templates and brochures.
- Identifying and approaching Health Services to encourage referrals.

Vignette – A Care Coordinator's role in negotiating access to specialist services

The Care Coordinator in a regional site has been key in reforming the system of referrals to specialist services for Aboriginal and Torres Strait Islander patients. It has taken time to break down the barriers, but persistence and the availability of ICDP funding has achieved more equitable access for site residents.

'[It is] hard work to get [specialists] on board. Getting past the receptionist is probably the hardest part in my job' (Care Coordinator).

Specialists had been reluctant to bulk bill and to accept referrals for Aboriginal and Torres Strait Islander patients because individuals had missed appointments in the past. One practice was persuaded to give it another try, saying, '*if the patient does not turn up there will be consequences'*.

The patient attended the appointment, the practice invoiced and was paid promptly. Several other Aboriginal and Torres Strait Islander patients have since used the specialist service.

' … the feel that I get now from the receptionist is completely different than when we first started going out to this service. Our patients will be getting a different feel when they go back to this service as well.'

REFERRALS TO THE CARE COORDINATION PROGRAM

In the majority of sites, given the early stage of implementation, the numbers of referrals to CCs continues to be low. However, in sites where the CC has been established for longer (for example in Campbelltown) more referrals were being received.

Across all sites with CCs, four of the twelve clinicians interviewed who were aware of the care coordination position agreed with the statement '*I regularly refer patients to the care coordination service.'* The finding that only one third of clinicians interviewed regularly refer patients to the care coordination service must be viewed in the context that the Health Services selected for interview are ones that have been identified as interested in Aboriginal health. The low referral rates is also consistent with state level program data supplied to DoHA by the SBOs, indicating low referral rates from GPs. However, there has been some improvement since the last reporting period (see Table 10.1).

> *'We only have eight people on our books and it is happening to an extent.'*
> (Interviewee, DGP, CC)

In order to appropriately refer to the CC it is necessary that service providers are aware of the position, appreciate its value and have some understanding of the role of the position.

Awareness of the position in those sites in which the position was established was generally high across the range of stakeholders interviewed. In this reporting period, for those sites with CC positions established, there was generally increased awareness of the positions compared to the previous reporting period. Of the 51 key informants interviewed, 77% were aware of the positions compared to 47% (18/36) in the previous reporting period. In this reporting period, levels of awareness in the AHS sector were similar to those in the General

Practice sector [82% (18/22) compared to 72% (21/29)]. As expected, there was low awareness of CC positions in Logan/Woodridge and Brisbane South sites, as the ICDP funded CCs (whose work covers the greater Brisbane area) are not focusing their work in these two sites. Interviewees were often initially confused about who the evaluation team were referring to when asked about the ICDP funded CC. This was apparently because of a number of state funded initiatives and local initiatives such as Care Plan Coordinators and Chronic Disease Nurses. Time was taken to ensure that responses to the SSE evaluation questions pertained to the ICDP funded position.

Some interviewees indicated that it is taking some time to gain confidence and trust in the care coordination program. A number of interviewees expressed concern about confidentially stating they would rather use in-house capacity.

Some CCs felt that where the position was not embedded into the Health Service, this diminished the potential effectiveness of the role.

> *'There is so very little clinical component in this job … need to look at more clinical work in the role and need access to medical records. Should be based in General Practice clinic, access to their medical records, I would like to go see results, should be based almost entirely in practices e.g. half a day in a practice each day, Outreach Worker needs to be in practice to get patients, time could be better spent in clinics better engagement with GP management plan, people get to know you.'* (Interviewee, DGP, CC)

The guidelines for the care coordination program indicate that referrals to CCs are to be accepted only from a PIP Indigenous Health Incentive registered practice and the patients are to be identified as having an established chronic disease and a care plan. Interviewees appear to have generally interpreted this requirement for the patient to have a 'care plan' as a requirement for the patient to be referred with a GPMP) and/or TCA. However, Health Services reported difficulty following these referral requirements. Factors identified as potential barriers to following this process were:

- Difficulty identifying eligible patients in practices where chronic disease registers are not well developed.
- The low proportion of Aboriginal patients with chronic disease in General Practice populations appeared to result in generally not being alert to the potential to refer an Aboriginal or Torres Strait Islander patient to a CC.

  > *'The General Practices that are referring are those with a high population of Aboriginal patients.'* (Interviewee, DGP, CC)

- Lack of registration as a PIP Indigenous Health Incentive Health Service, making some services ineligible to refer.

  > *'A colleague from the DGP Practice Support team has identified patients but they are not from an accredited practice so can't be referred to ICDP care coordination'* (Interviewee, CC)

- Minimal use by GPs of GPMPs and TCAs to manage and coordinate care needs of patients with chronic disease and a perception by CCs that without GPMPs and TCAs patients were not eligible for access to the CC service.

In order to increase referral rates CCs were starting to use a variety of other methods to establish a patient base. These include:

- CC attending community groups and functions and identifying community members, then taking the patient back to the Health Service and advocating for a referral and getting patient on a GPMP and/or TCA.

  '[Name of CC] is working in a community engagement model where she attends community events and programs and identifies patients this way. The model being advocated by DoHA is that the Care Coordinator accepts referrals from PIP registered practices of patients with a GPMP/TCA. [Name of CC] is working the other way and identifying community members who may need additional assistance then working with their regular GP to get the patient on a GPMP/TCA. If don't have a GP then identify to patient the practices and arrange an appointment.' (Interviewee, DGP, Manager)

- CC working with other programs and services such as hospital discharge programs to identify possible patients
- CC working with practices to identify patients through reviewing disease registers and expired GPMP and TCAs

  'A lot of referrals are from the local population health workforce, the allied health staff including diabetic educator and the dietitian. There have also been referrals from aged care and from a variety of other areas including some GPs and the AMS.' (Interviewee, DGP)

CCs across all sites indicated that they will be spending significant amounts of time following up with practices that have referred patients (or patients the CC has identified) to ensure the patients have GPMPs and/or TCAs and to determine what services are required. It was also recognised that once a relationship had been established between the GP and the CC, the GP began to refer patients to the CC.

> *'Sometimes GPs aren't referring … and what's happening is that the Care Coordinators are engaging patients prior to GPs, so they're [Care Coordinators] are engaging patients opportunistically through community, through their patients or a number of other circumstances and then the Care Coordinators are working to engage the patients with the GP and get them onto a care plan. It is a bit of a back door approach … but referrals start coming as soon as a relationship is established between the GP and the Care Coordinators … referrals start coming.'* (Interviewee, SBO)

A number of interviewees continued to indicate that for Aboriginal and Torres Strait Islander people a barrier in accessing the CCSS program was the restriction on access to the CCSS to patients referred by a PIP Indigenous Health Incentive practice and to patients with a GPMP and a TCA.

Different sources and mechanisms of referrals to the Care Coordinator, and different approaches to integrating the care coordination function into primary health care systems.

- CC based in DGP and is currently predominately getting referrals from AHS; this may be related to the prior employment of the CC as a nurse at the AHS.
- CC based at the DGP and is currently receiving referrals from General Practice (predominately).
- CC based in DGP and has established a roster at General Practices to have the OW and CC placed at General Practice for two hours twice a month.
- CC based in the DGP but has been prioritised to work in another area of the DGP, which is not within the Sentinel Site boundary.
- CC based in the DGP but is allocated to work in another area of the DGP, which is not covered by the Sentinel Site.
- CC based at the AHS and working in a clinical role in the clinic setting with access to patient records.

Despite this variation in approaches described above, the use of the funding in the Sentinel Sites has been in line with the first of the possible models proposed in the CCSS guidelines[128] developed by DoHA. The possible models proposed by DoHA include:

- full- or part-time employment of a CC;
- "sharing" a CC position/CC role across General Practices;
- contracting the services of an appropriately qualified clinician to provide care coordination;
- "topping up" the salary of an AHW or a nurse in an AHS.

The above list is not considered 'exhaustive' by DoHA and they express willingness to explore other models for funding that suit local circumstances.

GEOGRAPHIC COVERAGE

For some key informants, the large areas that the CCs are required to cover was seen as a constraint on their effectiveness and on their ability to reach a reasonable proportion of the people in these areas who could benefit from their services. At the site level, it seemed that in most instances CCs are directed to focus their efforts in certain priority locations. For some informants issues of equity are a cause for concern.

> *'With the care coordination program the Division made the decision that care coordination program will be available only in the [area name]. This is unfair in [service name] point of view. That means that Aboriginal people in [area name] of whom there are about 3000 do not have access to the Care Coordinator. This should be available for whole area.'* (Interviewee, Urban Site, DGP)

[128] DoHA, CCSS Program Guidelines, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/improving-frontline-health/$file/ICD-Package-Care-Coordination-and-Supplementary-Services-Program-Guidelines.pdf (accessed 28 May 2012).

EMERGING ROLES OF THE CARE COORDINATORS

Interviewees consistently reported that the role of the CC was 'administratively heavy.' CCs reported that much of their time was spent firstly establishing the program and then engaging in tasks related to referrals, facilitating access to other care providers and reporting.

A significant administrative burden was linked to the supplementary services funding component of the program.

> *'CCSS program is really paperwork intensive - requires enough paper work to demonstrate that the right patients are in for the right reason, as well as the actual payment mechanism. It is very admin heavy.'* (Interviewee, SBO)

For some CCs, the administrative component of the job meant that they were afraid of losing clinical skills. The role was emerging more as a service navigation role rather than managing patients' care with coordination of clinical interventions.

> *'It's been challenging, miss the clinical stuff, hands on, patient contact though I've learnt a lot from setting up this system. Reporting is six monthly, quarterly and monthly. Each month supplementary fund, quarterly we report the number of services I have referred to or used. We have a twelve month work plan – goals, strategy, outcome, hard to plan ahead. I can't understand why RNs are in a case management role, the only clinical thing is the GP management care plan but I don't even do this. I make sure I do stuff to keep clinical skills up, I can't let clinical skills lapse too far. The job's not clinical. This is office work. If they structured the role better RNs would stay.'* (Interviewee, DGP, CC)

AWARENESS OF SUPPLEMENTARY SERVICES FUNDING

There is a reasonably high level of awareness of the supplementary services funding across remote, regional and urban areas (Table 10.3). Because of the early stage of implementation few interviewees were asked about awareness of the SS funding in the previous round, but the data do provide an indication of increased awareness from 38% (5/13) in the previous reporting period to 73% (36/49) in this reporting period. In this reporting period the awareness amongst clinicians of access to the supplementary services funding was recorded across all sites with an allocated CC position, whereas in the last reporting period only clinicians in one site (Campbelltown) were aware of the funding.

Table 10.3: Managers, Project Officers and Clinicians awareness of availability supplementary services funding by rurality and sector [a]

	December 2011	June 2012
Overall	38% (n=13)	73% (n=49)
Remote	>5	77% (n=13)
Regional	>5	93% (n=14)
Urban	56% (n=9)	59% (n=22)
Aboriginal Health Sector	>5	65% (n=20)
General Practice Sector	>5	79% (n=29)

[a] Type of interview respondent, see Appendix D for listing of interview types and respondent types.

n = number of people who responded used. Aboriginal Health Sector includes: AHSs, NACCHO State and Territory affiliates. General Practice Sector includes: private General Practice, DGP and Division State-Based Organisations.

USE OF SUPPLEMENTARY SERVICES FUNDING

In response to the statement *'Supplementary Service funding has enabled patients to access services required through the private sector'* in the previous reporting period most respondents 73% (16/22) indicated that they 'don't know/can't say', compared to 31% (14/31) in this reporting period. Previously interviewees indicated that they were not accessing this funding for a variety of reasons, but in this reporting period there is not only increased awareness of the funding source but also an increase in reported utilisation of the source of funding. This is also evident in the program data provided by DoHA at a state level (Table 10.1).

Data from interviews and from DoHA indicate that funding has been utilised primarily for transport (Table 10.1).

Vignette - Use of CCSS funding to access specialist services

In a regional Sentinel Site, cost, travel and cultural safety are barriers to Aboriginal and Torres Strait islander patients attending specialist appointments. One patient with a very serious medical problem regularly needed specialist services that were only available in another regional city. The CCSS funding and the availability of the Care Coordinator to 'walk with her' enabled her to get the treatment she needed.

'*By offering the supplementary services through care coordination we are actually getting the patients to the service. It works, it's not rocket science. We take out the facts that prevented [patients from] going which is cost or transport. Now they are going. We do not have to re-invent the wheel. We have actually enhanced the existing structure'.*

Supplementary Services funding, together with advocacy and support from the Care Coordinator, has enabled patient access to care.

Despite the improved awareness and uptake of the SS funding there is still relatively low uptake overall and for funding of specialists and allied health in particular. Reasons provided for not accessing the SS funding included:

- Relatively recent commencement of CC with time taken to establish roles and relationships and establishing local guidelines to ensure equitable access.
- Continued confusion about what is funded and what is not under SS funding.

  'There is confusion with the criteria [for supplementary funding] and this has caused issues for us as a team.' (Interviewee, GP)

- Requirement to fully utilise existing funding sources prior to use of SS funding, for example, using the patient assistance transport scheme rather than using SS funding for transport.
- Perceived heavy administrative requirement particularly for the SS funding. In one site the IHPO was assisting with supporting the CC so they could maintain focus on their clinical role.

  'Care Coordinators have a lot of administrative work with the supplementary services. To get the gap paid the CC pays allied health who invoices AMS for full amount … CC

has to authorise through finance to pay and then get back the rebate through Medicare. Admin can't do this in the AHS as there is private information so the CC finds herself doing a lot of admin.' (Feedback provided from tracking site)

- SS funding unnecessary if specialist/allied health provider agrees to bulk-bill patient. This sometimes occurs because of advocacy by the CC.

  'Referrals mostly come from [AHS name] to specialists who sit in their own rooms in [site name]. Generally the patients do not need the care coordination services if they are through the MSOAP-ICD or USOAP. Endocrinologists goes to [AHS name] so that's free and [AHS name] usually organise that service.' (Interviewee)

A number of different perceptions regarding what can and cannot be funded under the SS guidelines have been identified. Gaps identified in SS arising from the funding criteria include:

- Equipment such as orthotics, glucose monitors, glasses, shower chairs and rails.
- Payment for escorts, particularly in remote sites, or for a person to meet the patient at the other end.
- Payment for the gap payment for medications if the patient is not eligible for free medications.

  'Received feedback from the CCs that even the $5 gap payment can remain as the access issue. CCSS cannot also cover this gap so that's a barrier issue. People are often in multiple drugs that build up.' (Interviewee, SBO)

- Payment for dose administration aids for medications such as Webster packs for Health Services that are not receiving QUMAX funding.

  'Webster packs are in demand to be provided for free but the pharmacies can't do that and the CCSS can't also subsidise this - which is a barrier. Feeling is that it is so simple but not covered which can prevent so much.' (Interviewee, SBO)

- Funding for surgical procedures has been identified as a gap, in particular, funding for procedures associated with ophthalmology.

  'CCSS cannot provide surgical care. The value of medical consultation then gets wasted if the patients cannot afford the surgery that is recommended in the consultation. It is a benefit that patients can access the specialists for their medical management under the CCSS program but surgery is definitely a barrier.' (Interviewee, SBO)

It is recognised that there may be good reasons for not including these in the guidelines from a DoHA perspective and that funding for these services may be able to be accessed elsewhere.

Vignette – The benefit of having medicines supplied in Webster packs

A focus group comprising older community members, many of whom have chronic diseases, discussed the benefits of access to Webster packs.

'It is good and very clever that way it is put together. There is information on the back of the packs that tell you what the medicine is, you don't have to carry around lots of bottles'.

The AHS in the site has a service through which Webster packs are delivered to patients. Patients of private General Practices in the site recounted positive experiences at local pharmacies.

'*The lady at the XX Chemist told me what [each of] the medicines [in the Webster pack] is and what it is for'.*

Community focus group participants in another site said, '*Used to get [medication in boxes ... New plastic Webster packs have made a difference – 3 week supply – I don't have to worry getting tablets'* and '*Webster Packs are good, more convenient*'.

COMMUNITY PERCEPTIONS OF CARE COORDINATION

Despite the commencement of a care coordination service in the majority of the sites, the community focus groups generally did not show any awareness of the new position. Given that the position targets those people with chronic disease who are considered particularly likely to benefit and the service is available to only a few people in the population, this is not surprising.

SUPPLEMENTARY SERVICE FUNDING AND MSOAP-ICD/USOAP INTERACTION

As reported in the previous round, there was some concern expressed that the supplementary service and USOAP/MSOAP-ICD measure are working in competition with potential to have a negative impact on each other as they may drive up costs of specialists.

In this reporting period some interviewees at site level have begun to question the logic of bringing specialists into primary health care services under USOAP suggesting that access to existing specialists should be encouraged instead with this being supported through the CCSS program.

10.5. Summary

1. The way this measure has been rolled out is fundamentally different to other measures. Organisations are required to apply for the funding and to demonstrate how they will integrate the funding into service delivery models. While this has delayed the roll-out of the measure at a site level, there is some evidence that it has allowed for more extensive planning to be undertaken.
2. Data provided by SBOs on care coordination activity across the country show that 1995 patients had received care coordination services from July to December 2011 and 1615 Supplementary Services had been purchased in total. There is some evidence of

progress with implementation across the majority of sites, with CCs appointed and commencing activities across the majority of sites.

3. CCs indicated that the role has emerged as administratively burdensome and for some CCs, the administrative component of the job meant that they were afraid of losing clinical skills. The role was emerging more as a service navigation role rather than managing patients' care with coordination of clinical interventions.

4. There is early evidence that the uptake of the SS funding is limited partly because of uncertainty about how to use the funding and how to dispense it equitably and partly because of the requirement that other potential sources of funding are expended before SS funding can be used.

5. There is some evidence that the CC positions will have limited population coverage (even in reaching specific vulnerable groups who would stand to benefit most from the program) because of small numbers of positions with responsibility for coverage of large geographic areas or large populations and the consequent need to focus their effort in specific areas.

    5.1. Whether these positions are in fact reaching the target population (or just the easiest to reach) is difficult to ascertain with current data. Within Sentinel Sites, the CC positions are generally based within DGPs and are expected to cover the whole Division. CCs are being directed to work in specific locations where need is seen to be greatest.

    5.2. The processes used for identifying how the CC resource should be deployed are not clear, but appear to be primarily about identifying a specific geographic area of focus for their work. However, the target population may be dispersed over a wide geographic area, and there may be more effective ways of distributing the CC resource in order to reach those who are likely to benefit most (for example through records of frequent avoidable hospitalisations).

    5.3. The model of employing a specific person in the CC position is the only approach that has been used in Sentinel Sites. Use of alternative models (as outlined in the DoHA guidelines for the CCSS measure) may provide benefits in terms of population coverage and greater integration of care coordination functions into existing primary health care systems.

6. Generally, the program roll-out is designed to accept referrals to CCs only for PIP Indigenous Health Incentive registered patients who have a care plan. This appears to have been generally interpreted as a requirement for referred patients to have a GPMP and TCA. In theory, this enables the CC to be listed as a provider on the team care arrangement and to provide feedback to the GP through the TCA feedback process. In one site where the service has been accepting referrals, the CC was finding it challenging to have patients referred with the appropriate care planning documents and processes in place. This may be a significant barrier to the effective operation of the care coordination measure, especially given the very low rates of Tier 1 payments nationally.[129] There is emerging evidence that Aboriginal and Torres Strait Islander patients are being registered for the PIP Indigenous Health Incentive, but that care plans are not necessarily being completed to trigger a Tier 1 payment.

[129] DOHA reporting - In 2010, 26 073 patients were registered for the PIP Indigenous Health Incentive and of those, 1382 (5.3%) triggered a Tier 1 payment and 24 796 (95.1%) triggered a Tier 2 payment.

7. There is evidence of efforts to ensure that the care coordination positions are complementing and coordinated with positions with similar roles funded through other sources.

    7.1. 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 CCs. However, there are some emerging issues in regard to tensions between the philosophy of the USOAP and Supplementary Services.

    7.2. The SBOs provide a support structure for CCs at a state level. Interview data suggest that this has been beneficial in linking, not only CCs, but also other ICDP funded workers. It is not clear how the role of SBOs may be continued with the establishment of Medicare Locals. It will be important to ensure there is a mechanism for ongoing support and linking of CCs at the state and territory level.

11. HELPING INDIGENOUS PEOPLE SELF-MANAGE THEIR RISK OF CHRONIC DISEASE (*MEASURE B4*)

11.1. Description of measure

This measure aims to increase the capacity of Indigenous people living with chronic disease to optimally manage their health condition and slow disease progression, through increasing the capacity of participating Health Services to support self-management. 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 of AHSs and other organisations such as DGPs providing care to Aboriginal and Torres Strait Islander people.[130]

The Flinders Closing the Gap Program of Chronic Condition Self-Management (herein referred to as 'Flinders CDSM') training is facilitated by the Flinders Human Behaviour and Health Research Unit and is available to health professionals (nurses, AHWs, GPs and allied health professionals) across Australia. Professional development units for GPs and registered nurses are available. Health practitioners who complete the Flinders CDSM will receive a certificate of competency which includes three Vocational Education and Training competencies that can be credited to a Health Care Certificate IV.[131]

Post-training support for participating health professionals includes mentoring (face to face, telephone and email) to support practitioners to apply the Flinders CDSM tools to patient care planning and to integrate this into the Health Service practice. Follow-up training has included smaller group sessions; one to one support with individual 'shadowing' sessions of patient contact; general certificate of competency follow-up for care plans and telephone mentoring. This follow-up is provided at the participant's workplaces or at the Flinders centre. [132]

11.2. Program logic

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

Expected outputs for year 1 and beyond:

- There are strong participation rates for B4 activities.
- Accredited courses successfully provide the necessary skills and information to deliver B4.

[130] DoHA, Improving Indigenous participation in health care through chronic disease self-management – Fact sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/chronic-disease-self-management/$file/DHA6136%20B4%20Factsheet.pdf> (accessed 10 May 2012).
[131] Flinders University [website] <http://www.flinders.edu.au/medicine/sites/fhbhru/atsi-ccm/> (accessed 13 May2012).
[132] Flinders University [website] <http://www.flinders.edu.au/medicine/sites/fhbhru/atsi-ccm/> (accessed 13 May2012).

Expected early results for years 2-4:

- Participants in B4 activities have an improved understanding of their health condition and chronic disease.
- Participants in B4 activities are better able to plan for and implement personal health goals.
- Primary health care services involved in B4 are able to offer more support services for Indigenous Australians with chronic disease.
- The workforce implementing B4 is adequately trained and resourced to deliver this measure.

11.3. State of implementation – national context

The following information was provided by DoHA and by program implementers about the state of implementation of measure B4 at a national level (relevant to the SSE) as at 31 December 2011:[133]

As at 31 December 2011, 316 health professionals had been trained using the Flinders CDSM training, exceeding the target of 175 health professionals. It is anticipated that the final numbers trained will exceed the target of 400 health professions trained by 31 May 2013.

Training has been conducted across the States and Territories, with the training location in Victoria having trained the most health professionals until the end of 2011 (Table 11.1).

Table 11.1: Flinders CDSM workshop locations by state and numbers trained to 31 December 2011[134]

State	Number trained
Victoria	105
Queensland	101
South Australia	39
New South Wales	30
Northern Territory	21
Western Australia	20
Tasmania	0

In November 2011 a two-day Flinders CDSM workshop was held in Sydney, initially arranged for the ICDP funded CCs. With places still available, the training was then opened to OWs and IHPOs.[135]

Further implementation updates were published in the Chronic Condition Management News:[136]

- Chronic Condition Coordinators in the Pilbara and Kimberley Health Services, Western Australia, are being engaged to facilitate the integration of the Flinders CDSM tools into patient management systems. This project is separate to the ICDP.

[133] DoHA, B4 report, 27 February 2012.
[134] Flinders Closing the Gap Chronic Condition self-management program, personal communication, 23 January 2012.
[135] GPNSW list - serve, Flinders CDSM Program, 3 November 2011.
[136] Chronic Condition Management News, Flinders Human Behaviour and Health Research Unit vol 9 no 1, April 2012.

- Flinders University is working with the University of Western Australia Centre for Software Practice, to embed the Flinders CDSM program as an on-line component within Medical Message Exchange (MMEx) clinical software system. Pilot testing in the Pilbara and Kimberley regions of Western Australia will be project managed through the Puntukurnu Aboriginal Medical Service in the East Pilbara.
- Region-based planning meetings, led by Flinders CDSM program staff and supported by local accredited trainers, are planned at a number of locations across Australia to assist in consolidating regional approaches to implementation of the Flinders CDSM Program including provision of ongoing local support to trainers.
- The Flinders CDSM Program two-day workshop is being developed for online delivery, a flexible approach to training that is particularly relevant for regional and remote locations.
- A three-day Closing the Gap Train the Trainer Accreditation workshop has been developed by Flinders and was first held in Victoria in March 2012. Subsequent Train the Trainer workshops will be open to other health professionals across Australia.

11.4. Findings from Sentinel Sites

NOTES ON COLLECTION, ANALYSIS AND INTERPRETATION OF DATA

Data were derived from evaluation visit interviews. Information pertaining to measure B4 was obtained through interviews and visits in all eight case study sites and one enhanced tracking site. Activity related to this measure at the local site level has, to date, been limited. This is due to early stages of implementation and the relatively small number of staff accessing the training from organisations in Sentinel Sites. Consequently, community focus group discussions did not include aspects related to this measure in this evaluation round.

PROGRESS WITH IMPLEMENTATION

Staff from organisations in thirteen of the twenty-four Sentinel Sites had participated in Flinders CDSM training until 31 December 2011.[137] The numbers of staff participating per site varied, with most sites having five or fewer staff trained. The proportion of participants who have completed full accreditation has not yet been provided.

Katherine West, Dubbo, Tamworth, Newcastle, Canberra, and Derby had one to two staff trained, Barkly and East Pilbara each had five staff attend, and Cairns, Port Augusta and Adelaide (potentially Elizabeth site) had seven to eleven staff trained. Swan Hill/Mildura organisations had over 60 staff trained. [138] There were five training sessions held in the region by 31 December 2011.[139]

In Mildura Victoria, 6-8 March 2012, the first Closing the Gap Trainer Accreditation workshop was held for trainers from WA, QLD, Victoria and NSW. An Accredited Trainer workshop is planned for Cairns in May 2012. It is open to trainers from all over Australia.[140]

[137] DoHA, B4 table of Sentinel Sites, 27 February 2012.
[138] DoHA, B4 table of Sentinel Sites, 27 February 2012.
[139] Flinders Closing the Gap Chronic condition self-management program, personal communication, 23 January 2012.
[140] Chronic Condition Management News, Flinders Human Behaviour and Health Research Unit vol 9 no 1, April 2012.

PERCEIVED APPROPRIATENESS OF THE MODEL FOR DIFFERENT STAKEHOLDERS AT LOCAL LEVEL

Large numbers of people have been trained across the sites and many people interviewed regarded the training positively. However, there were concerns related to the ability of the participants to benefit from the training, possibly owing to the limited potential to use the skills for their current roles. Concerns were also raised for the appropriateness of the model for remote sites, and/or certain organisational cultures.

The training provided in Darwin was popular with a large number of health professionals. Although interviewees commented that the training was largely provided to people unable to deliver self-management support to significant amount of people and therefore the potential impact on health of people in the community was limited.

> *'No GPs attended. Worried it was not hitting the correct audience it was overloaded with government staff.'* (Feedback from enhanced tracking site)

Staff from the AHS in this site did not attend as they felt uncomfortable providing practice patients, which is a requirement of the course. A further reason for non-participation was doubt of the appropriateness of this self-management model for their site.

By contrast, both interviewees from case study sites who had attended the Flinders CDSM training spoke positively of the experience. One of the interviewees, a CC in the DGP, also highlighted the challenge of GP engagement.

> *'The Flinders training, it was worthwhile, the care plan is better as it is holistic, patients set their own goals. Doctors don't like change; they are not taking this on board.'* (Interviewee, DGP, CC)

One interviewee in a remote site commented that the model was not appropriate for their local self-management needs.

> *'Self-management training is very valuable for a health literate population. Self-management is very text heavy, rating scales not useful [site name]. Staff need to plan patient care, then staff rate patient need, patient to rate their need and compare two, then come up with score, then work on self-identified issues, e.g. transport to shopping or doctor, not picture based, attractive for us (workers), we complete one hour adult health check, one hour self-management on top we don't have appointments, people come in when there is a problem, recall is possible re health checks, there is no problem solving here - there are no options.'* (Interviewee, AHS, program manager)

Other interviewees were aware of other self-management training offered by Flinders University (not ICDP funded):

> *'I am aware of the Flinders training purely because I did a year long course in chronic disease management and that course was part of that. If I hadn't done that I wouldn't have known.'* (Interviewee, private General Practice)

It is too early to comment on effectiveness of training in increasing the capacity of Health Services to support Aboriginal and Torres Strait Islanders with chronic disease to self-manage their conditions. As one clinician at a remote Sentinel Site noted:

'There are huge numbers of people out there that require self-management plans and one person to do them is not enough. As usual, it's going to be a slow process.' (Interviewee, DGP, program manager)

11.5. Summary

1. By the end of this reporting period, staff from organisations in thirteen of the twenty-four Sentinel Sites had accessed the ICDP funded self-management training. Interviewees who had accessed the training were generally positive about it. Interviewees at the Sentinel Sites were mostly aware of the training.
2. Although large numbers of people have been trained across the sites and a number of people interviewed regarded the training positively, there were also a number of concerns expressed. These related to:
    - 2.1. Perceptions of the lack of ability of the attendants to pass on the benefit of the training (not being in roles where they could provide self-management support). Few GPs, who would be in a good position to apply the skills gained in the training, attend the training, while other staff, less likely to be in positions to apply the skills, attended in large numbers.
    - 2.2. Perceptions that the model may not be well suited for some remote sites and/or certain organisational cultures.
3. Owing to the early stage of implementation it is not possible to comment on the effectiveness of the training in enhancing self-management support for people in the community. This will be explored in the next evaluation period, particularly in sites where large numbers of staff have attended the training.

12. INCREASING ACCESS TO SPECIALISTS AND MULTIDISCIPLINARY TEAM CARE (*MEASURE B5 PART A*)

12.1. Description of measure

This measure provides for the introduction of an USOAP that will support outreach services focusing on chronic disease management in major cities and inner regional areas.[141]

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.[142]

12.2. Program logic

As specified in the National Framework the following outcomes hierarchy 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.

[141] As identified by the Australian Standard Geographical Classification (ASGC) – Remoteness Areas (RA) 1 and 2.
[142] USOAP Program Funding Guidelines <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary/$FILE/Increasing-Specialist-Follow-up-Care.pdf> (accessed 10 April 2012).

12.3. State of implementation – national context

The following information was provided by DoHA in January 2012 on the state of implementation of measure B5 part A at a national level (relevant to the SSE):[143]

- On 15 September 2011, Minister Snowdon approved implementation arrangements for USOAP in Tasmania, South Australia and the ACT.
- Funding agreements between the Commonwealth and fund holders in Tasmania and South Australia were executed in December 2011.
- Variations to funding agreements with existing fund holders in WA, QLD and Victoria were executed in December 2011 to provide additional funding until 30 June 2013.
- The existing fund holder in NSW has also been offered a variation to the funding agreement to provide additional funding until 30 June 2013 and deliver services in the ACT.
- Fund holders will submit revised or new implementation plans in early 2012.
- DoHA is currently considering expanding the program to include allied health. This would need ministerial approval before moving forward.[144]

12.4. Findings from Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from program activity data supplemented by evaluation visit interviews and, for case study sites, community focus groups.

Program activity data are received from DoHA as per jurisdictional fund holder service updates. Data have been received until 31 December 2011 for specialty type and location. Some patient attendance data are available and current as at 31 August 2011. These are extracted from progress reports. The timing of these reports does not align with the six monthly reporting periods of the SSE. More current data were gathered where possible through the evaluation visit interviews and fund holder interviews. As there is not one prime source of data, we have attempted to construct as accurate a picture as possible, but there are some inconsistencies between data sources.

In the previous report due to the limited activity at a site level the focus of the interviews were with state-wide organisations. For this round of interviews the focus has been on site level information. Interviewees were asked about the USOAP measure in the three urban case study sites of Brisbane South, Campbelltown and Logan/Woodridge. In two tracking sites the feedback sessions included feedback on the USOAP, and during this reporting period, fund holder organisations in QLD and NSW were interviewed in relation to USOAP. 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. The findings reported here are based on two community focus groups held in an urban case study site, and whilst not true to all sites, these provide an indication of the types of issues that may be faced by community members in respect to this measure.

[143] DoHA, B5a report, 11 January 2012.
[144] DoHA, B5A personal communication, 11 January 2012.

PROGRESS WITH IMPLEMENTATION

Service populations from thirteen of the twenty-four Sentinel Sites were eligible to access the USOAP in accordance with the funding guidelines. USOAP activity was evident in USOAP program data from DoHA in eight of the thirteen eligible Sentinel Sites, and a further two sites indicated that they were preparing for participation (Elizabeth and Hobart). Although there is no USOAP host organisation located within the Brisbane South Sentinel Site boundary, we have included data from Brisbane South, because there is at least one USOAP host organisation nearby (Woolloongabba). This organisation will potentially be accessed by the population in the site owing to the geographical proximity (Table 12.1).

The three remaining sites that were eligible but were not participating and/or not intending to participate included one urban site (Canberra) and two regional sites (Tamworth and Dubbo).[145] Dubbo and Tamworth are already receiving MSOAP-ICD funding and therefore not accessing USOAP. Canberra is a tracking site and we are not aware of the reasons why USOAP funding is not accessed.

As indicated in Table 12.1, there were between two and six specialists providing care under USOAP in various sites. The majority of the specialist services were relatively new. These were either not yet operational or were commencing in early 2012 (10/29 services) or in the last quarter of 2011 (13/29 services).

For all Sentinel Sites that have USOAP activity, the host organisation is the AHS in the site. There was no evidence to date from the SSE of alternate models, such as USOAP providers being hosted by other primary health care facilities, although other models are possibly in place in other geographic areas.

Table 12.1: USOAP activity by participating Sentinel Sites as at 31 December 2011

Site	Host Organisation	Specialty	Number of services/ visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
Case study sites					
Logan/ Woodridge	Woodridge Medical Centre[a]	Dermatologist	NR	3[b]	Monthly visits[c]
		Cardiologist	NR	NR	
		Ophthalmologist	NR	NR	This service was listed in the previous SSE report No clear report on current status.
		Endocrinologist	NR	NR	Monthly visits to start in November 2011[c]
		Psychiatry	NR	NR	New service
Brisbane South	Aboriginal and Torres Strait	Dermatologist	NR	NR	Commenced August 2011′ for 11

[145] Dubbo township is ASGC-RA2 classified and therefore would be eligible for USOAP. The remainder of the site has large areas of ASGC-RA3 not eligible for USOAP.

Site	Host Organisation	Specialty	Number of services/ visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
					visits per year[c]
		Physician Respiratory	NR	NR	Commenced August 2011 for 10 visits per year[c]
		Physician – Cardiologist	NR	NR	Commenced September 2011 for 10 visits per year[c]
	Islander Community Health Services, Woolloongabba[d]	Paediatrics	NR	NR	One of two new paediatric services. Commenced March 2012 for 5 visits per year[c]
		Paediatrics	NR	NR	One of two new paediatric services Commenced March 2012 for 1 visit per year[c]
		Psychiatry – Adult	NR	NR	New service Commenced October 2011 for 18 visits per year[c]
		Surgery Orthopaedics	NR	NR	New service. Commenced February 2012 for 5 visits per year[c]
Campbelltown	Tharawal Aboriginal Medical Service	Orthopaedics	1[e]	8[e,f]	Commenced July 2011 for 12 visits per year[g]
		Endocrinology	NA	NA	New service. Due to commence March 2012 for 12 visits per year. No clear report on current status[g]
		Ophthalmology	NA	NA	Not yet operational[g]
		Obstetrics	NA	NA	Not yet operational[g]
		Cardiology	NA	NA	New service. Commencement due March 2012 for 12 visits per year. No clear report on current status[g]

Site	Host Organisation	Specialty	Number of services/ visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
Enhanced tracking sites					
Newcastle	Awabakal Newcastle Aboriginal Cooperative	Physician - Geriatrics	2[e]	11[e]	Commenced August 2011 for 12 visits per year[e]
		Physician - General	3[e]	17[e]	Commenced July 2011 for 6 visits per year[e]
Tracking sites					
Dandenong	Dandenong and District Aboriginal Cooperative	Psychiatry	NR	18[b]	
		Physician – General	NR	15[b]	New service
North Lakes/Caboolture	North Lakes Medical Centre (Institute for Urban Indigenous Health)	Physician- General	NR	NR	Commenced September 2011 for 11 visits per year[c]
		Physician – Cardiology	NR	NR	Commenced September 2011[c]
		Psychiatry – Adult	NR	NR	Commenced October 2011[c]
		Paediatrics	NR	NR	Commenced February 2012[c]
Grafton	Bulgarr Ngaru Medical Aboriginal Corporation	Physician – Cardiology	NA	NA	Not yet operational[e]
		Physician – Endocrinology	7[e]	57[e, h]	Commenced November 2010 for 12 visits per year[e]
Gladstone	Nhulundu Wooribah Indigenous Health Organisation	Ophthalmologist	NR	NR	This service was listed in the previous report. No clear report on current status.
		Paediatrics -Ear Nose, and Throat (ENT)	NR	NR	Commenced August 2011 for 4 visits per year[c],
		Psychiatry – Adult	NR	NR	Commenced October 2011 for 9 visits per year[c]
		Surgery – Orthopaedics	NR	NR	Commenced January 2012 for 6 visits per year[c]

[a] This host organisation was listed as Aboriginal and Torres Strait Islander Community Health Services in the last report. Woodridge Medical Centre is part of that organisation. They have two premises in Woodridge (evaluation visit update, 27 February 2012).

[b] DoHA, B5a service report, 28 February 2012. Patient numbers updated since January.

[c] General Practice Queensland, personal communication, 27 March 2012.

[d] Services will be provided outside the boundary but in a nearby suburb. Brisbane South residents may be attending those clinics.
[e] NSW Rural Doctors Network, USOAP and MSOAP-ICD Sentinel Site service report, 13 January 2012.
[f] Seven of the eight patients identified as Aboriginal or Torres Strait Islander.
[g] NSW Rural Doctors Network, personal communication, 2 April 2012.
[h] Fifty-five of the 57 patients identified as Aboriginal or Torres Strait Islander.
Note: Patient numbers are from progress reports and are correct as at 31 August 2011 unless otherwise specified. The next update on patient numbers will be provided by fund holders in progress reports due on 30 April 2012 (30 September 2012 for Tasmania).
No service/visit data were available for this report through DoHA.
NR - Not reported, fund holder progress reports not yet available to DoHA.
NA - not applicable.
Sentinel Sites eligible for USOAP but not included in the table are: Hobart, Canberra, Elizabeth, Tamworth and Dubbo.
The Hobart site has MSOAP-ICD currently and is organising to have USOAP specialist clinics in the future; General Physician, Psychiatrist, Respiratory Physician. They will have monthly clinics alternating weeks (Evaluation visit update 27 February 2012). Elizabeth site is investigating potential future USOAP services (Rural Doctors Workforce Agency (SA), personal communication, 2 April 2012).
Source: DoHA, B5a service report, 28 February 2012 unless otherwise indicated in footnotes.

Some discrepancies in the different data sources in relation to information on specialty types and locations were noted, and some data were unavailable. However, these limitations do not change the overall conclusions about the state of implementation of this measure. To some extent, data discrepancies can be explained by the earlier period of reporting covered by the available program data, owing to the lag time in these data becoming available. It is also to be expected that systems of reporting routine and embedding these will take some time before providing complete data.

Regions that are classified as ASGC-RA 2 Inner Regional can attract both MSOAP-ICD and USOAP funding as the eligibility criterion for both programs cover this rurality classification.[146] We note that two of the Sentinel Sites identified themselves as eligible to receive ICDP services through both funding sources. Grafton currently receives USOAP and MSOAP-ICD funding for different health professionals. Likewise, Hobart has indicated to be accessing both USOAP and MSOAP-ICD funding.

RECRUITMENT OF SPECIALISTS TO USOAP

Recruitment of specialists appeared to work more effectively where recruitment was not left up to the Health Service or GPs, but included active involvement from the fund holder. For example, whilst recruitment of specialists was a problem in some sites, in others, informants felt that recruitment had progressed well and that the fund holder had managed this process effectively.

> *'Sourcing of specialists is managed by the IUIH in collaboration with us in terms of making the relationship, scheduling the time, and coordinating all these with the clinic staff including the Care Coordinator in terms of which of the patients need to access to these referral services.'* (Interviewee, AHS)

One USOAP fund holder with an active role in the recruitment and placement of specialists felt that their recruiting process had been straightforward. Some of this success was attributed to effective utilisation of networks.

> *'We speak to contractors; go to colleges such as RACGP. We actually have more than we can place at the moment.'* (Interviewee, SBO)

[146] USOAP Program Funding Guidelines <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary/$FILE/Increasing-Specialist-Follow-up-Care.pdf> (accessed 24 May 2012).

In contrast, recruitment had not proceeded well at a number of other sites. Whilst availability of specialists may have been a factor for some sites, for others, lack of support for the recruitment process appeared to be an issue. For example, in one AHS recruitment remains an ongoing barrier. The GP at the AHS was left to recruit specialists and at the time of the evaluation visit only one of the five approved positions was filled. It appears that the fund holder in this state does not take an active role in recruitment and recruitment of specialists to approved positions is seen to be the responsibility of the Health Service.

Vignette – Local strategies to meet demand for specialist care.

Interviewees in an urban Medicare Local raised concern about an acute shortage of specialists in the area and the consequences for patients.

'Access to specialist care is terrible here. People have to go on the long public waiting lists. People get to see a specialist here by ending up in hospital as an emergency presentation.'

To overcome this problem, the Medicare Local is exploring options for tele-health. A tele-health trial with specialists is being planned. The Medicare Local has also funded ten GPs to undertake masters degrees in diabetes care as a strategy to meet local demand among patients, including Aboriginal and Torres Strait Islander patients.

A general lack of awareness of USOAP by private GPs and DGPs was evident in the Sentinel Sites, and this may have contributed to both difficulties with specialist recruitment and under referral in some sites. As previously indicated, this lack of awareness is likely to be related to the nature of the fundholding arrangements in different sites; all of the fundholding organisations were AHSs. In one urban tracking site eligible for USOAP, the DGP was not aware of the existence of this funding stream and regarded the lack of availability of specialists in the local area as a significant problem. They could not recall being approached by the fund holder as part of a needs assessment process.

Low patient volume was identified as a factor influencing recruitment and retention of specialists – this is linked both to low referral volume and low patient attendance. The low patient numbers being referred and/or attending make it difficult to continue attracting specialists to participate in USOAP. Provision of these outreach services is generally less financially rewarding for specialist than working in their own rooms and if patients do not attend the outreach clinics, it creates a further financial disincentive.

> 'Trying to get the patients attend the specialist clinics. May still have about 50% turnout and lot of specialist always would say they are not going to come back because they maybe are getting two patients per day.' (Interviewee, AHS)

A number of interviewees suggested that rather than trying to get specialists to the AHS it would be better to fund the AHS for the gap payment to facilitate access to the specialist rooms. In this way the specialist would also have access to the usual range of equipment required.

> *'The AMS then would have fewer issues with setting up the outreach clinic and trying to find space etc.'* (Interviewee, AHS)

REFERRALS TO SPECIALISTS

Recognition that referrals to USOAP specialists needs to increase to retain specialist commitment has led to trialling innovative ways to increase referrals to USOAP specialists in some case study sites. A lack of referrals to specialists (along with non-attendance) was recognised as an issue that threatened the ongoing commitment of specialists to participate in USOAP. Across the sites, it was recognised that the volume of referrals to specialists needed to increase. One state-wide organisation has recently developed referral pads in an attempt to overcome the lack of referrals. They have also reduced the frequency of visits of some specialists, e.g. from twice a month to once a month, in an attempt to counteract non-productive use of specialists time due to a combination of lack of patient attendance and low volume of referrals.

Reasons for low volume of referrals by clinicians were two-fold. They were reluctant to refer to a consultation-only service where procedures would not be covered and believed that patients would not attend anyway, even though they required the specialist service. Some sites reported linking with OWs to facilitate patient attendance; this is discussed further below.

Lack of awareness of USOAP amongst private GPs appeared to be a key limiting factor in achieving better volume of referrals, with this factor likely to be particularly important in urban areas. Overall in the Sentinel Sites, data indicate that referrals to USOAP specialists are almost exclusively from AHSs. There were no reports of private General Practices referring to the USOAP services. This is not surprising given the reported lack of awareness of the services amongst GPs. Again this may be a feature of the nature of USOAP fund holding arrangements in the sites, where all fund holding was with AHSs, and specialist services were in general located in AHSs.

USOAP fund holders indicated that it is the responsibility of the host organisation to advertise the availability of the service.

> *'Not getting enough referrals is contributing to the low turnout because locum doctors often do not understand what services the clinic can offer for their patients.'* (Interviewee, AHS, nurse)

Within AHSs, improved communication about the USOAP was also identified as a key issue affecting referrals, particularly in the context of locum or temporary staff. In one AHS, clinicians were not necessarily being made aware of the availability of the recently established specialist service and mechanisms for communication within the clinic were yet to be developed. Communication barriers to effective use of specialist services are exacerbated when there are new GPs and locum doctors at a Health Service.

> *'Not getting a lot of referrals … it's difficult to tell because just starting with this service … had a lot of locum doctors come through. When you have a high turnover of doctors they do not have an understanding of the system and the referrals tend to drop off.'* (Interview, nurse AHS)

Reducing the frequency of services was another strategy to maintain specialist commitment.

Interviewees consistently raised concerns that, despite good recruitment of specialists to positions, retention to these positions was at times problematic due to both low referrals and patient non-attendance.

'There have been a number [of services] where lack of referrals or 'did not attends' aren't supporting the service so specialist discontinues. This is a valid response and particularly relevant to urban services, where specialists come from a very busy home practice. How to overcome? We have initiated discussions with the Institute at all levels re how to overcome lack of referrals or 'did not attends'. A strategy may include doing service with less frequency.' (Interviewee, AHS)

VIGNETTE – MANAGING GOOD ATTENDANCE AND MEDICAL SPECIALIST SERVICES

In one urban site, the AHS has established a specialists outreach program without the use of the funding available for the Urban Outreach – USOAP Measure.

The long-serving Medical Director of the service has used his professional networks to build up a team of visiting specialists. A pediatrician is employed two days a week, while an ophthalmologist, cardiologist and endocrinologist each consult once a month. Laser eye surgery and echocardiograms are performed at the AHS facility.

Excellent patient attendance and capacity to perform some procedures on site make the service financially viable for the specialists and attractive to patients, '*The cardiologist had two no-shows in six months',* despite the service not providing patient transport. Three of the four specialists bulk bill Medicare for their services, thus ensuring the services are financially accessible for patients.

The arrangement is working well. Consistency in the attending specialists and positive patient experiences have built community trust. Good facilities, systems and patient numbers are incentives for the specialists to continue their outreach services at the AHS.

UTILISATION OF SERVICES BY PATIENTS FOLLOWING REFERRAL

Linkage with OWs, and to some extent the CCSS program, was a strategy used by some Health Services to address the issue of patient non-attendance. Concern about low patient attendance rates at USOAP specialist clinics continues to be reported in sites with USOAP services. Interestingly, this was the main issue raised consistently at all sites with USOAP funding. As discussed above, low patient attendance was impacting on recruitment to specialist positions, retention of specialists and also general motivation from Health Service staff about the program and referral rates.

'Patients don't always turn up – 60-70% turns up.' (Interviewee, AHS)

Sites reported that they were spending plenty of time working towards getting patients to the clinics. Transport was consistently noted in community focus groups as a barrier to access to Health Services. Sites noted the use of the AHS funded OW being a resource assisting with access.

'At the moment there is quite a bit of work going on to maintain the organisation of patients getting to their specialist appointments, it's getting better but can't be said that it is good.' (Interviewee, AHS)

There was recognition at the site level about possible synergies with other measures to facilitate access to specialist services, such as the CCSS funding. Some services also reported using OWs to encourage use of specialist services and to assist with access to follow-up care after being seen by the USOAP specialist.

> *'… but some people may not turn up because may be afraid of seeing a specialist. The Care Coordinator and Outreach Worker play some role in supporting those people.'* (Interviewee, AHS)

As previously reported there appears to be some overlap between the USOAP measure and the ICDP SS funding (Measure B3 Part B). The SS is providing funding for gap payments to specialists and enabling access by taking patients to the specialist, whereas the USOAP aims to encourage delivery of specialist services in the primary care setting and therefore closer to where patients regularly access care. In this reporting period a number of interviewees at the site level questioned the logic behind getting specialists to travel to the AHS rather than just supporting access to the specialist within the specialist's regular premises.

One of the barriers experienced by patients in accessing coordinated care is the lack of support through USOAP of follow-up investigations, procedures, aids or equipment and the barriers of long waiting lists in public hospitals and high costs of accessing these services in private facilities. These issues have previously been reported and were raised again by interviewees from fund holders and from NACCHO affiliates.

> *'We have started people on a journey which we can't finish off.'* (Interviewee, SBO)

> *'Patients do not have access to higher levels of services such as cataract removal if they see an ophthalmologist.'* (Interviewee, NACCHO affiliate)

Community focus group participants noted that a specialist funded under USOAP referred an individual to have a cortisone injection at the hospital and the patient was now on the hospital outpatient waiting list for this procedure.

> *'I'm on the waitlist for six months to have a cortisone injection at the hospital.'* (Community focus group, urban site)

In response to some of these issues, one USOAP fund holder has identified the need for surgical services and has made a proposal to the DoHA to use a part of the USOAP under spend to set up a surgical services pilot. The arrangement is targeting individuals who are accessing CCSS *'to provide a complete cycle of care.'*

Linkages with the CCSS program were also reported in some sites as a means to achieve better care coordination. However, as previously reported, there are a number of limitations, primarily due to the limited population coverage one can expect of the CC positions. Patients can only access the SS funding if they have been referred to a CC from a PIP Indigenous Health Incentive registered practice (see Section 10 for more information on the CCSS measure).

CULTURAL APPROPRIATENESS

At this early stage of establishment of USOAP, the extent to which services were regarded as culturally appropriate was not clear. Early indications were that this issue is a priority concern for the AHSs, and cultural appropriateness was a key consideration for some AHSs in establishing relationships with specialists.

Community focus group participants were positive about the commencement of the specialist service at the AHS under USOAP, primarily because of removal of the cost of access to a specialist service under this arrangement. One of the challenges community members face in accessing

specialists is having to pay the consultation fee up front, so the access to a free service was highly valued.

> *'Last time I saw other doctor I had to pay $180 and got $80 and I can't afford that.'* (Community focus group, urban site)

Interviewees in one site indicated that some specialists are already providing other outreach services or have experience in AHSs, but local-specific issues may need greater attention. This concern appeared to be more about the need for specialist to be able to adapt to the culture and style of operation of primary care services than about Indigenous community culture per se.

> *'The majority of specialists have existing experience in providing these clinics. What is then relevant is what's needed locally.'* (Interview, AHS)

In another site, the perceived lack of cultural competency on the part of the USOAP specialist resulted in the cessation of the service by the AHS.

> *'Cultural awareness has been one of the concerns. There is slight concern around that. For example there was a specialists assigned to the [AHS name] but at the end of the day we did not think they have the right perspective in regards to the Aboriginal community so that relationship ended.'* (Interviewee, AHS)

Challenges related to billing for services:

Fund holders and other state-wide organisations consistently noted that there had been challenges associated with working out arrangements for specialists billing at the Health Service. These issues are relevant to both MSOAP-ICD and USOAP. These challenges were due to a) a lack of overarching program procedural guidance around this issue, b) each specialist having a preference in the way they like to bill and c) Health Services likewise having their own preferences for billing arrangements.

Various issues related to billing were raised:

- Some specialists bring computerised Medicare vouchers and concern was raised about the process if the patient doesn't turn up - do the specialists still claim Medicare?
- Some specialists wanted the AHS staff to assist with administration and this may not always be possible with stretched staff at the AHS.
- Some specialists turn up without having considered how the billing arrangements might work and having made no preparations for billing.
- Some specialists have wanted to bill the patient and then get them to claim back from Medicare.
- Some specialists want to be paid a salary and for the Health Service to bill Medicare for the cost of the service.
- Many specialists appear generally not to bulk-bill at their rooms, and therefore don't have established systems for bulk billing.

- Where they are willing to bulk-bill, specialist have different systems for this, and there has been confusion around what is required by Medicare.

'*It's just about what staff working [think is] the best way of billing. For a number of more established services, bulk billing isn't their usual billing stream. Work is being done to smooth this though.*' (Interviewee, SBO)

12.5. Summary

1. Overall, there is evidence of an increase in activity with regards to implementation of this measure at the local level since the previous reporting period. In the majority of Sentinel Sites service hosts and fundholding arrangements are in place and a range of potential specialists have been identified and recruited.
2. Fundholding is exclusively through the AHSs in the Sentinel Sites. This is not expected to be typical for the rest of Australia, where other organisations, such as DGP, may be the fund holders. Implementation of the measure in areas with types of organisations as fund holders may differ, for example, other processes may be used to identify and recruit specialists. There may be varying patterns of awareness amongst GPs, different referral patterns and challenges with patient attendance.
3. Some discrepancies in the different data sources in relation to information on speciality types and locations were noted, but these do not change the overall conclusions drawn. To some extent, data discrepancies can be explained by the earlier period of reporting covered by the available program data (owing to the lag time in these data being provided to the fund holders in each site, then to DoHA and finally to the SSE team) compared to the timing of the SSE visits. It is also to be expected that systems of reporting will take some time to be routinised and embedded before they can be expected to provide complete data.
4. A range of specialist services are being funded through USOAP across the Sentinel Sites. In some sites, the identification of specialists was guided by patient need, whereas in other sites it seemed to be determined by availability and willingness of particular types of specialists.
5. Important emerging barriers to ongoing participation in USOAP by specialists are a) the potential for loss of income for specialists if patients do not arrive for scheduled appointments and b) lack of funding for procedures. There was also recognition by specialists, GPs and community members that the consultation itself was of limited value if procedures required during or following specialist consultations could not be funded or had to be accessed through the public hospital system or at the specialists private rooms (with the usual barriers to access).
6. Underuse of specialist outreach services in many locations is evident in the program data and in interviews with key informants. The low numbers of patients referred and/or attending these clinics is affecting the interest of specialists in continuing to participate in the outreach services and is also affecting the motivation of Health Service staff.
7. OWs played an important and valued role in some of the sites in facilitating patient attendance. For example the position has helped minimise barriers through advocacy, support and transport for patients.
8. At the patient-level, community members were somewhat informed and in principle supportive of USOAP. The value of not having to pay out of pocket (even if the amount could later be claimed back from Medicare) was highlighted as a key valued element of USOAP.

Community members did not indicate that they regarded the location of services (whether in the AHS or elsewhere) as particularly important – the fact that services were free seemed to be more valued.

9. Processes to establish USOAP and recruit specialists varied by site, with some fund holder organisations consulting professional bodies such as the Royal Australian College of Physicians, to identify appropriate specialists, and others showing more limited consultation.

10. Limited awareness of USOAP by GPs in the Sentinel Sites was reflected by few referrals to USOAP services by GPs outside of AHSs, with most referrals originating from within the AHS. This needs to be interpreted in the light of the nature of the fundholding to date in sites, (which has been exclusively through AHSs), as well as the lower numbers of Aboriginal and Torres Strait Islander peoples accessing General Practice compared to AHSs in the Sentinel Sites and the early stage of development of USOAP services.

11. Innovative ways to address barriers to effective implementation have been suggested by interviewees, or are under development in some of the sites. These include simple interventions such as use of referral pads, proposals that specialists should be able to provide USOAP funded services on their own premises to reduce some of the burden on AHSs, and more complex proposals such as to set up a pilot to cover surgical services using program under spend. Linkages with other programs, including OWs and CCSS, were also noted to be important in a number of sites in enhancing implementation of USOAP.

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.

13. INCREASING ACCESS TO SPECIALISTS AND MULTIDISCIPLINARY TEAM CARE (*MEASURE B5 PART B*)

13.1. Description of measure

The aim of the 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, GPs 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, regional (including inner regional) communities are also eligible to be supported under this measure.[147]

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.[148]

The composition of MSOAP teams varies depending on the specific health and treatment needs of each community and may include specialists, GPs and allied health professionals.

Funding agreements have been signed with fund holder organisations (two each in NSW and QLD and one each in TAS, WA, VIC, SA and the NT) for the period 2009-10 to 2012-13.[149]

TERMINOLOGY

Terminology used in this section of the report is based on the MSOAP-ICD guidelines where:[150]

- '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.
- 'Fund holder' is the state-based organisation that auspices the funds on behalf of the Commonwealth. Generally the fund holders 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.

[147] DoHA, MSOAP-ICD 2009-2013 Guidelines. <http://www.health.gov.au/internet/ctg/publishing.nsf/AttachmentsByTitle/MSOAP-ICD-guidelines.pdf/$FILE/MSOAP-ICD-guidelines.pdf> (10 April 2012).
[148] DoHA, Increasing Specialist and Allied Health Care Follow Up – Fact Sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary> (accessed 10 April 2012).
[149] DoHA, Report ICDP Update, March 2012.
[150] DoHA, Medical Specialist Outreach Assistance Program Guidelines. <http://www.health.gov.au/internet/ctg/publishing.nsf/AttachmentsByTitle/MSOAP-ICD-guidelines.pdf/$FILE/MSOAP-ICD-guidelines.pdf> (accessed 10 April 2012).

13.2. Program logic

As specified in the National Framework the following outcomes hierarchies in relation to measure B5 Part B and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond included:

- Effective fundholding arrangements in place.
- Indigenous Australians utilise and value services.
- Specialists demonstrate cultural awareness.

Expected early results for years 2 – 4 include:

- Increased specialist and allied health services.

Expected medium term results for years 4+ include:

- Care coordination is improved.

13.3. State of implementation – national context

The following information was provided by DoHA in February 2012 on the state of implementation of measure B5 Part B (relevant to the SSE):[151]

- The MSOAP-ICD measure has funding agreements all States and Territories. The fund holders continue to manage the workforce recruitment.
- There have been no major changes to MSOAP-ICD guidelines or focus of the measure.[152]

13.4. Findings from Sentinel Sites

NOTES ON COLLECTION AND ANALYSIS OF DATA

Data were derived from program activity data supplemented by evaluation visit interviews, and, for case study sites, community focus groups.

SSE program activity data are received from DoHA as per jurisdictional fund holder service updates. Data have been received from 1 July to 31 December 2011 for specialty type, patient attendances, visits and location. The timing of these reports does not align with the six monthly reporting periods of the SSE. More current data were gathered where possible through the evaluation visit interviews and fund holder interviews.

Data have been derived from interviews and focus groups in the five case study sites eligible to receive MSOAP-ICD funding. These sites included Port Augusta, Bairnsdale, Tamworth, East Pilbara and Katherine West. We also conducted interviews about this measure in enhanced tracking sites of Darwin and Barkly and with the fund holders in the respective states and territories.

[151] DoHA, B5b Sentinel Site Service Report, 28 February 2012.
[152] DoHA, B5b personal communication,11 January 2012.

Seven community focus group discussions were held in four case study sites. 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. In this evaluation period, discussion on this measure relates to community focus groups held in regional sites. We were unable to cover this measure in community focus group discussions in neither of the eligible remote sites, East Pilbara and Katherine West. East Pilbara has no MSOAP-ICD funding in the region and the community focus groups held in Katherine West had other priorities for discussion and constraints with interpretation for local language speakers on a range of issues.

PROGRESS WITH IMPLEMENTATION

Service populations from sixteen of the twenty-four Sentinel Sites were eligible to access the MSOAP-ICD services in accordance with the funding guidelines. MSOAP-ICD activity was evident in MSOAP program data from DoHA in twelve of the sixteen eligible Sentinel Sites. This is an increase of three more sites since the previous reporting period.

The MSOAP-ICD guidelines stipulate the eligible areas are ASGC RA2-5, however, where possible the aim is to focus delivery of services to remote and very remote areas (RA4, RA5) areas.[153] There is evidence that MSOAP-ICD activity is expanding in three of the four remote sites including Derby, Barkly and Katherine West. The lack of MSOAP-ICD activity in the fourth remote site, East Pilbara, is discussed below. There were four Sentinel Sites that were eligible for MSOAP-ICD funding but were not participating or not intending to participate. These included Darwin, East Pilbara, Cairns and Gladstone. In East Pilbara, the DGP and the AHS have agreed not to submit for MSOAP-ICD funding, as the existing services were already covered by the MSOAP and there was no need for additional services through MSOAP-ICD. The AHS indicated that the fund holder had advised Darwin being a regional site, not eligible to apply and the SBO was unaware of the funding opportunities. We were unable to ascertain underlying reasons for lack of participation in MSOAP-ICD for Cairns and Gladstone, as these are not case study sites.

For the majority of the Sentinel Sites that have MSOAP-ICD activity, the AHS in the site is the host organisation. There was no evidence, to date, from the SSE of alternative models, such as MSOAP-ICD providers being hosted by other primary health care facilities, although these other models are possibly in place in some other geographic areas.

Based on program data provided by DoHA, Tamworth, Derby, Dubbo, Grafton and Swan Hill/Mildura appear to have the most established MSOAP-ICD related services. All of these regions also have new service operational or expansion planned.

As indicated in Table 13.1, there continues to be a wide range in the number of reported visits and the number of patients seen by visiting providers and in the different sites. Some data inconsistencies were noted: two Victorian sites, Bairnsdale and Swan Hill/Mildura, have recorded consecutive visits by health professionals without patients being seen. This is the second report where this has occurred. This may be a recording error, as was indicated to the evaluation team in relation to Bairnsdale.

[153] Medical Specialist Outreach Assistance Program 2009-2013 Guidelines, Closing the Gap tackling Indigenous chronic disease [website]. http://www.health.gov.au/internet/ctg/publishing.nsf/AttachmentsByTitle/MSOAP-ICD-guidelines.pdf/$FILE/MSOAP-ICD-guidelines.pdf> (accessed 25 May 2012).

Table 13.1: Reported MSOAP-ICD services in Sentinel Sites for 1 July 2011 to 31 December 2011

Site	Location	Type of service	Number of visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
Case study sites					
Bairnsdale	Bairnsdale	Aboriginal Health Worker	25	0	No patients listed for this or previous report [a]
		Dietitian/Nutritionist	21	7	Low patients numbers for this report [a]
		Diabetes Educator	25	4	
		Podiatrist	15	2	
Port Augusta	Port Augusta	Occupational Therapist	9	51	Fortnightly visits [a]
		Endocrinologist	3	19	Commenced September 2011 for monthly visits [b]
		Physician Respiratory	NR	NR	This service was listed in the previous report, no clear report on current status. Was to start in October 2011 [b,c]
		Clinical psychologist	NA	NA	New service this report. To commence respiratory outreach service April 2012, 10 visits per year[c]
		Physiotherapist	NA	NA	New service this report. To commence respiratory outreach service April 2012, 25 visits per year[c]
Katherine West	Katherine	Physician - Cardiology	NR	NR	This service was listed in the previous report but current status unknown
		Rehabilitation	1	19	Two rehabilitation services reported
		Rehabilitation	2	18	
		Cardiac Educator	1	29	
		Diabetic Educator	1	29	
		Exercise Physiology	2	0	New service
		Rehabilitation -prosthetics	1	27	New service
	Lajamanu	Cardiac Educator	1	3	New service
		Diabetic Educator	2	11	
		Podiatrist	1	8	
	Timber Creek	Diabetic Educator	1	6	New services. Two exercise physiology services reported
		Cardiac Educator	1	6	
		Exercise Physiology	10	164	

Site	Location	Type of service	Number of visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
		Exercise Physiology	1	0	
		Podiatrist	1	10	
	Yarralin	Cardiac Educator	2	9	New services. Two Diabetic Educator services reported
		Diabetic Educator	1	6	
		Diabetic Educator	1	5	
	Kalkarindji	Cardiac Educator	1	4	New services
Tamworth	Tamworth	Physician - Endocrinology	5	35	Commenced July 2010 for 11 visits per year [d e f]
		Diabetes Educator	13	52	Commenced July 2010 for 26 visits per year [d]
		Dietitian/Nutritionist	12	49	Commenced July 2010 for 26 visits per year [d]
		Podiatrist	NA	NA	New service not yet operational for 9 visits per year [d e]
		Exercise physiologist	NA	NA	New service not yet operational for 9 visits per year [d e]
		Physician-Cardiologist	NA	NA	New service not yet operational for 9 visits per year [d e]
		Physiotherapist	NA	NA	New service not yet operational for 9 visits per year [d e]
Enhanced tracking sites					
Derby	Derby[g]	Psychiatrist	NR	NR	This new child and adolescent service was listed in the last report as not yet commenced. No clear report on current status. Was to be one visit per year for 14 days
		Physician Respiratory	NR	NR	These respiratory services were listed in the previous report as newly recruited but not yet commenced. No clear report on current status. They were to visit twice a year (4 days each visit)[f]
		Aboriginal Health Worker – respiratory	NR	NR	
		Registered Nurse	2	16	
		Aboriginal Health Worker	3	15	
		Orthoptist[h]	1	25	Orthoptist is being funded to link into the existing WA country health diabetes team. Planned 8 visits per year for two days each time[h]
		General Practitioner	3	32	
	Fitzroy Crossing	Registered nurse	2	27	
		Aboriginal Health Worker	2	25	

Site	Location	Type of service	Number of visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
		Orthoptist[h]	1	25	
		General Practitioner	2	43	
	Fitzroy Crossing Aboriginal Community	Registered nurse	NR	NR	These services were listed in the previous report as operational at this location. No clear report on current status.
		Aboriginal Health Worker	NR	NR	
		General Practitioner	NR	NR	
Dubbo	Dubbo[h]	Physician - Cardiology	5	31	Commenced November 2010 for 12 visits per year[d]
		Physician - Respiratory	3	11	New service listed. Commenced July 2011 for 12 visits per year[d]
		Endocrinology	NA	NA	New service not yet operational for 12 visits per year[d]
		Podiatrist	NR	NR	New service to commence February 2012 for 12 visits per year. No clear report on current status[d]
	Wellington	Diabetes Educator	1	0	
		Asthma Educator	3	3	
		Dietitian/Nutritionist	3	15	
		Nurse - Cardiac Rehabilitation	0	0	This service was listed in this and the previous report as no visits and no patients. No clear report on current status.
Barkly	Tennant Creek	Cardiac Educator	1	11	New services
		Diabetes Educator	1	11	
		Rehabilitation-Prosthetics	1	17	
Swan Hill/Mildura	Mildura	Physician – Cardiology	5	30	
		Aboriginal Health Worker	21	0	No patients listed this report and previous report
		Podiatrist	18	81	New service
		Physiotherapist	7	11	New service
	Robinvale	Physician – Cardiology	5	26	
		Aboriginal Health Worker	5	0	No patients listed this report and previous report
		Nurse – clinical specialist	16	0	New service– no patients listed
	Swan Hill	Physician – Endocrinology (Diabetes)	6	23	

Site	Location	Type of service	Number of visits	Number of patients	Changes since the December 2011 SSE report and as found at evaluation visits
		Aboriginal Health Worker	17	0	No patients listed this report and previous report
		Diabetes Educator	11	20	
		Dietitian/Nutritionist	12	15	
Tracking sites					
Grafton	Grafton	Physician - Respiratory	2	8	Commenced May 2011 for 4 visits per year [d e]
		Diabetes Educator	NR	NR	This service was listed in the previous report as operational. No clear report on current status.
		Exercise Physiologist	7	25	Two exercise physiology services reported. One commenced February 2011, Additional one is a new service commenced June 2011. Both to do 12 visits per year [d e]
		Exercise Physiologist	NR	NR	
		Psychologist	NA	NA	New service not yet operational [d]
		Asthma Educator	7	12	Commenced February 2011 for 12 visits per year [d]
		Dietitian/Nutritionist	NA	NA	New service not yet operational [d]
		Nurse - Mental Health	NR	NR	Commenced December 2010 for 12 visits per year, Operational in the previous report but no activity this report. No clear report on current status [d e]
		Podiatrist	NA	NA	New service not yet operational [d]
Kalgoorlie	Kalgoorlie	Paediatric -Respiratory	2	8	New service
		Sleep Scientist	3	4	New service
Hobart	Hobart	Physiotherapist	NA	NA	New cardiopulmonary pre- and rehabilitation services planned but not yet operational [i]
		Exercise Physiologist	NA	NA	
Geraldton	NR	Physician-Nephrologist	NR	NR	Renal team services are to commence January 2012 for 2 visits per year at 3 days each time. Pre-existing nurse and AHW, with new Endocrinologist [j k]
		Registered nurse	NR	NR	
		Aboriginal Health Worker	NR	NR	
		Administration/Coordination	NR	NR	

[a] Evaluation visit update, 27 February 2012. The patient numbers are described as lower than in actuality.
[b] Rural Doctors Workforce Agency (SA), personal communication, September 2011.
[c] Rural Doctors Workforce Agency (SA), personal communication, 26 March 2012.

[d] NSW Rural Doctors Network, USOAP and MSOAP-ICD Sentinel Site service report, 13 January 2012.

[e] NSW Rural Doctors Network, personal communication, 22 March 2012.

[f] December 2011 report evaluation visit update. Endocrinologist comes from Sydney. He has been visiting since 2007 under ISOAP previously. Diabetes educator and dietitian are local.

[g] DoHA, B5B Sentinel Sites data report 2 September 2011. The service models for Derby are generally part of the services that cover the entire 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.

[h] DoHA, B5B Sentinel Sites data report 2 September 2011.

[i] Evaluation visit update, 27 February 2012. TAC (Launceston – outside the site boundary) piloted a cardio-pulmonary team where eight patients have sessions two at a time and then feedback sessions with the physiotherapist and exercise physiologist over 10 weeks. TAC Hobart is planning to run this service.

[j] DoHA, B5B Sentinel Sites data report 2 September 2011.

[k] DoHA, B5b report, 11 January 2012.

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, and Gladstone.

Notes: Katherine township is the largest town near to but outside the Sentinel Site boundary. It is included in the table as it may be accessed by some Katherine West community members even though it is a long distance from the communities. Other towns near Sentinel Sites have been reported by DoHA as having received MSOAP-ICD services. 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 are three services). Each health professional (or service) may visit an outreach location a number of times in a reporting period.

NR – Not reported in the DoHA template therefore potentially lacking full information for this table.

NA - Not applicable.

Source: DoHA, B5b Sentinel Site service report, 28 February 2012 unless otherwise specified in footnotes.

Regions that are classified as ASGC-RA 2 Inner Regional can attract both MSOAP-ICD and USOAP funding as the eligibility criteria for both programs cover this rurality classification.[154] We note that two of the Sentinel Sites identified themselves as eligible to receive ICDP services through both funding sources. Grafton currently receives USOAP and MSOAP-ICD funding for different health professionals. Likewise, Hobart has indicated they are planning to be accessing both USOAP and MSOAP-ICD funding.

RECRUITMENT OF SPECIALISTS AND ALLIED HEALTH PROFESSIONALS

The measure guidelines envisage that fund holder organisations and local service organisations will be involved in collaborative needs assessment and planning processes to develop proposals for health professionals. These are to be funded under MSOAP-ICD at a site level and recruitment is to be based on local needs identified during this process.

Diverse perceptions regarding the comprehensiveness and effectiveness of planning processes were held by different stakeholders at local level. From the perspective of the fund holder organisations, planning processes have been extensive and collaborative. However, informants from some of the service provider organisations reported mixed views, at times a lack of consultation or disappointment that services eventually provided were little related to the needs identified during the planning processes. Sometimes the disjuncture between planning and recruitment appeared to be the lack of available specialised health professionals in the required areas. This was particularly a problem for remote sites.

> *'Not sure if the current service delivery model meets the needs of the local area. It is more the tail wagging the dog at the moment. The recruitment of specialists and allied health providers is based on who is available.'* (Interviewee, NACCHO affiliate)

> *'We get specialists we're given not those we need.'* (Interviewee, GP, AHS)

As highlighted in the previous reporting period, fund holders continue to play a role in recruitment of personnel to the MSOAP-ICD teams through targeted mail outs to specialists, advertisements and presentations.

In one site the fund holder negotiated with the tertiary hospital Endocrinology department to roster Endocrinologists to a number of sites. It was recognised that this approach will not necessarily provide consistency of service for patients, but at least an overall consistent specialist service is offered to the site, and this was valued.

In response to the statement *'arrangements for the outreach team under the MSOAP-ICD meet the needs of local Aboriginal and Torres Strait islanders'*, 69% (18/26) of interviewees 'strongly or partly agreed' with the statement and 31% (8/26) indicated that they 'don't know/can't say'. These data indicate that the service meets local needs.

DELIVERY OF THE RANGE OF SERVICES AT HOST ORGANISATIONS

The health professionals who are visiting under the MSOAP-ICD may be funded as a team but may not necessarily visit the site simultaneously. The need for better coordination of service providers at site level was consistently identified by interviewees as a barrier to more effective use of MSOAP-ICD

[154] USOAP Program Funding Guidelines <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-multidisciplinary/$FILE/Increasing-Specialist-Follow-up-Care.pdf> (accessed 10 April 2012).

funded services at the local level. In some sites, identifying roles and responsibilities regarding coordination of services was useful in achieving more effective delivery.

Scheduling of service visits was a concern, particularly in the context of space constraints; too many visiting service providers at the same time stretch the ability of Health Services to provide appropriate consulting space. In the current reporting period, and as previously reported, accommodating new specialist teams within existing physical infrastructure was a common concern for stakeholder interviewees. The coordination role was crucial to avoid having a number of outreach teams in one location concurrently when space was limited on site. Informants also recognised the need for better coordination of care provided by different health professionals as a team or individually. In some cases, coordination was provided by the local host organisation. In two sites where the MSOAP-ICD services are being used to fund a range of services for diabetes patients, it took some time to develop the appropriate coordination mechanisms. Initially, different people were 'coordinating the visits' and once this was identified as an issue and rectified, the potential for the diabetes clinics could be realised better.

The coordination of service providers (and the provision of coordinated care for service users), seems to be largely dependent on the capacity of host organisations. Whilst there is provision in the guidelines for the funding for coordination at the host organisation, sites often have difficulty releasing existing personnel to undertake this role with no one to fill their positions. In the current and previous reporting period interviewees expressed a concern about the lack of coordination support for both health professionals funded under MSOAP-ICD and for service users.

Vignette – Lack of coordination and awareness of services provided through MSOAP-ICD

Site X is a remote site in which Rural Primary Health Care funding, held by the AHS, is being used to fund podiatry, dietitian, occupational therapy, physiotherapy, diabetes education and nutrition services. MSOAP-ICD services funding is held by a jurisdiction-wide specialist outreach service. The two funding sources are regarded as complementary, but do not appear to be coordinated.

A relevant manager in the AHS was, until very recently, not aware of the scope of services available, nor the MSOAP-ICD funded services reported to be delivered in the site. The manager expressed concern that the potential of the funding to be utilised in the site is limited by lack of capacity to offer administrative support, lack of transport available to support service delivery and space constraints in consult areas at the AHS. Another concern was that allied health providers in a large town in the neighbouring site were not the 'first port of call' to provide outreach services.

There is a perception that the services offered are not necessarily based on consultation to ascertain the specialists and allied providers, nor the lead-in time needed to arrange client appointments. For example, an allied health provider had contacted the service directly, indicating that they had received funding and would be doing a fly-in-fly-out visit (of approximately four hours) the following week.

'*It is a 'grab what you can get' model. We would like to see a more negotiated model, which … encourages … a coordinated and consultative process … a strategic approach where they can look at gaps and seek funding for those.'*

USE OF MSOAP-ICD SERVICES BY ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE WITH OR AT RISK OF CHRONIC DISEASE

Use of MSOAP-ICD services shows wide variation between sites and between different service professionals. Potential barriers to patients using MSOAP-ICD services appropriately included factors related to changing referral practice of GPs in private General Practice (to refer to AHSs), cultural awareness amongst administrative support staff, coordination at the host organisation, difficulties with transport, lack of funding for specialist procedures and investigations, perceptions among some Health Service staff that Aboriginal and Torres Strait Islander patients lack interest in their own health. It was also indicated that program data may underestimate services delivered in some areas. Solutions to various barriers were found as outlined below.

In the previous reporting period concern was expressed about the inability of private General Practice to refer patients to MSOAP-ICD services hosted by AHSs. This concern, in particular, was raised in two regional sites. In this reporting period both of these sites had made some progress towards ensuring that private GPs were able to refer patients to health professionals based in the AHS. Lack of referrals to MSOAP-ICD by private GPs may be to some extent due to a lack of awareness of MSOAP-ICD services. However, levels of awareness of MSOAP-ICD were not markedly different, eleven of nineteen private GPs indicated they were aware of these compared to eleven of fifteen interviewees in the AHS sector

Whilst health professionals who participate in MSOAP-ICD are required to undergo training in cultural awareness, there was uncertainty whether the specialists were receiving this training and orientation to Health Service. Community focus groups identified a lack of cultural awareness amongst the reception/administrative staff being a potential barrier for use of existing specialist services (not funded through MSOAP-ICD). Informants suggested that reception and front-line staff would benefit from cultural awareness training.

> *'Getting through the receptionist is challenging for Aboriginal patients – I think if there was a national course for receptionists especially in the specialist areas if they could mandatory go through it, it is a basic customer service skill they are lacking, their attitude is 'holier than thou' it is hard enough for us to liaise with them, we don't know how patients deal with them.'* (Interviewee, DGP, program manager)

Vignette - cultural awareness needs of administrative staff in practices

In a regional site, the Care Coordinator is working to negotiate improved access to private specialist services for Aboriginal and Torres Strait Islander patients. Specialists are being asked to consider invoicing and bulk billing Medicare in order to remove the financial barriers to access.

Receptionists in private practices are often the gatekeepers for practitioners - they have the potential to enable or, as the following example illustrates, present a barrier to negotiating patient access.

'*[The receptionist] … has given me an absolute 'no, they are not interested' answer … but I think if I get to talk to [the specialist] he would change his service [policy].'*

Cultural awareness training for practice staff is an important first step in attitude change. However, the need to improve cultural safety in services used by Aboriginal and Torres Strait Islander patients is immediate. The Care Coordinator accepts that, even when a change in billing policy can be

negotiated, Aboriginal and Torres Strait Islander patients are unlikely to feel welcome in some specialist practices.

'She has quite racist attitude, … [so] at the end of the day the patients may have to be referred to a different specialist.'

A further barrier experienced by patients in accessing coordinated care through MSOAP-ICD (and also through USOAP in urban areas) is the lack of support of follow-up investigations, procedures, aids or equipment. Long waiting lists in public hospitals and high costs of accessing these services in private facilities present further barriers to accessing required services. These issues have previously been reported in relation to MSOAP-ICD and were raised again by interviewees in fundholding organisations and the NACCHO affiliates. This emerging theme is also discussed in Section 12 in relation to USOAP.

Whilst non-attendance by patients was consistently reported as a particular challenge by fund holders, host organisations and health professionals, it seems that the program data may be an underestimate of service delivery in some sites. When shown the data provided by DoHA interviewees, one site indicated that they had seen significantly more patients than reported in the data. This may be due to differing capacity amongst Health Services and health professionals in relation to recording and reporting services delivered. At the same time, a number of health professionals funded under MSOAP-ICD expressed frustration about the non-attendance of patients suggesting that this is an ongoing issue in several sites.

There was an obvious need identified for better facilitation of use of services. The barriers addressed by patients were, getting patients to be appropriately directed to the MSOAP-ICD services and enable them to utilise the services. In some sites this is being addressed through staff (including practice managers, GPs and OWs) taking on a greater facilitation and enabling role.

CARE COORDINATION FOR PATIENTS

From the clinicians' perspective, service providers and MSOAP-ICD outreach teams were generally providing coordinated care. This is reflected in clinician's responses to the statement *'there is good coordination of care for patients between service providers and the MSOAP-ICD outreach team'*, where eight of the eleven clinicians either 'strongly or partly agreed' with the statement. The other three clinicians responded 'don't know/can't say'. This suggests that where the program is operating, and stakeholders are able to make an assessment of coordination between service providers and the outreach team, the assessment is generally positive.

A potential barrier to good care coordination identified in this period of implementation was the inconsistent use of existing clinical information systems including PIRSs by some MSOAP-ICD providers. In some instances access was not granted by the Health Service and/or the health professional was not familiar with the system and not willing to use it. From the perspective of the Health Services/host organisations, this lack of consistency to utilise existing information systems resulted in non-timely feedback and poor flow of information between the various service providers.

> *'One specialist comes and works at [AHS] is not good at using Communicare which is difficult. Diabetes Educator and dietitian are good at using Communicare so they can look at it and figure it out what's going on. If good at the information system the patients notes can be shared easily and the specialists can address those issues.'* (Interviewee, AHS, GP)

> *'We use Communicare so if they use that there is potential for good communication. But if they don't enter information into Communicare it's at least a week before they send a letter back to us and more if you factor in administration time, so there are delays in finding out what the patients' needs.'* (Interviewee, AHS).

As indicated in the section on recruitment above, the other main barrier to achieve greater care coordination for patients is sometimes the limited availability of complementary health providers in any particular site.

PROGRAMS THAT MAY COMPLIMENT OR CONFLICT WITH MSOAP-ICD

A number of existing programs that are not part of the ICDP were identified by interviewees as having a potentially positive impact on the implementation of the MSOAP-ICD. In the previous reporting period a number of these programs were identified and discussed in some detail. Key issues are briefly summarised below, together with new issues that have emerged in this reporting period.

Medical Specialist Outreach Assistance Program

MSOAP funding was viewed by fund holders as a complementary program that has enabled relatively rapid implementation of MSOAP-ICD owing to previous experience with contract negotiations with health professionals and host organisations. DoHA has identified the following Sentinel Sites that have both MSOAP and MSOAP-ICD funding: [155]

- NSW - Dubbo, Grafton and Tamworth
- NT - Katherine West and Barkly
- SA - Port Augusta
- VIC - Bairnsdale and Swan Hill/Mildura
- WA - Derby and Kalgoorlie

In addition, East Pilbara as a remote Sentinel Site is eligible for MSOAP-ICD but has not applied for this funding. Informants at this site indicated that they already receive specialists' services through MSOAP and the existing MSOAP funding, coupled with availability of public facilities including specialist services at the site, meant that they did not see the need for additional services and did not intend to apply for MSOAP-ICD.

Indigenous Specialist Outreach Assistance Program (NSW only)

Indigenous Specialist Outreach Assistance Program (ISOAP),[156] (an outreach program funded by the Office for Aboriginal and Torres Strait Islander Health to increase medical specialist outreach to rural Aboriginal communities in NSW) was viewed by the fund holder as a program that had complemented the roll-out of the MSOAP-ICD for their service. This program had provided experience with contract negotiations, collaboration between AHSs and the workforce agency, and implementation of services in Aboriginal communities. This, together with prior experience with MSOAP, was perceived to have contributed to the relatively rapid implementation of MSOAP-ICD at this particular site.

[155] DoHA, B5b Sentinel Site service report, 28 February 2012.
[156] Rural Doctors Network, <http://www.nswrdn.com.au/site/index.cfm?display=221721> (accessed 18 November 2011).

The More Allied Health Services Funding Scheme

The More Allied Health Services (MAHS)[157] funding scheme was established in 2001 to increase access to allied health services for General Practices in rural areas. While the fund holder 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.

Rural Primary Health Care funding

The Rural Primary Health Care (RPHC)[158] funding was established to consolidate four previously separate primary and allied health programs into the RPHC program (one of them being the MAHS program described above). The RPHS was borne out of a review by DoHA that indicated that many rural health programs were trying to achieve the same or similar outcomes through different strategies. Consolidation of the funding streams would enable better service coordination and responsiveness and improve access to the services identified as priorities for the communities.

A number of interviewees in one site indicated that though the RPHC funding was perceived to be complimentary to the MSOAP-ICD funding. There has been no coordination between the two funding streams.

Supplementary Services funding under Measure B3 Part B

The SS funding was the only program identified at the Sentinel Sites that was considered by some informants to have potentially negative impact on the implementation of the MSOAP-ICD (and also on implementation of USOAP). Informants felt that services located away from the patients' primary point of care (the local health centre) may work against multi-disciplinary team based care. However, we noted that in some sites, SS funding was used to provide transport to MSOAP or MSOAP-ICD funded specialists; in this way it could be viewed as complementary.

Where SS funding was being used to bring allied health and specialist services to the site, in addition to specialist services through MSOAP and MSOAP-ICD, there was concern that this would lead to a distortion in fees charged by health professionals.

> *'I am worried that with all this money around for specialist services [through CCSS] that what will happen is our existing specialist services through MSOAP or other specialists will up their fees.'* (Interviewee, AHS)

Whilst this was a concern expressed at this particular site, there were no reports that fee distortions had in fact occurred at this or at other sites.

[157] DoHA, Program Guidelines, 2008. <http://www.health.gov.au/internet/main/publishing.nsf/content/25D42BDE5715FD35CA25700A001ECC03/$File/MAHS%20Guidelines_%20May%202008.pdf> (accessed 18 November 2011).

[158] DoHA, Rural Primary Health Care Funding Operational Guidelines, December 2009. <http://www.health.gov.au/internet/main/publishing.nsf/Content/Rural-Primary-Health-Services-Program> (accessed 6 May 2012).

13.5. Summary

1. Overall, there is evidence of an increase in activity related to implementation of this measure at the local level since the previous reporting period. In the majority of eligible Sentinel Sites, fundholding arrangements are in place, some collaborative needs identification and service planning has been conducted, a range of potential health professionals have been identified and recruited and some service delivery is reflected in program data.
2. It appears that in all of the Sentinel Sites, the MSOAP-ICD host organisation is the AHS in the site. This may not be typical of the rest of Australia, where other organisations, such as the DGP/Medicare Local, may host the service. This probably reflects the way the sites were selected, with one of the criteria for selection being the existence of an AHS in the site.
3. A range of health professionals are funded under MSOAP-ICD and program data continue to indicate wide variation in the numbers of reported visits and numbers of patients seen by different types of providers. There are indications that some program data may be an underestimate of service delivery at site level. This may be related to varying capacity in reporting by different categories of health professionals and by different service organisations. It is also to be expected that systems of reporting will take some time to be routinised and embedded before they can be expected to provide complete data.
4. There appeared to be different perceptions about the extent and effectiveness of the local level planning and needs assessment for MSOAP-ICD amongst different stakeholder groups. The fund holders, usually workforce agencies, generally reported extensive and effective collaboration. Informants from host service organisations reported more mixed views and/or service delivery arrangements that did not correspond to needs identified during planning processes.
5. There are positive reports of improved access for patients to categories of needed specialists, e.g. Endocrinologists, for whom they had previously had limited access. A range of specialist services are being funded through MSOAP-ICD across the Sentinel Sites. However, within any particular site, the range of specialists funded does not cover the range of priority needs. It appears some sites continue to have difficulty obtaining the health professional services most needed by their patients; in a way that promotes interdisciplinary team care.
6. Whilst around 58% of GPs in private General Practice were aware of the MSOAP-ICD services in the Sentinel Sites, referrals to these services by private GPs were considered negligible. Most referrals seemed to originate from within the AHS. It may take time for GPs in private General Practice to re-orientate their referral patterns, if they are used to referring to public hospitals or private facilities. On the other hand, it may be that the GPs in the Sentinel Sites are not providing care to many Aboriginal and Torres Strait Islander patients; primary health care service utilisation patterns are expected to be different in Sentinel Sites, compared to the rest of Australia, owing to the existence of an AHS in the site.
7. Potential factors related to underuse of MSOAP-ICD services were identified in the Sentinel Sites. These included difficulties with changing referral practice of GPs in private General Practice (to refer to AHSs) and also for GPs based in the AHS, limited human resources for coordination at the host organisation, difficulties with patient transport, lack of funding for specialist procedures and investigations, and issues related to clinic management.
8. Approaches to improving care coordination for patients appear to be still developing in most sites. Emerging barriers to achieving greater effectiveness in care coordination included:

8.1. Lack of consistent use of patient recall systems by health professionals funded under MSOAP-ICD leading to inability to communicate information in a timely way.

8.2. Limited ability to provide additional administrative or coordination support in service host organisations.

8.3. Gaps in the types of health professionals available under the program in particular areas, for example, the relevant allied health professional to support a follow-up from a specialist consultation may not be funded, or provide services on different days. This may be due to a lack of planning and/or a lack of availability of the range of professionals able and willing to visit the site at all at the optimal times.

9. Innovative ways to address barriers to effective implementation of MSOAP-ICD have been suggested by interviewees, or are under development in some of the sites.

9.1. One Health Service is considering exploring if funding can be used for specialists to provide their own administrative support since the organisation feels unable to offer this support.

9.2. Some service hosts have been able to take a more proactive role in coordinating care and ensuring health professional visits are optimally scheduled to suit local context and the needs of their patients. This contrasts with a more passive role, where the service organisation is just told what to expect.

9.3. Some Health Services have found that a greater emphasis on group consultations rather than one-on-one consultations has been more effective in terms of increasing patient attendance for certain types of services, e.g. nutritionist services.

10. Programs considered being to some extent complementary to MSOAP-ICD included MSOAP, the Indigenous Outreach Assistance Program and the More Allied Health Services Funding Scheme. These were considered complementary primarily because of the experience and knowledge they had provided local stakeholders, particularly in collaboration across sectors.

11. Whilst funding under the SS was sometimes used to fund patient transport to attend specialist clinics, this funding stream, in general, was considered to be potentially at odds with MSOAP-ICD in providing services away from patients' main site of primary care.

14. WORKFORCE SUPPORT, EDUCATION AND TRAINING (*MEASURE C1*)

14.1. 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:[159]

- Orientation and training opportunities for OWs employed in AHSs (through measure C2) and DGP (through measure C3). The intention is for on-the-job orientation to occur during the first six months of employment, with mentoring and encouragement to undertake further accredited training.
- A total of thirty-eight additional GP registrar training posts in AHSs have been created. This builds on the existing training option as part of the Australian General Practice Training (AGPT) postgraduate vocational training program for medical graduates wishing to pursue specialist registration as a GP with the Medical Board of Australia.[160] Special registrar salary funding arrangements are available to support these posts.[161] This funding is currently managed by General Practitioner Education and Training (GPET). The ICDP initiative seeks to expand the number of training posts available in AHSs.
- The Nursing Scholarship and Clinical Placement Programs are being expanded.
- Fifty professional development scholarships for Enrolled Nurses, Registered Nurses and Midwives working in AHSs to deliver clinical services. The initiative seeks to support these nurses to undertake professional development at an Australian university or registered training organisation. Scholarships are worth up to $15 000 each.[162]

At least fifty clinical placements are offered to students enrolled in an approved undergraduate or entry level nursing course. These are accredited, registered or enrolled nursing programs that result in nationally recognised and accredited qualification either on a part-time or full-time basis. Scholarships are worth up to $11 000.[163] The money is to support placement cost for the student (living, accommodation etc.) but also provides the organisation with $300 per week of the

[159] DoHA, Workforce, Education and Training – Fact Sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/workforce-education/$file/Copy%20of%20DHA6136%20C1%20Factsheet.pdf> (accessed 10 April 2012).
[160] Australian General Practice Training [website] <http://www.gpet.com.au/AGPTtheProgram/AGPTHandbook/> (accessed 15 May, 2012).
[161] Australian General Practice Training [website] <http://www.gpet.com.au/Registrars/Guide/> (accessed 15 May 2012).
[162] Royal College of Nursing Australia [website] <http://www.rcna.org.au/WCM/RCNA/Scholarships/Government/NAHSSS_PD_AMS/rcna/scholarships/government/NAHSSS_PD-Nurses_working_in_Aboriginal_medical_service.aspx> (accessed 20 February 2012).
[163] Royal College of Nursing Australia [website], <http://www.rcna.org.au/WCM/RCNA/Scholarships/Government/nahsss_cp_ams/rcna/scholarships/government/nahsss_clinical_placement-Aboriginal_medical_services.aspx > (accessed 20 February 2012).

placement and money for the supervisor. Clinical placements are organised through the educational institution.[164]

14.2. Program logic

As specified in the National Framework the following outcomes hierarchies in relation to measure C1 and relevant to the current stage of implementation include:

Expected outputs for year 1 and beyond:

The measure is implemented in accordance with the work plan:

- The workforce required to implement C1, C2 and C3 measures are oriented and trained.
- Thirty-eight additional GP Registrar training posts in Indigenous Health Services are allocated.
- Fifty additional nursing scholarships per year and 50 additional nursing placements per year are allocated.

Expected early results for years 2-4:

- Participants in C1 activities are effectively oriented, trained and supported to provide quality care to Indigenous Australians.
- Participants in C1 activities value and benefit from the training and the placements.

Medium term result years 4+:

- There are more people working in the health workforce who are trained to provide quality primary health care to Indigenous Australians.
- Participants in C1 activities intend to continue working in primary health care and other services assisting Indigenous Australians.
- Primary health care services improve their capacity to identify and provide quality care for Indigenous Australians with or at risk of chronic disease.

14.3. State of implementation – national context

The following information was provided by DoHA for the period of 1 July 2011 to 1 March 2012 on the state of implementation of measure C1 (as relevant to SSE):[165, 166]

As previously advised by the measure area, data are not collected at the Sentinel Site level but are aggregated at the jurisdictional level and provided below.

[164] RCNA, nursing scholarship freecall phone line, private conversation, 28 February 2012.
[165] DoHA, C1 report, 6 March 2012.
[166] DoHA, C1, C2, C3 update, personal communication, 25 January 2012.

OUTREACH WORKER ORIENTATION

- The next national workshop held by NACCHO is being planned for 2013; no documents are available for this workshop yet.
- DoHA report that OW orientation occurred in SA, NT and QLD (Table 14.1).

Table 14.1: Outreach Worker orientation, by state and territory, 1 July 2011 - 1 March 2012

State or Territory	Date	Number of OW participants
SA	5 August 2011	10
NT	26-27 October 2011	8
QLD	21 and 24 February 2012	19

- All jurisdictions have funding agreements in place to develop and deliver orientation, except for Tasmania. New funding agreements were being developed in early 2012. Victoria had offered to deliver the training for Tasmania but there had been no follow-up requests. Further discussions have been taking place between OATSIH and NACCHO affiliate to facilitate the orientation options for OWs in Tasmania.

OUTREACH WORKER INDIVIDUALISED TRAINING

The process to apply for the individualised training funding is for OWs to discuss their training needs with their managers who should then contact OATSIH to arrange funding for the training identified.

DoHA report that:

- Eleven OWs in WA commenced the Certificate III Unit - Facilitate Communication between Patients and Service Providers on 11 November 2011.
- Proposals for OW training in NSW were expected to be lodged in early 2012, however, no requests for funding for training had been received by DoHA since October 2011.

NURSING SCHOLARSHIPS[167]

- Nursing scholarships are offered annually and are advertised on the Royal College of Nursing Australia (RCNA) website.
- No data have been received as to the proportion of uptake nationally. However, DoHA reported in January 2012 that demand was quite low.
- DoHA has been liaising with the RCNA and NACCHO to improve the uptake of the clinical placement and professional development AHS scholarships. [168]

[167] DoHA, C1 Nursing scholarship report, 17 February 2012.
[168] DoHA, C1 Nursing Scholarship update, 19 April 2012.

CLINICAL PLACEMENT SCHOLARSHIPS

- DoHA report that the low uptake of the clinical placement scholarships in AHSs appears to have been partly due to the timing of the scholarship application timeframes in relation to the date that universities choose for clinical placements. RCNA will now accept applications for AHS clinical placement scholarships throughout the year and will assess the applications on a monthly basis. This new process commenced in March 2012.
- All universities were emailed information about the clinical placements scholarships.
- A letter was sent by NACCHO to the CEOs in all AHSs to determine the availability of clinical placement opportunities and to promote the AHS clinical placement scholarships. Promotional material was included in this correspondence.
- A letter was sent by RCNA to universities (Council of Deans of Nursing and Midwifery as well as heads of school) to determine the ability to link with AHSs for clinical placements and to promote the AHS clinical placement scholarships (in consultation with NACCHO).
- RCNA held a trade booth at the November 2011 NACCHO annual general meeting and conference held in Sydney.
- DoHA promotional material was sent to AHSs.
- RCNA held a trade booth at the November 2011 NACCHO annual general meeting and conference held in Sydney.

In 2011, two clinical placement and one professional development scholarships were awarded in three Sentinel Sites.[169]

GP REGISTRAR TRAINING POSTS IN ABORIGINAL HEALTH SERVICES[170, 171, 172]

The ICDP component of the GP training program is only a portion (28%) of the program delivered by GPET. DoHA states that it is not possible to identify the actual sites of the thirty-eight posts funded through the ICDP package. However, DoHA has provided the following information:

- Prior to measure implementation there were approximately 101 GP training posts being funded.
- In the 2010 calendar year/training year, GPET funded 147 training posts in AHSs. This equates to an additional 46 (eight more than funded through the ICDP).
- In the 2011 calendar year/training year, GPET delivered 138 training posts in AHSs. This equates to an additional 37 (one less than funded through the ICDP).

In 2009 there were 214 vocationally registered GPs, 92 GP Registrars and 27 other medical practitioners who indicated that an AHS is their primary place of work across Australia. This is in comparison to 18 837 GPs who indicated that private General Practice was their primary place of work.[173]

[169] DoHA, C1 Nursing scholarship report, 17 February 2012.
[170] DoHA, C1 GP report, 29 February 2012.
[171] DoHA, C1 GP update, 1 May 2012.
[172] DoHA, C1 GP update, 29 May 2012.
[173] Australian Institute of Health and Welfare, Medical Labour Force 2009 [website], <http://aihw.gov.au/publication-detail/?id=10737419680&tab=3> (accessed 10 May 2012).

14.4. Findings from Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from evaluation visit interviews. Information pertaining to measure C1 was obtained through interviews and visits in all eight case study sites, two enhanced tracking sites and four tracking sites. The interviews included both closed-ended and open-ended questions about progress with implementation, experience of access and effectiveness of training, experience and awareness of the GP Registrar positions and nurse placements and scholarships. Information from visits to tracking sites was derived from information that was volunteered by local stakeholders in the process of feeding back SSE findings.

When asking about training in the sites, we noted that there was a high level of activity around training and orientation for OWs (to a lesser extent nurse training). Sometimes respondents were unclear what type of training they had attended. Care was taken to ensure that responses to questions about the training and support pertained specifically to ICDP funded activities under this measure. In interpreting these data, we also considered other contextual information including progress with implementation of other ICDP measures at each of the sites.

OUTREACH WORKER ORIENTATION

Progress with implementation

By the end of this reporting period, orientation packages for OWs had been developed for each of the participating jurisdictions with the exception of Tasmania. In the tracking site of Hobart it was reported that the reason for the lack of development of the package in Tasmania related to lack of demand. Neither the NACCHO affiliate nor the DGP felt that there was a need to develop a specific package for Tasmania.

During this reporting period, OWs in six of the eight case study sites had attended ICDP orientation. This is an increase over the previous reporting period, in which OWs in three of the eight case study sites had accessed orientation. The two sites which had not accessed OW orientation were both remote sites; these were Katherine West and East Pilbara. Underlying reasons for this lack of uptake of orientation in these sites are discussed below.

Two of the eight OWs interviewed in this reporting period were currently accessing DoHA allocated training funds in support of individualised training. Other OWs and their managers reported that OWs had attended training that was funded through other sources.

In addition to orientation, OWs had opportunities to attend the NACCHO and SBOs' workshops and conferences.

The following sections describe the processes used to develop the orientation, early indications of barriers and enablers to access and to effectiveness of the orientation.

Development of Outreach Worker orientation

Differing levels and effectiveness of consultation between sectors in the design of orientation packages were evident across the Sentinel Sites. The process of development of the orientation was the responsibility of the NACCHO affiliates in each jurisdiction. In broad terms, the intention was to

develop specific orientation in each jurisdiction in consultation with local service providers including AHSs, DGPs and possibly other stakeholders.

Amongst the NACCHO affiliates responsible for developing and delivering the orientation, one key informant expressed concern over the considerable investment and development of a whole range of orientation packages for OWs, TAWs and HLWs. The informant suggested that money would be better spent developing generalist training and/or an orientation package that addresses issues across all three worker types with the option for special topics such as tobacco, healthy lifestyles and community engagement work. This may partly reflect the mobility of the health workforce at this level. Some workers are called upon to fulfil various roles depending on the complement of staff available in any particular area.

Some key informants in remote areas questioned the appropriateness of orientation in the first place suggesting that 'training pathways' were needed for remote workers, not orientation packages. The informants felt that given the very differing needs of this workforce, a jurisdiction-wide 'one size fits all' approach in relation to orientation could not meet the particular needs of the remote workforce.

> *'The OW did not attend orientation as this is not relevant in a remote setting. You don't send a remote traditional person to national orientation training - it's irrelevant. If you want training or orientation to be effective the government need to invest in on-the-job training where you have people coming out to the workplace and doing that training in their community and in their health centres and then it becomes real and relevant. We need training pathways - not training packages in remote. It puts remote employees with huge literacy and numeracy challenges often with English as a second language at a great disadvantage.'* (Interviewee, AHS, program manager)

Lack of uptake of orientation by the remote workforce, in both this and previous reporting periods, indicate the significance of this and other reasons given for low uptake by remote workers. In previous periods, reasons for non-attendance at orientation provided by informants in remote sites included reluctance (on the part of the OW) to be away from family and home. For some remote OWs, travel to central/town locations necessitated considerable logistical and practical support from their managers, for example, in managing cash flow without credit cards, negotiating transport and accommodation requirements.

> *'Access to orientation has not happened. The OW has attended a conference in Darwin but it was not orientation. The OW needs a lot of support to attend something off community - for example often don't know how to check into accommodation, need a credit card on check in, or about travel allowance.'* (Interviewee, AHS, program manager)

The issue of the appropriateness of orientation packages for those OWs located within DGPs was identified in previous reporting periods and again in this reporting period.

INDIVIDUALISED OUTREACH WORKER TRAINING

Development and uptake

As indicated in the section on 'state of implementation', uptake of funding for individualised training was low overall within the Sentinel Sites. Across the case study sites, enhanced tracking sites and tracking sites, we were able to identify only two OWs who were currently accessing individualised training funds through DoHA.

Contributing factors to the low uptake of funding for individualised training were identified as lack of awareness of the funding and confusion over eligibility; lack of capacity in some employing organisations to identify training needs and match these to training opportunities; lack of capacity to complete the administrative requirements for access to training (often for a single individual) and early stage of recruitment of OWs in some areas. There were also some issues identified with regards to rurality and sector. Further details about these factors are provided below.

Low levels of awareness of funding available for individualised OW training have previously been reported. During this reporting period we noted however higher levels of awareness of the existence and scope of the training funding amongst respondents at all sites.

One SBO interviewee commented that this was a *'hidden aspect of the package and not well publicised'* and another perceived that the funding for the training aspects of OWs was a new addition to the ICDP package. Other SBO informants believed that aspects of the measure had been expanded since inception, for example, perceptions that allowed training had been increased from the level of Certificate II to level of Certificate IV. Others felt that a barrier had been the lack of availability of the orientation training and OWs could not access individualised training funding until they had completed it.

Some confusion remained about what type of training could be funded under this measure. This was not altogether surprising for the following reason. Whilst OW positions were originally intended to be entry-level positions with OWs drawn from the local community, in practice, the skills and qualifications of OW appointees was seen to vary widely. Some appointees in the Sentinel Sites have been entry-level workers as envisaged, whereas others have been working in other outreach type roles, such as health promotion and nutrition work, some OW recruits are AHWs with formal qualifications and some are Registered Nurses. This clearly presents a situation where training needs are likely to be highly diverse, and OW roles and training needs and expectations are not consistent across sites.

Divergent perceptions amongst informants both at the jurisdictional and service level and across both sectors regarding eligibility for funding for further training and what kind of training could be accessed under this measure indicates that there may be some gaps in communication of this measure to local level. There may also be some uncertainty regarding what is appropriate use of the funds.

In some circumstances, the ability to access funding for individualised training was seen to be constrained by the capacity of the employing organisation to identify appropriate training opportunities and to apply to DoHA for this funding. In order to access training funds, the employing organisation (AHS or DGP) needs to apply on an individual basis for training for a particular individual OW directly to DoHA bypassing the SBO. Some organisations, both AHSs and DGPs, indicated that the administration required to access this measure was not worth the effort; they either did not utilise formal training courses, or they bypassed the funding available through this measure, and utilised their own internal training budgets or other sources of funding for this purpose.

> *'There was no need for individualised training money at the moment as the NT government organising access to Certificate four in Population Health and our team are doing this therefore do not need to access ICDP funded training.'* (Feedback from enhanced tracking site)

> *'The OW accesses training funded through the DGP which is not funded by DoHA and therefore would not be showing up in data.'* (Interviewee, DGP)

The current situation requiring individual-level applications to DoHA for training was perceived by SBO informants to limit the capacity of the SBO to assist in coordinating the training. Some SBO informants felt that training would be more effectively delivered if, for example, common training needs across the jurisdiction could be identified and appropriate training opportunities were identified and supported. In response to this, one SBO indicated that they have recently been advised by DoHA that if they can identify needs for training that are better suited to a state-based roll-out rather than individually accessed then DoHA will allocate funding to the SBO or NACCHO affiliate to implement the training across the state.

In one site where there was a large Aboriginal health team, the organisation indicated that often the training is required for the whole team rather than just for one individual; therefore they were accessing core funds to run training for the entire team.

Other informants felt that organisations were possibly grappling with recruitment and getting staff orientated initially rather than focusing on training needs. This implies that uptake of individualised training may improve in future.

Uptake of the individualised training varied in different sites with some general patterns emerging by rurality and by sector of OW employment as illustrated by the examples below:

- In remote sites, at least in one instance the OW had not accessed any individualised training due to the challenges with limited literacy and reluctance to go off community.
- There appeared to be an emerging concern in one state that OWs based in DGPs were less able to access appropriate training than OWs based in AHSs. SBOs felt that they were taking the role of trying to get information out to the DGPs about the funding for individualised training. In one state they had spent significant time and energy negotiating with the NACCHO affiliate to enable access for the DGP-funded workers to attend the training offered. In one specific instance, the OW based in the DGP had an individualised training plan developed as part of the yearly performance review, but the identified training was not accessible through the NACCHO affiliate. This DGP felt that their requests for collaboration on training had been rebuffed by the affiliate. This negative experience may have been a relatively isolated occurrence. The informants from this DGP did comment that they had heard of successful progress on individualised training plans. There were also instances in other Sentinel Sites where an individualised training plan for a DGP-based OW was in place through the NACCHO affiliate. In one case this was for Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care and in another, for formal training as an AHW.
- OWs based in AHSs with established networks and capacity to access this training, there may have been more opportunities for OW training. For example, one OW based in an AHS had undertaken a variety of training courses such as an Indigenous Leadership Course, Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice), Quality Use of Medicine in Hypertension, Quality Use of Medicines in Asthma and, during the reporting period, was engaged in a Diploma of Aboriginal Primary Health Care. Smaller AHSs or those with weaker administrative or organisational capacity struggled to complete the requirements of identifying training needs, matching these to opportunities and applying for the funding.

Effectiveness of workforce support, education and training – Outreach Workers

At site level, there were various perceptions regarding the extent to which the orientation and other ICDP training contributed to the ability of OWs to fulfil their roles.

It was recognised by some informants that OW training needed to be supported by broader capacity development efforts if the objective of equipping OWs to work effectively was to be achieved. Some interviewees in this reporting period suggested that some training was needed for managers of the OWs within DGPs and AHSs that addressed how best to support the OWs to ensure that they are able to carry out the required program of work. Some OWs had returned to their organisations after training and found that their managers did not share the vision of the OW role outlined in training.

> *'There needs to be training for the people who are expected to support the OW in how to support the position.'* (Interviewee, AHS, GP)

A number of interviewees indicated that the new cadre of OWs coming on board either through a new wave of funding or due to staff turnover would be better supported; they would have access to orientation and also the support of established OWs and benefit from the broad learning about the positions.

> *'The new OWs that are coming on board are in a better position to be supported by the existing OWs as there is a vast knowledge within the existing workforce. The [DGP name] OW demonstrates useful leadership within the network. Other OWs do call on him for support when required.'* (Interviewee, SBO)

Delays in the delivery of orientation to OWs were cited as a factor limiting effectiveness of the orientation training. Some OWs had been in positions for a year or more before receiving formal orientation. The orientation has now developed across the jurisdictions, so this may not be as much of an issue in the future. For the training sessions already conducted however, the delay in rolling out training may have meant that the first orientation training sessions became perhaps less about orientation to roles and more about networking and support. This was reflected in some of the interviews, where various support and networking opportunities provided by the SBOs were identified. Informants were unsure if these were supposed to be orientation sessions or whether they had some other function.

> *'Yes we are just accessing that ICDP orientation two years down the track. That's two years too late! It only just become available and now the Outreach Worker is undertaking it.'* (Interviewee, DGP, program manager)

> *'There is a lot of confusion around if OW has accessed orientation … the OW has attended a number of workshops but not sure if this is classed as orientation or just project get togethers ... Feedback is that they enjoyed networking.'* (Feedback from enhanced tracking site)

In the current reporting period about half of OWs, seven out of twelve 'strongly or partly agreed' with the statement *'The training provided has equipped me with the skills to carry out my role.'* Although this statement was not directly referring to the orientation training (OWs may have been responding about orientation training, individualised training or training offered through other avenues), the overall positive responses are encouraging. Responses indicate improvement over the previous reporting period, in which only one out of eight respondents interviewed, agreed with the same statement. This previous low agreement was predominately due to the OWs not yet accessing training at that early stage of implementation.

Ongoing challenges

A number of consistent themes have emerged over the SSE reporting periods and across sites. These themes highlight challenges in the design and implementation of the OW orientation package:

- Range of skills and experience of the recruited OWs and diversity and changing nature of roles for OWs in different settings present challenges in designing appropriate training. For example, skills for OWs based in DGP differ in some important respects from those based in AHSs. Some respondents felt that existing training was too focused on work within the AHS sector. Requirements change over time, partly a result of ongoing and phased implementation of other components of the ICDP and other factors.
- Staff turnover and roll-out of new waves of OWs present challenges in terms of delivering orientation early on in the employment contract.
- Access is constrained by organisational capacity and to some extent by relationships between sectors.

ADDITIONAL GP REGISTRAR TRAINING POSTS

Across the Sentinel Sites, none of the AHSs interviewed had taken up the funding for an ICDP GP Registrar training posts. However, interviewees in all sites were aware of GP Registrar training posts available generally in AHSs, and about half (17/33) of interviewees indicated that they have had a GP Registrar attend the Health Service either currently or in the past.

Of the eight AHSs asked about GP Registrars, five did not currently have any GP Registrars at the AHS, either ICDP funded or non-ICDP. Reasons for this primarily related to lack of ability to accommodate and/or supervise such positions and, to some extent, difficulty filling available positions. The situation in each of the case study sites is briefly described below.

The AHS in Dandenong was looking at establishing a GP Registrar post and indicated awareness of the ICDP funding for this purpose, but felt constrained by a lack of space to accommodate the position. Bairnsdale and Tamworth have had numerous GP Registrar positions in the past (not funded by ICDP), but these GP Registrars posts are currently vacant and the AHSs are looking to fill these posts. Katherine West currently has no GP Registrar posts and felt that they lack capacity to supervise Registrars. East Pilbara does not currently have a GP Registrar position but indicated that they may be interested in investigating the feasibility of establishing such a position.

The three other sites Barkly, Brisbane South and Campbelltown all have existing GP Registrar training posts currently filled. All three sites indicated though they are aware of the availability of funding for additional posts, but they do not have the space or the capacity to supervise additional GP Registrars.

> *'The funding does encourage AHSs to take them [GP Registrars] but you need an experienced GP as a supervisor. We don't have capacity to increase number at moment in terms of supervision capacity and rooms.'* (Interviewee, AHS, GP)

Several issues were identified by key informants as posing challenges to successfully implementing training posts in AHSs and predominantly related to concerns about supervision of GP Registrars:

- Low numbers of GPs in the AHS sector and inability of the AHS workforce to supervise owing to a large proportion of part-time GP appointments and/or GPs not being vocationally registered.
- Perception of a high patient load and complex care needs of patients reducing the time available for supervision.
- High staff turnover and difficulty filling GP positions in some areas were associated with concerns that some AHSs may not be able to fulfil the supervisory obligations for GP Registrars.

At the same time, informants felt that such placements needed to be available to encourage GP Registrars to develop experience and consider a career in Aboriginal health. These comments were, in general, for GP Registrar placements in AHSs and not necessarily just the ICDP placements.

> *'It's crucial to have Aboriginal health training posts to encourage exposure to Aboriginal health.'* (Interviewee, AHS, GP)

A number of AHSs provided examples of GP Registrars undertaking placements and going on to provide a service at the AHS where they had their placement once qualified. Other sites witnessed GP Registrars moving on to other positions in Aboriginal health.

> *'The last two placements have returned to remote clinics. Most of the Registrar placements have an interest in Aboriginal Health.'* (Interviewee, AHS, practice manager)

The reimbursement of the salary to the AHS for GP Registrars was generally seen as an encouragement to offer a placement. An interviewee noted that previously the salaries for GP Registrars was refunded to the AHS through GPET on an invoice system and not necessarily capped. There was a perception that GP Registrars in AHS were possibly paid more than if they were placed in private General Practice, as an incentive to attract Registrars to AHSs.

> '*We pay them pretty well too!'* (Interviewee, AHS, practice manager)

This same interviewee noted that the GP Registrars are now to be refunded through regional training providers as opposed to GPET and this will mean a cap will be placed on the maximum the AHS can get reimbursed. Concern was raised this will put salaries for GP Registrars in AHS under pressure as they may drop the salary to meet the capped reimbursement level available through the regional training provider.

The following suggestions were made for refinement to arrangements for GP Registrar positions in order to enable AHSs to take on more GP Registrars:

- Establishment of models of remote or roaming supervision.
- Establishment of 'centres of excellence which develops AHSs to be like teaching hospitals in the community.' Establishment of capacity and a culture within AHSs whereby GP Registrars see the placement as an excellent learning opportunity and it becomes a coveted training placement.
- Funding for a staff development coordinator within the AHS to coordinate promotion, placements, organisation and supervision for all trainees including GP Registrars, medical students, nursing and allied health students.
- Increased funding for supervision and teaching to the AHS to release GP from clinical work.

- Provision of funding for physical infrastructure to accommodate trainees.

NURSING SCHOLARSHIPS FOR PROFESSIONAL DEVELOPMENT OF NURSES IN ABORIGINAL HEALTH SERVICES

We identified two apparently conflicting issues with regard to nursing scholarships. On the one hand, some informants felt that these scholarships were unnecessary as there were already many training opportunities. On the other hand, some informants expressed strong views that there was a need for better communication about these opportunities implying that this was the main barrier to better uptake. The reasons for these divergent views were not clear.

About one third (12/33) of interviewees in case study sites indicated that they were aware of the new ICDP funded scholarships for nurses working in AHS to undertake professional development. When probed further it was evident that interviewees generally were not aware of the ICDP funded scholarships, but rather were aware of existing scholarships for ongoing training. There was often uncertainty about how to access information about the scholarships. Responding to requests for information expressed by interviewees, the SSE team often showed web links to the RCNA following the interview.

A CEO of an AHS felt that the availability of nurse scholarship opportunities was not well communicated from DoHA to AHSs. It was suggested communication be channeled to human resource managers.

> *'Aware of the nursing scholarship but do not think made a good use of that. This is a poor part of the package as it is poorly communicated. Not sure how this is communicated now even couple of fact sheets and letters would be sufficient … email received from different sources but not all emails get looked at. One scholarship opportunity was referred to the HR Manager of the [name of AHS]. Ideally the information should be forwarded to the HR Managers of the Health Services because they are generally responsible for coordinating the training within the organisation.'* (Interviewee, AHS, CEO)

In one site a nurse indicated that a colleague at the AHS had applied for one of these ICDP funded scholarships. The nurse had obtained information directly from email communication from the NACCHO state/territory affiliate.

In contrast to perceptions of lack of communication outlined above, other interviewees reported that there were many training opportunities already available through various means and that there was therefore, from their perspective, little need for additional scholarships.

> *'Most nurses currently working in an AHS are already fully involved in continued education. They often can't take on any more activity.'* (Interviewee, AHS, practice manager)

> *'[NACCHO affiliate] often funds scholarships for nurses so unsure if this refers to the Australian Government scholarships.' (*Interviewee, AHS, GP)

SCHOLARSHIPS FOR NURSES UNDERTAKING A CLINICAL PLACEMENT IN AN ABORIGINAL HEALTH SERVICES

Almost half (16/36) of interviewees in case study sites indicated awareness of the ICDP funded scholarships for undergraduate nurses to undertake a clinical placement in an AHS. As far as the SSE team could ascertain none of the organisations visited in the Sentinel Sites in this reporting period

had had an undergraduate nurse approach them to undertake a clinical placement using this ICDP funded scholarship.

The key issues emerging from interviews held in the variety of site types included:

- There was confusion at the site level about the clinical placements funded through the ICDP as opposed to the regular clinical placements which a number of AHSs had already established through collaborations with universities.
- A number of interviewees commented that it is to be expected that awareness at AHSs would be quite low as the scholarship is for the student who should initiate contact with the AHS through the university.

  'It's up to individuals [undergraduate nurse] if they would link with the AHS for a placement. It is not the AHSs who will go out and actively promote the clinical placement.' (Interviewee, AHS, CEO)

- Similar to the issues outlined for GP Registrar placements, there was concern about lack of supervision capabilities of existing staff at AHS.

14.5. Summary

1. During this reporting period, national and Sentinel Sites data indicate that orientation for OWs had been developed by NACCHO affiliates across all jurisdictions with the exception of Tasmania. Lack of demand owing to low numbers of OWs explained the absence of Tasmania-specific training.
2. Uptake and effectiveness of OW orientation has shown improvement since the previous reporting period overall, although the extent of uptake of orientation in remote sites remains problematic.
3. Differing levels and effectiveness of consultation between sectors in the design of orientation packages was evident across jurisdictions. This impacted on the appropriateness and accessibility of OW orientation packages for OWs based in DGPs. Whilst the effectiveness of consultative processes in remote settings was unclear, there is evidence that the orientation packages were considered inappropriate for OWs in this work environment and that their design does not suit remote area needs.
4. OW participation in orientation was to an extent tied in with manager perceptions of its appropriateness and usefulness in particular contexts. Challenges in design and delivery of appropriate orientation training included:
   - 4.1. wide diversity in OW skills sets and experience, with some remote sites highlighting low literacy and social and cultural barriers to participation and for others, having OWs who had already completed formal accredited programs such as AHW or Registered Nurse training
   - 4.2. differing task demands depending on work environment and team composition
   - 4.3. changing roles as other aspects of ICDP are progressively implemented and established.
5. Low overall uptake of funding for individualised training was evident across the sites. Factors identified as contributing to the low uptake of funding for individualised training included:

5.1. lack of awareness of the funding and confusion over eligibility

5.2. lack of capacity in some employing organisations to identify training needs and match these to training opportunities

5.3. lack of capacity to complete the administrative requirements for access to training (often for a single individual)

5.4. early stage of recruitment of OWs in some areas with needs still being identified.

6. Whilst GP Registrar and training opportunities for nurses were valued in Sentinel Sites, capacity constraints, primarily related to lack of adequate supervision and to some extent lack of physical infrastructure, constrained their uptake (particularly for GP Registrars). Some potential refinements were suggested including establishing alternative models of supervision and provision of funding for infrastructure to accommodate trainees, and funding for coordination of training within AHSs.

7. There are a range of scholarships available for nurses. There was little evidence from the Sentinel Sites that the ICDP funded scholarships has created opportunities that were not previously available to support training for nurses.

8. There is no clear evidence to date on the extent to which the funding and resources allocated for training packages had been used to develop training pathways with greater flexibly, or a broader approach to capacity development in various settings. There were suggestions that in some cases different approaches to developing and implementing individualised training (such as identifying common training needs across a jurisdiction and planning at jurisdictional level) were being considered by at least one SBO, with support from DoHA. There seemed to be a gap in development of systems to support (and ongoing supervision for) OWs to work most effectively in different settings.

15. EXPANDING THE OUTREACH AND SERVICE CAPACITY OF INDIGENOUS HEALTH SERVICES (*MEASURE C2*)

15.1. Description of measure

This measure provides funding for local Aboriginal and Torres Strait Islander people to work as OWs in AHSs. OWs will encourage and support Aboriginal and Torres Strait Islander peoples 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.

OWs will be drawn from the local community and are not expected to have existing qualifications. OWs will be supported, mentored and supervised by practice managers and AHWs based in AHSs. Training and orientation for OWs 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 AHSs , and for additional housing and clinic upgrades to support this workforce.[174,175] The workforce allocation is being implemented in three stages.[176]

15.2. Program logic

As specified in the National Framework the outcome hierarchies in relation to measure C2 include:

Expected outputs for year 1 and beyond

- The measure is implemented according to the work plan.
- Eighty-six OWs, forty-three practice managers and thirty-three additional health professionals are recruited and retained.
- Capital infrastructure works relevant to this measure are undertaken.

Expected early result for years 2-4

- Stronger links are forged between AHSs 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.
- Collaboration is improved between AHSs and other health providers to identify and address barriers to provision of primary health care to Indigenous Australians.

[174] DoHA, Expanding the Outreach and Service Capacity of Indigenous Health Services – Fact Sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/expanding-outreach/$file/Copy%20of%20DHA6136%20C2%20Factsheet.pdf> (accessed 10 April 2012).
[175] Urbis, ICDP Monitoring and Evaluation Framework, September 2010. <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/ICDP-monitoring-and-evaluation-framework > (accessed 10 April 2012).
[176] DoHA C2 report, 8 March 2012.

Medium-term results year 4+

- Access to AHSs for Indigenous Australians with or at risk or a chronic disease is improved.
- AHSs enhance their system and workforce capacity to respond to increased service demand.
- OWs have established effective links to increase access to AHSs and other Health Services by Indigenous Australians.

15.3. State of implementation – national context

The following information was provided by DoHA on the state of implementation of measure C2 at a national level as at 25 January 2012 (relevant to the SSE).[177,178]

- Positions for this measure have been allocated in stages. In 2011, the next funding allocation for twenty-one OWs, eleven practice managers and nine health professionals was approved by Minister Snowdon.
- Timeframes for overall implementation of the measure are being met. There has been a slight delay with completing funding agreements with funded organisation for the roll-out of the new positions in 2011-12. This is due to delays in receiving advice from the State and Territory Indigenous Health Partnership Forums about the recommended locations for the new workforce. New funding agreements have been executed with funded organisations in New South Wales and Tasmania. Funding agreements are being developed or soon will be executed for new positions in the Australian Capital Territory and the Northern Territory.
- Discussions with the Indigenous Health Partnership Forums and the DoHA State and Territory Officers about the focus for the next roll-out for 2012/13 was to start early in 2012. The same criteria for allocation of funding were to be used as previously; such as, organisational capacity and need, and population characteristics. The 2012/13 year is to have a worker allocation of twenty-three OWs, twelve practice managers and ten health professionals.
- State and Territory Officers are working with individual organisations to develop action plans for each year. They provide some clarification regarding the OW role and make sure it is consistent with the aim of the measure.
- There are two funded capital works projects within Sentinel Sites reported by DoHA. As at 14 February 2012, funding agreements had been executed for the following: [179]
  - The health administration facility at Grafton, NSW, funded through the Bulgarr Ngaru Aboriginal Corporation reached practical completion in August 2011.
  - The medical centre facility at Tamworth, NSW, funded through the North West Slopes Division of General Practice reached practical completion in November 2011.[180]

[177] DoHA, C1 and C2 update, personal communication, 25 January 2012.
[178] DoHA C2 report, 8 March 2012.
[179] DoHA, C2 report, 14 February 2012.
[180] DoHA, C2 report, 14 February 2012. The main element of 'Practical Completion' is that the facility is 'fit for its designated use'.

- Measure C2 also manages and reports on the eight IHPOs that have been recruited nationally (one employed by NACCHO and one each employed in seven of the NACCHO state/territory affiliate organisations, not including the ACT). IHPOs based in the NACCHO and its affiliates are expected to take an active role in providing support and state-wide coordination. IHPOs are to assist member organisations in implementing the range of ICDP measures relevant to the AHS sector and to encourage increased cooperation and partnership between the AHS sector and the DGP network.
- Activities specified in the Closing the Gap in Chronic Disease schedule funding agreements with NACCHO and its affiliates include:
  - Leadership activities and support for member organisations in implementation of the ICDP, including activities to improve access to primary health care and promote best practice.
  - Activities to increase understanding of the ICDP measures relevant to Aboriginal community controlled Health Services.
  - Leadership in development and maintenance of strategies used to coordinate and support ICDP measures relevant to community controlled Health Services.
  - Collaboration between AHSs, DGPs and related organisations to address shared planning and priority setting.
  - Strategies developed to support OWs including development of an effective OWs' network.

15.4. Findings from Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from evaluation visit interviews. Information pertaining to measure C2 was obtained through interviews and visits in six case study sites and two enhanced tracking sites. The interviews included both closed-ended and open-ended questions about progress with implementation.

In case study sites where OW positions based in AHSs had been filled, stakeholders were interviewed about their awareness and perceptions of the additional workforce capacity. Six case study sites had recruited five OWs based within the AHSs, compared with four case study sites last reporting period. Of the five OWs in AHSs, four were available for interview during this reporting period. One enhanced tracking site had OWs recruited to positions in AHSs and was able to provide feedback on the OW roles.

The figures contain data on views of interviewees in the AHS and private General Practice sectors. The data presented for AHSs are generally referring to OWs based in the AHSs and the data presented for the private General Practice sector are referring to the OWs based in the DGP. Data from both sectors are presented here for comparison purposes.

Focus group discussions covered perceptions of access to Health Services (both General Practices and AHSs), participants' awareness of the new OWs based in AHSs and perceptions of the contribution this expanded workforce had on the quality of care received. The findings reported here are based on discussions held in all nineteen focus groups in the eight case study sites.

PROGRESS WITH RECRUITMENT

Twenty of twenty-four Sentinel Sites, have funding to support OW positions within AHSs (four remote, nine regional, and six urban) (Table 15.1). Eight of these sites also have practice manager positions allocated within AHSs, and two further sites have practice manager positions allocated without OW positions.

Since the previous reporting period, there are two new sites receiving support for OW positions. These are recipients of the 2011-2012 OW funding allocation round.

Most sites have 1.0 FTE allocated to the OW role, however, one site has a part-time allocation, one site 1.5 FTE, and three sites each have 2.0 FTE OW positions allocated. Similarly most of the practice manager positions are 1.0 FTE allocations, with two of the positions 0.8 FTE and one 0.7 FTE.

Overall, AHSs with allocated positions have been successful in recruiting and to a large extent retaining the allocated positions for practice manager and OWs across urban, regional and remote Sentinel Sites. Most OW positions, 83% (20/24), were filled at the time of the evaluation visits. Of the five vacancies for OW positions, one had resulted from a loss of staff since the August 2011 - October 2011 quarter, one had never been filled and three were recent new allocations where recruitment may not yet have commenced. Three OW positions had been filled since the previous reporting period (August 2011 - October 2011). Eight of the practice manager positions allocated are filled. The two with vacancies are recruiting to newly funded positions.

Table 15.1 presents the allocation and recruitment findings from two sources - the DoHA reported allocation and recruitment as at 31 December 2011 and the findings at evaluation visits that occurred between February 2012 and April 2012. 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, and vice versa. Data on the number (and %) of positions filled, as reported in the text below, are based on the findings at the evaluation visit.

There were no major differences in recruitment by rurality:

- Remote sites had three out of six OW positions filled; one new vacancy, two new allocations.
- Regional sites had the majority of OW positions filled (nine out of eleven); one never filled, one new allocation.
- Urban sites had full recruitment of OWs (seven out of seven).

As reported previously a number of sites have amended the structure of the OW positions to be more locally relevant, particularly in remote and regional sites. Local amendments included:

- Pooling all the state and commonwealth ICDP funding for HLWs and OWs and using these to fund several generalist positions, including partial funding for a Receptionist position (remote site).
- Pooling funding for a number of OW and HLW positions and made the positions into ‘family support workers’ (regional site).
- Using the allocation of one position to fund two part-time positions to allow for a male and a female OW, for reasons of cultural appropriateness in that area (remote site).

Table 15.1: Recruitment and retention data for measure C2 workforce by Sentinel Site

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
Case study sites					
Katherine West	Remote	Katherine West Health Board	2.0 OW	0.5	A part-time female position is filled but the part time male position is now vacant at Lajamanu[a]
			1.6 additional health staff	0	Positions filled previously, now vacant
			0.8 practice manager	0.8	Position remains filled
Port Augusta	Regional	Pika Wiya Health Service Aboriginal Corporation	1.0 OW	0	Recruitment commenced Not yet filled
Campbelltown	Urban	Tharawal Aboriginal Medical Service	1.0 OW	1.0	Position remains filled
East Pilbara	Remote	Puntukurnu Aboriginal Medical Service	1.0 OW	1.0	Position remains filled[b]
Bairnsdale	Regional	Gippsland and East Gippsland Aboriginal Cooperative	1.0 OW	1.0[c]	Position filled since previous report[c]
			0.8 additional health staff	0.8	Position remains filled
Logan/Woodridge	Urban	Aboriginal and Torres Strait Islander Community Health Services	2.0 OW	2.0	Positions remain filled[d]
		The Institute for Urban Indigenous Health	1.0 practice manager	1.0	Position remains filled

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
Enhanced tracking sites					
Derby	Remote	Derby Aboriginal Health Service	1.0 OW	1.0	Position remains filled
			1.0 additional health staff	1.0	Position remains filled
Swan Hill/Mildura	Regional	Mildura Aboriginal Corporation Inc	1.0 OW	1.0	Position filled since previous report
		Murray Valley Aboriginal Corporation	0.7 practice manager	0.7	Position remains filled[e]
Cairns	Regional	Wuchopperen Health Service Ltd	1.0 OW	1.0	Position remains filled
			1.0 practice manager	1.0	Position remains filled
Newcastle	Urban	Awabakal Newcastle Aboriginal Cooperative Ltd	1.0 OW	1.0	Position filled since previous report
Darwin	Regional	Danila Dilba Health Service	2.0 OW	2.0	Positions remain filled
			1.6 additional health staff	1.6	Positions remain filled, part-time receptionist and full-time AHW[f]
			0.8 practice manager	0.8	Position remains filled
Elizabeth	Urban	Nunkuwarrin Yunti Inc.	1.0 OW	1.0	Position remains filled
Dubbo	Regional	Thubbo Aboriginal Medical Service	1.0 OW	0	New allocation[g]
Barkly	Remote	Anyinginyi Congress Aboriginal Medical Service	1.5 OW	0	New allocation[g]
			1.0 practice manager	0	New allocation[g]
			1.5 additional health staff	0	New allocation[g]

Site name	Rurality	Fund holder organisation	Positions allocated (FTE)	Positions recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and as found at evaluation visits
Tracking sites					
Canberra	Urban	Winnunga Nimmityjah Aboriginal Health Service	1.0 OW	1.0	Position remains filled
			1.0 practice manager	0	New allocation[g]
Geraldton	Regional	Geraldton Regional Aboriginal Medical Service	1.0 OW	1.0	Position remains filled
Grafton	Regional	Bulgarr Ngaru Medical Aboriginal Corporation	1.0 OW	1.0	Position remains filled
			1.0 practice manager	1.0	Position remains filled
Hobart	Regional	Tasmanian Aboriginal Centre	0.5 OW	0.5	Position remains filled
Dandenong	Urban	Dandenong and District Aboriginal Cooperative	1.0 OW	1.0	Position remains filled
Gladstone	Regional	Nhulundu Wooribah Indigenous Health Organisation	1.0 OW	1.0	Position remains filled
			1.0 practice manager	1.0	Position remains filled
Kalgoorlie	Regional	Bega Garnbirringu Health Services Aboriginal Corporation	1.0 practice manager	1.0	Position remains filled
			1.0 additional health staff	1.0	Position remains filled

[a] Evaluation visit update, 19 March 2012. The DoHA data reports 2.0 FTE recruited positions but there has only ever been a part-time male and a part-time female OW at Lajamanu with the male role now vacant. Other OW positions in Katherine West have not been identified.

[b] Evaluation visit update, 19 March 2012. East Pilbara has an OW/health promotion role and works in the town of Newman only, within the site.

[c] Evaluation visit update, 9 April 2012. DoHA reports the position is vacant but on evaluation visit the position was found to have been recruited to since the previous SSE report.

[d] There are four OWs allocated to the organisation; two OWs with responsibility for Logan/Woodridge area as confirmed at evaluation visit , 6 February 2012.

[e] DoHA, report National ICDP workforce 31 December 2011. Other stakeholder organisation within the site boundary with measure C2 workforce allocation.

[f] Evaluation visit update, 15 March 2012.

[g] The Hon Warren Snowdon MP, media release <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-ws-ws052.htm?OpenDocument&yr=2011&mth=10#> (accessed 10 April 2012).

Note: Excluded from this table are Brisbane South, Tamworth, and North Lakes/Caboolture sites as they currently do not have C2 allocations.

Full-Time Equivalents (FTE).

Source: DoHA, report on ICDP workforce 31 December 2011, unless otherwise indicated.

AWARENESS OF THE WORKFORCE

In order for OWs to link effectively with other service providers as envisaged in the program logic, it is important that staff in other organisations and community members, are aware of the presence of these workers in the AHS. During this reporting period, about one half [53% (39/74)] of interviewees indicated they were aware of an OW based in the AHS in the Sentinel Site (Table 15.2). As would be expected, the AHS sector awareness of the OW in the AHS continues to be higher than in the General Practice sector. Awareness in the GP sector had almost doubled since the previous reporting period. Community focus group participants in this reporting period often indicated awareness of the new OW positions. This is in contrast to the previous reporting period where no references were made to the OWs and there appeared to be minimal awareness of these positions in the community.

Table 15.2: Trends in awareness of Outreach Worker in the Aboriginal Health Service (% who responded 'yes') overall and by sector

	Sector	December 2011	June 2012
Are you aware of an Outreach Worker based in the Aboriginal Health Service in the Sentinel Site? MS, CS, PM[a]	Overall	42% (n=84)	53% (n=74)
	Aboriginal Health Sector	64% (n=39)	66% (n=35)
	General Practice Sector	22% (n=45)	41% (n=39)

[a] Type of interview respondent, see Appendix D for listing of interview and respondent types.

Note: n=number of people who responded to statement.

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

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

Within AHSs, similar proportions of clinicians and practice managers were aware of these OWs (eight out of thirteen clinicians compared to three out of seven practice managers). This differs from the previous reporting period, in which awareness of the OWs based in the AHS was lower for clinicians. This increased awareness amongst clinicians is likely to be important for appropriate use of the OW in assisting with follow-ups, referrals and chronic care coordination.

ROLES OF THE OUTREACH WORKERS AT LOCAL LEVEL

The OW role is a new position within AHSs, although some of the functions of the OW role were perceived in some cases to be similar to those performed by other positions, such as AHWs.

There was little change in the reports of roles undertaken by the OWs since the previous reporting period. OWs were reported to continue to undertake a variety of roles within the AHSs. These include: engaging community, increasing awareness of the ICDP, assisting with follow-up of patients, 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, language interpretation in the clinicians' rooms, coordination of specialist clinics and development of culturally appropriate resources.

Within the AHSs, just over half of interviewees [55% (17/31)] 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'.* This was a decrease from the previous reporting period (Table 15.3).

Table 15.3: Trends in perceptions of the role and contributions of Outreach Workers based in AHS and DGP (% who responded 'strongly agree' or 'partly agree'), overall and by sector

	Sector	December 2011	June 2012
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]	Overall	70% (n=79)	67% (n=67)
	Aboriginal Health Sector	66% (n=35)	55% (n=31)
	General Practice Sector	73% (n=44)	78% (n=36)
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]	Overall	67% (n=70)	78% (n=78)
	Aboriginal Health Sector	56% (n=32)	67% (n=36)
	General Practice Sector	76% (n=38)	88% (n=42)
Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker. MS, CS, PM, OW[a]	Overall	46% (n=78)	55% (n=79)
	Aboriginal Health Sector	40% (n=35)	49% (n=37)
	General Practice Sector	51% (n=43)	60% (n=42)
The Outreach Worker has helped to provide more culturally appropriate care to local Aboriginal and Torres Strait Islanders. CS, PM, OW[a]	Overall	45% (n=36)	68% (n=44)
	Aboriginal Health Sector	50% (n=14)	65% (n=20)
	General Practice Sector	41% (n=22)	71% (n=24)

[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 numerator are the respondents who indicated 'don't know/can't say'.

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

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

Clinicians and practice managers likewise were less likely to agree with this statement than in the previous reporting period (Figure 15.1). By contrast, more than three quarters of interviewees in the General Practice sector [78% (28/36)] agreed with this statement.

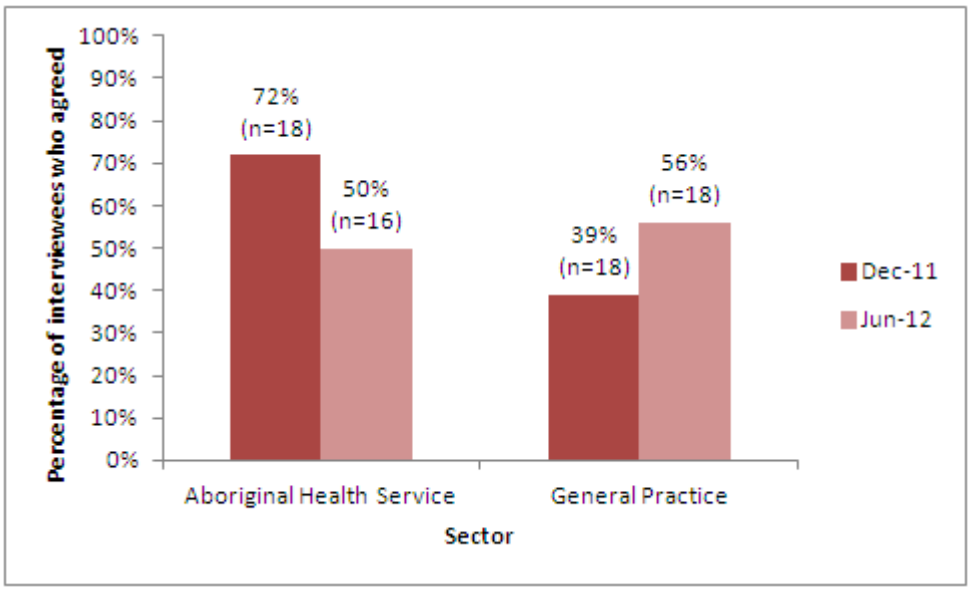


Figure 15.1: Trends in clinicians' and practice managers' responses to the statement 'The Outreach Worker is providing a service for the local Aboriginal and Torres Strait Islander community that was not previously available' (% who responded 'strongly agree' or 'partly agree'), by sector

AHS interviewees often noted that the role being provided by the OW was not new. In a number of instances an existing worker had moved into the OW role and continued to carry on similar duties to ones previously performed. This is not in conflict with the intention of the positions, as the funding aimed to increase capacity of AHSs and not to introduce new roles to these organisations. There were also OWs who felt that their role was similar to an AHW role and had not changed despite moving from an existing role in the AHS to the OW role.

> *'The OW role here is not too dissimilar to how we use AHWs here. We have put the OW through Cert III in Aboriginal health. The role needs to have some clinical skills/background.'* (Interviewee, AHS, practice manager)

However, amongst clinicians and other interviewees in the AHSs, there was little evidence of confusion between the roles of OWs and AHWs. It appears that the role of the OWs is increasingly becoming more clearly defined and understood within the AHSs or at least the AHSs are able to define the OW role within their own Health Service more clearly.

In this reporting period, interviewees continued to view the work performed by OWs as alleviating pressure on clinic staff allowing them to concentrate more on clinical work while the OW focused on community engagement and increasing access to services through their work linking community members with services. A number of OWs based in the AHSs were being used to fill gaps in clinic operations.

Within this reporting period there was a decline in the percent of clinicians and practice managers in AHSs who agreed that OWs are providing a new service (50% compared to 72% in the previous reporting period), reasons for this decline are not clear. By contrast, practice managers and clinicians based in the General Practice sector were becoming increasingly positive about the new roles that the OWs brought to primary health care services. This is consistent with the preexisting strengths of AHSs having fulfiled these roles in the past, whereas OWs based in DGP will need to take some time to establish relationships with staff in General Practices and to impact on the work of these practices.

LINKAGES BETWEEN OUTREACH WORKERS AND COMMUNITIES

It was intended that the OWs would develop effective relationships with communities enabling better access to AHSs. The GPs, nurses and OWs interviewed indicated that this was to a large extent being achieved. One aspect of this work included increasing community awareness and 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, as well as, attending and organising community events.

Community linkages and the importance of OW relationships with communities was described in various ways at the Sentinel Sites by a range of informants, including CEOs, GPs, nurses and OWs themselves.

> *'The OW is definitely the eyes and the ears and connected to the community and we would see bit of improvement and we have done a bit of work lately and will do more work on community engagement in [site name] and the OW will be critical to that.'* (Interviewee, AHS, CEO)

One GP described the OW at the AHS where they worked as assisting with follow-up of patients overdue for appointments, and assisting people on chronic medications. For this GP, a future role for the OW was envisaged in increasing uptake of health assessments.

> *'The clinicians would use the Outreach Workers to follow-up people when they are overdue for follow-up care or having an abnormal test result. Used them for urgent follow-up care for example antenatal care. The Outreach Workers are assisting with home medicine reviews and making them appropriate for the pharmacies. Have not started to use the Outreach Workers for reminders such as health checks may do that in future.'* (Interviewee, AHS, GP)

> *'Couple of things the Outreach Workers will do: i) if having difficulty finding some patients and need to contact them the Outreach Worker would personally go to their home and find them. ii) if need to give some information to the patients the Outreach Worker would do that. iii) if we need to do the medication home review the Outreach Worker would accompany the pharmacy to their home. Also keeping contact with the more elderly people we may need them at the health centre but the Outreach Worker can drop some information to them.'* (Interviewee, AHS, nurse)

The provision of transport for patients appeared to be viewed by some OWs as a core part of their role in some cases, both for the role as community linkage (identified in the quote below) and for facilitating access to other Health Services, outlined in the following sub-section.

> *'Having a vehicle to transport community members to the clinic if necessary … acting as an in between to get patients to clinic or clinic staff to visit patients in their homes … being able to talk to parents and have them take children to clinic for treatment … checking older community members in their homes … building relationships with community members in order to deliver programs and to have community members participate in them.'* (Interviewee, AHS, OW)

Transport was also a key issue highlighted in the community focus groups; this was seen as a major part of the OW role. Other roles identified by focus group participants included bringing medications

and doing home visits. As in the previous reporting period, community focus group participants identified transport as a major barrier to accessing AHSs.

A greater proportion of AHS interviewees in this reporting period 'agreed or partly 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'* [67% (24/36) compared to 56% (18/32) in previous reporting period] (Table 15.3). This may indicate that OWs are becoming more established in the AHSs and their role better understood.

Clinicians and practice managers in both sectors were more likely to agree with this statement in the period covered by this report than in the previous reporting period (Figure 15.2).

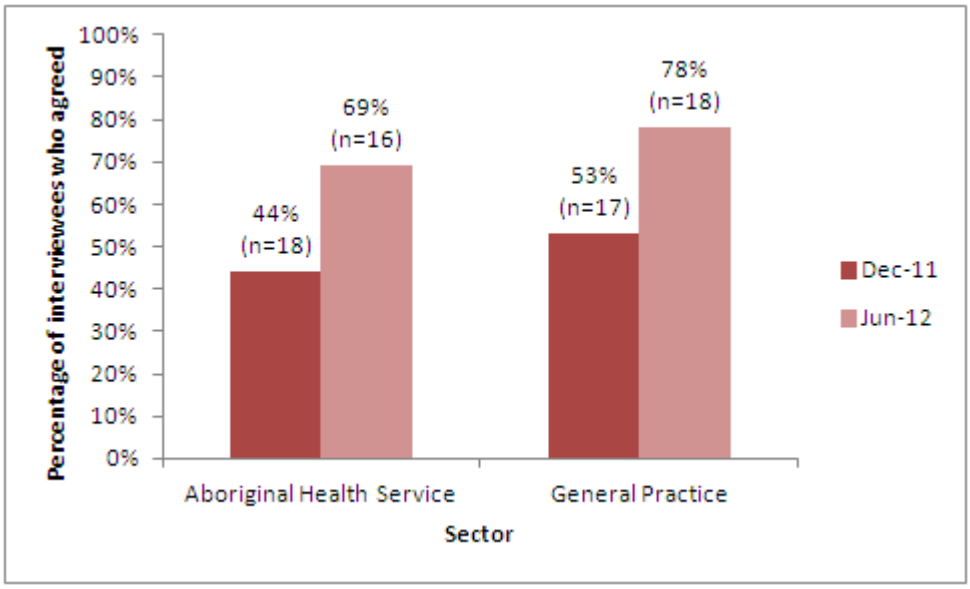


Figure 15.2: Trends in clinicians' and practice managers' responses to the statement 'The Outreach Worker has helped to develop links between Health Services and the local Aboriginal and Torres Strait Islander community that were not there previously' (% who responded 'strongly agree' or 'partly agree'), by sector

About half of interviewees from AHSs [49% (18/37)] 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'.* The proportion of AHS interviewees agreeing with this statement is similar to that for the previous reporting period, and this pattern was also evident when the data are restricted to responses from clinicians and practice managers (Figure 15.3). However, the role of the OW in encouraging regular attendance of patients in the AHS sector is reflected in other data presented above and continues to appear valued by a range of stakeholders in the AHS sector.

While the proportion of clinicians and practice managers in the GP sector that 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'* was the same as for the AHS sector for this reporting period, this reflects a marked increase in agreement in the General Practice sector compared to the previous reporting period.

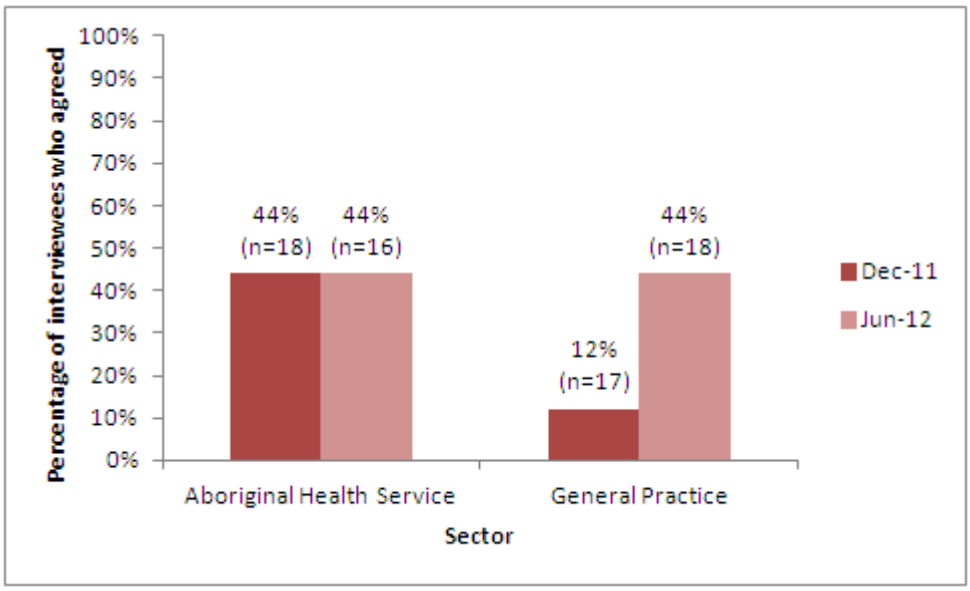


Figure 15.3: Trends in clinicians' and practice managers' responses to the statement 'Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker' (% who responded 'strongly agree' or 'partly agree'), by sector

LINKAGES BETWEEN INDIGENOUS HEALTH ORGANISATIONS AND OTHER SERVICE PROVIDERS

The role of the OW in maintaining linkages between the AHS and various service providers was outlined by a range of interviewees at Sentinel Sites in relation to hospitals, pharmacists and specialists. These aspects to the OW role were described by GPs, nurses and OWs.

> *'Outreach Worker assist to chase information for patients of other health service providers mainly with the hospitals. Have also linkages with hospital's Aboriginal Liaison Officer.'* (Interviewee, AHS, nurse)

> *'I sit in on specialist appointments with patients. I still have my original job description. My job description says pay particular attention to chronic care but I pay particular care to all patients because little sickness can turn into chronic care sickness. I do the Webster packs as well the pharmacy delivers them here to [name of AHS] and I deliver them to the community at the same time I'm taking the PIP forms out with me and getting people registered and reregistered. I also do the home medication reviews with pharmacist. I have a car so am lucky and can provide transport.'* (Interviewee, AHS, OW)

For this OW, the ability to provide transport for patients who needed it was described as 'luck', owing to private car ownership. As mentioned previously, in some of the sites, community focus group participants identified lack of transport as a major barrier to accessing Health Services. It is also notable that this informant felt that the focus on chronic care specified in the OW job description was not particularly relevant and/or workable in the context of high background levels of chronic disease risk.

There were some links established between the OWs in the DGP and the OW in the AHS, but these links were not strong and were only evident in a small number of sites. Links were generally based on previous or existing relationships rather than on organisational focus to work together. The SBOs were often inviting the OWs based in the AHS to attend the state-based workshops that bring together the OW and IHPOs in the DGP. These opportunities for networking were valued.

KEY ORGANISATIONAL AND MANAGEMENT FACTORS

Informants identified sufficient supervision and direction as the main factor enabling OWs to work effectively in their role in AHSs. Provision of supervision and direction was determined by the organisation's capacity being one of the factors that seemed to be underlying rurality differences in perceived effectiveness of the OW role, as outlined below.

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 a valued member of the service team. This OW brought significant experience, clinical understanding and skills to the position.

Interviewees in remote case study sites continued to perceive the support structure for the OWs to be inadequate. In one of the remote sites this was perceived to be the distance from the place of work to the administration centre. In the other remote site a range of interviewees indicated that the local work environment did not provide adequate support for the OW because the busy clinic focused on acute care. Interviewees expressed concerns that the OW was not adequately supported and that there was inadequate supervision and direction for the person in this position. The entry level nature of the position and the associated challenges of recruitment in a remote site are highlighted in the quotes below.

> *'The OW positions have been entry level community people … I am not certain about how the OW position is supported. The Chronic Disease Nurse who has since left was providing support to the OW but she was travelling to other communities and the OW was unsupervised for days … the nurse also was quickly consumed with acute care. The OW often does not know what they are required to do and possibly gets dragged into acute care aspects of delivery in the clinic and all the programs are often calling on the OW.'*
> (Interviewee, AHS, GP)

> *'OW picks up patients occasionally - used in consultation to find out what people are thinking - they get involved in family consultation. If she doesn't know anything she's a transport agent only, not an Outreach Worker. [Name of OW] is having difficulty without mentoring and difficulty being knocked by her own people, knocked by us. Can see why she may not come very often ... she won't accept direction ... part of your job is ongoing mentoring if you are employed as an expert any direction is seen as criticism ... is staying at home playing cards having a cup of tea community liaison? Doesn't seem to be measures of outcome - nobody willing or able to keep an eye, no one got an eye on this. She's had no support, no training. As long as you are warm and breathe you get the job, and they get sick of it, and when someone does try and say something or offer direction they get angry. I could not get out of anyone what the liaison officer's (Outreach Worker) ongoing job was, they don't know what their job was - nebulous 'go out and liaise' no clear role, no expectation. I think it's a really important role but unfortunately not supported.'*
> (Interviewee, AHS, GP)

In contrast, for the OWs based in DGPs, the main management and organisational factors emerging in this reporting period included the development of culturally safe team based approaches, networking, collaboration and other aspects of central organisational support. These contrasting findings suggest that there may be different capacity development needs for OWs employed in the AHS compared to the DGP sector. The findings also highlight that the capacity needs of supervisors

and other team members should also be considered and that these may differ in some respects between sectors.

15.5. Summary

1. Overall, data from Sentinel Sites indicates that recruitment to OW positions in AHSs is largely on track across urban, regional and remote sites, with twenty of the twenty-four sites having OW positions allocated and 83% of positions filled. Eight of these sites also had funding for recruitment of a practice manager and two further sites had practice manager funding without OW funding. At the time of evaluation visits, the majority of practice manager positions were filled.
2. Local amendments to positions, such as pooling of funding from different sources to support generalist positions (which were sometimes called something other than OW positions), or splitting a FTE position into two part-time gender-specific positions were noted in two of the remote sites and one regional site.
3. The OW positions appeared to have become more established within AHSs, with around 66% of interviewees in the AHS sector and 44% of General Practice sector interviewees indicating awareness of the AHS OW. There was considerable local adaptation of roles evident in different sites, with OWs' focus of work varying widely across the broad scope of community engagement with the AHS. This seemed to be effective, as long as there was adequate day to day supervision and direction in place.
4. There appeared to be some overlap in roles between OWs and AHWs and other Aboriginal health positions, for example, one OW had completed a Cert III in AHW, and some others had moved to an OW position from AHW or other Aboriginal Health positions in the organisation. These arrangements appear to have been beneficial at the site level in meeting local needs. However, the variation in levels of training and experience of people in OWs positions has led to unanticipated complexity in terms of orientation and training for positions that were generally entry level positions.
5. The main roles performed by OWs within AHSs differed by site, but generally included provision of transport for patients to attend AHSs, promotion of ICDP measures and health services at community events. OW roles also included assisting with follow-up of patients, increasing cultural awareness of clinicians and, to a lesser extent, assisting with home medication reviews, language interpretation in the clinicians' rooms, coordination of specialist clinics and development of culturally appropriate resources.
    - 5.1. The role that appeared to be most recognised and/or valued in community focus groups was assistance with transport.
    - 5.2. It appeared that the role of the OWs is increasingly becoming more clearly defined and understood within the AHSs, or at least the AHSs are able to define the OW role within their own Health Service more clearly.
6. The OW role in strengthening relationships between the AHS and the community was valued by the AHS. One aspect of this work included increasing community awareness and engagement with ICDP funded services, in particular, the PIP Indigenous Health Incentive and the PBS Co-payment measure.
7. Adequate supervision and support in time-poor environments seemed to be a key constraint on the effectiveness of these new positions for some of the sites, particularly in smaller

remote health centres. This was not as relevant in sites where there were several OWs, including experienced OWs, who could provide peer support. In areas where `capacity of organisational support' was very constrained, it was perceived that the OW role was severely compromised.

8. It is evident that the OWs are being introduced into Health Services where existing AHW positions have various roles in different services. Because of the types of AWH roles in different locations, the range of levels that AHWs operate at, and the particular priority needs that a newly funded position within a specific service may be used to address, there is often no clear distinction between the perceived roles of AHWs and the types of OW roles that services perceive as most important. The new OW role therefore needs to be open to adaptation to fit in with local needs and priorities, existing resources to address these priorities and the types of additional and complementary resources available for new positions.

16. ENGAGING DIVISIONS OF GENERAL PRACTICE TO IMPROVE INDIGENOUS ACCESS TO MAINSTREAM PRIMARY CARE (MEASURE C3)

16.1. Description of measure

To improve the accessibility and quality of General Practice for Aboriginal and Torres Strait Islander peoples, OWs and IHPO are to be employed within the DGP. It is expected that the OWs 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.[181] OWs will encourage and support Aboriginal and Torres Strait Islander peoples 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 within DGPs, 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 appropriate services to Aboriginal and Torres Strait Islander peoples (including support for 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 peoples and to support OWs.

Funding is also provided for IHPO positions in SBOs and the Australian General Practice Network to lead and coordinate Indigenous health activities at the state and national levels.[182] In addition, IHPOs have been funded in NACCHO affiliates to provide a similar leadership and coordination role within the community controlled sector, and together with the workforce within DGPs, to encourage cooperation between the two sectors (reported under measure C2).[183] DGPs have been transitioning into Medicare Locals during this reporting period and the associated funding is being transferred.

[181] 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 General Practice Health Primary Care Indigenous Health Project Officers and Aboriginal and Torres Strait Islander OWs Program Guidelines, Website,. <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-to-mainstream-primary-health/$file/Improving-Access-Guidelines.pdf> (accessed 10 April 2012).

[182] DoHA, Engaging Divisions of General Practice to improve Indigenous access to mainstream primary care – Factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/access-to-mainstream-primary-health/$file/Copy%20of%20DHA6136%20C3%20Factsheet.pdf> (accessed 10 April 2012).

[183] DoHA, ICDP Annual Progress Report, November 2010.

16.2. Program logic

As specified in the National Framework the outcome hierarchies 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 (eighty OWs and eighty IHPOs positions are recruited and retained).

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.
- Collaboration is improved between participating General Practice networks and Indigenous Health Services to identify and address barriers to the provision of primary health care to Indigenous Australians.
- Specific initiatives addressing the needs of local Indigenous people are developed and implemented.
- Indigenous Australians in contact with participating primary health care providers value the enhanced services.

Expected medium term results 4 years +:

- Access to mainstream primary health care for Indigenous Australians with or at risk of chronic disease is increased.
- General practices deliver better quality primary health care to Indigenous Australians.
- OWs have established effective community links to increase access to mainstream primary health care by Indigenous Australians.

16.3. State of implementation – national context

The following information was provided by DoHA on the state of implementation of measure C3 at a national level as at 10 January 2012 (relevant to the SSE).[184]

- Eighty-four FTE IHPOs and eighty-one FTE OWs were recruited in the DGP Network as at 30 September 2011.
- Funding for IHPOs and OWs is being progressively transferred to Medicare Locals as they are established and have capacity to take on programs. DoHA Central Office is working with the DoHA State and Territory Offices to ensure transition arrangements for the program will provide continuity of funding and service provision.

[184] DoHA C3 report, 10 January 2012.

Funding under the program has been transferred from DGPs to Medicare Locals in seven of the twenty-four Sentinel Sites. The Australian General Practice Network is subcontracting the Australian Mentor Centre to develop a set of resources to facilitate the transition of program funding from Divisions to Medicare Locals.

There have been concerns at national level regarding the roles of OWs and IHPOs. Particular concerns had been raised by DGPs regarding the appropriateness of OWs undertaking clinical work and there had been a degree of uncertainty over this issue at the Aboriginal and Torres Strait Islander OWs national workshop in June 2011. Responding to concerns, the DoHA drafted a letter to Australian General Practice Network and the SBOs to clarify expectations regarding roles of OW and IHPO (August 2011). The most recent DoHA reports available during this evaluation period indicate that there has been no further feedback received from the SBOs or DGPs on this issue.[185]

16.4. Findings from the Sentinel Sites

NOTES ON DATA SOURCES

Data were derived from DoHA reports on allocation and recruitment, findings from evaluation visit interviews and, for case study sites, community focus groups.

Program activity data are received from DoHA as per jurisdictional fund holder service updates. Data have been received until 31 December 2011.

Available DoHA workforce allocation and recruitment data do not align with the six monthly reports on reporting periods of the SSE. Up to date data were gathered where possible through the evaluation visit interviews and fundholder interviews. As there is not one primary source of data, we have attempted to get as accurate a picture as possible from different data sources, but there are some inconsistencies between data sources. The final assessment of data, including retention of staff, includes findings at evaluation visits that occurred between February 2012 and April 2012.

Interviewees were asked about their awareness of and perceptions about the IHPO and OW positions based within DGPs. Focus group discussions covered community members' perceptions of access to Health Services (both private General Practice and AHSs) and awareness of new OW positions based in DGPs. The findings reported here are based on discussions held in nineteen focus groups in the eight case study sites. See Appendix E for further information on focus group profiles.

PROGRESS WITH RECRUITMENT

The DGPs have been successful in recruiting and to a large extent retaining the allocated IHPO and OW workforce across urban, regional and remote Sentinel Sites. Whilst there were some delays in recruitment to OW positions and these positions initially experienced high turnover, indications are that for most sites recruitment seems to be on track and early problems with retention of staff are less apparent.

[185] DoHA, C3 report, 17 February 2012.

Recruitment Overall

Twenty-two of the twenty-four Sentinel Sites have funding for IHPO and OW positions (Table 16.1). These sites represent a spread of rurality including eight urban sites, twelve regional and two remote sites. The Barkly and Katherine West sites have been excluded from Table 16.1 as the workers based in the DGP in the NT (Northern Territory) do not cover these Sentinel Sites. Included in the table are two remote sites, East Pilbara and Derby, but they do not have coverage by the local DGP IHPOs or OWs as the DGP offices are outside the boundaries of the sites and the distances between the DGP offices and the Sentinel Sites are prohibitive. This is indicative of the vast areas covered by DGPs/SBOs/Medicare Locals in remote regions and of the challenges of service provision by personnel who have responsibility for these regions.

Altogether there have been 52 positions allocated to organisations in the Sentinel Sites. One organisation has been funded for one OW but has created a second position with other funding. Both positions are included in the numerator and denominator for positions (totaling 53). 89% (47/53) of positions were filled at the time of the evaluation visits. Two-thirds (35/53) of positions had been filled by the same workers for at least six months (since the August 2011 - October 2011 period). Table 16.1 presents the allocation and recruitment of Measure C3 workers in Sentinel Sites and changes in allocation, recruitments or vacancies since the previous reporting period.

Table 16.1: Allocation, recruitment and retention for Measure C3 workforce by Sentinel Site

Sentinel Site	Rurality	Fund holder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and found at evaluation visit
Case study sites					
Port Augusta	Regional	Country North Medicare Local (formerly Flinders and Far North Division of General Practice)	1.0 IHPO	1.0	Position remains filled
			1 .0 OW	1.0	Position filled for about 9 months[a]
Brisbane South	Urban	Accoras (encompassing former Brisbane South Division of General Practice)	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Campbell-town	Urban	Sydney South West GP Link (formerly Macarthur Division of General Practice	1.0 IHPO	1.0	Position remains filled[b]
			2.0 OW	2.0	Positions remain filled[c]
Tamworth	Regional	North West Slopes Division of General Practice	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Bairnsdale	Regional	East Gippsland Primary Health Alliance	0.75 IHPO	0	Position filled during this reporting period but recently vacant[d]
			1.0 OW	1.0	Position remains filled

Sentinel Site	Rurality	Fund holder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and found at evaluation visit
East Pilbara	Remote	Pilbara Health Network	1.0 IHPO	1.0	Position remains filled. Does not cover the site
			1.0 OW	1.0	Position filled since previous report. Does not cover site
Logan/ Woodridge	Urban	South East Primary Health Care Network	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Enhanced tracking sites					
Derby	Remote	Boab Health Services (formerly Kimberley Division of General Practice)	1.0 IHPO	1.0	Position remains filled. Does not cover the site [e]
			1.0 OW	1.0[e]	Position vacant in previous report but filled after December 2011. Does not cover the site [e]
Newcastle	Urban	GP Access	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Cairns	Regional	Far North Queensland Rural Division of General Practice	1.0 IHPO	1.0	Position remains filled
			2.0 OWs	1.0	One position vacant since previous report
Swan Hill/ Mildura	Regional	Mallee Health Care Network (formerly Mallee Division of General Practice)	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Darwin	Regional	General Practice Network NT	1.0 IHPO	1.0	Position filled but about to be come vacant, moving back to Hobart IHPO position [f]
			1.5 OWs	1.5	Full-time position filled but currently on maternity leave. Part-time male OW position filled since previous report [g]
Elizabeth	Urban	Adelaide Northern Division of General Practice	1.0 IHPO	1.0	Position remains filled
			1.0 OW	2.0	Positions remain filled [h]
Dubbo	Regional	Dubbo Plains Division of General Practice	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Tracking sites					
Canberra	Urban	ACT Division of	1.0 IHPO	0	Position had been filled

Sentinel Site	Rurality	Fund holder organisation	Positions Allocated (FTE)	Positions Recruited (FTE)	Recruitment/retention and changes since the December 2011 SSE report and found at evaluation visit
		General Practice			now vacant since previous report
			1.0 OW	1.0	Position remains filled
Geraldton	Regional	Goldfields Mid-West Medicare Local formerly Mid-West General Practice Network	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Grafton	Regional	Mid North Coast (NSW) Division of General Practice	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Hobart	Regional	Tasmania Medicare Local (South) (encompassing former General Practice South)	1.0 IHPO	0	Position had been filled now vacant since previous report. Past IHPO returning from interstate to take up the position after April 2012[i]
			1 0 OW	1.0[j]	Position remains filled[j]
Dandenong	Urban	Dandenong Casey General Practice Association	0.75 IHPO	0.15	Position filled until November 2011, position now 0.15FTE until new recruitment
		Peninsula GP Network	0.75 IHPO	0.75	Position remains filled
			1.0 OW	1.0	Position remains filled
Gladstone	Regional	Capricornia Division of General Practice	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
Kalgoorlie	Regional	Goldfields Mid-West Medicare Local (encompassing former Goldfields Esperance GP network)	1.0 IHPO	1.0	Position remains filled
			1.0 OW	1.0	Position remains filled
North Lakes/ Caboolture	Urban	Metro North Brisbane Medicare Local (encompassing former GP Partners and Moreton Bay General Practice Network)[k]	4.0 IHPO	2.0	Position rearrangements occurred since previous report with Medicare Local formation. Two positions remain filled with 2 new allocated to the organisation[l]
			2.0 OW	1.0	One position remains filled , one vacant since previous report

[a] DoHA report as vacant, found to be same person in same position at evaluation visit 9 April 2012.

[b] One full-time IHPO position split into two part-time positions to cover Campbelltown and Fairfield/Liverpool regions.
[c] Evaluation visit update, 27 February, 2012. One OW is based at Tharawal and covers Campbelltown region within the site and the second OW is based at Marumali and covers Fairfield-Liverpool region, outside the site. Both are included in the site allocation as the Marumali workers assists people to access GPs in the Campbelltown region.
[d] Position recently vacant at the time of evaluation visit, although IHPO interviewed.
[e] Boab Health Service website.[186] The IHPO and OW do not work in the Derby site boundary but focus on Broome (Evaluation visit update, 15 October 2011).
[f] General Practice Network NT is funded for IHPOs and OWs 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. [187] 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.[188]
[g] Evaluation visit update 12 March, 2012.
[h] DOHA reports one allocation funded but two positions filled. The organisation stated in the last report that they had used other funding to top up to two FTE as they felt it important to have one male and one female OW.[189] This reporting period the OW positions are however filled by males. The requirement for a female worker is still a priority and is undertaken by the female IHPO. (Evaluation visit update 6 June 2012).
[i] Evaluation visit update, 27 February, 2012.
[j] DoHA reports OW position as vacant but evaluation visit confirms position remains filled.
[k] Moreton Bay General Practice Network is no longer part of the site with the new Medicare Local.
[l] It is not known how many of the IHPOs cover the North Lakes/Caboolture site or elsewhere in the Medicare Local
Note: This table excludes Katherine West and Barkly as there are no ICDP workers allocated to the DGP with coverage of the site. In the previous report it was unclear whether the GPNNT workforce covered Barkly, it has been identified at evaluation visit in March 2012 that this is not the case.
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).
Source: DoHA, report on ICDP workforce 31 December 2011 unless otherwise specified.

[186] Boab Health Service [website], <http://www.boabhealth.com.au/index.php/staff/corporate-services-team> (accessed 10 May 2012).
[187] DoHA, Report on ICDP measure C3, 14 June 2011.
[188] DoHA, Division of General Practice 12 month report, 1 July 2010 – 30 June 2011.
[189] Adelaide Northern Division of General Practice, personal communication, 10 October 2011.

Recruitment - Indigenous Health Project Officer

During this reporting period, the majority of sites had at least one filled IHPO position and three quarters (20/26) of IHPO positions had been filled and stable for more than six months. There are more positions than sites as Dandenong site has two DGPs and North Lakes/Caboolture has four IHPOs since Medicare Local formation. Most of the IHPOs were full-time, however three IHPO positions in Sentinel Sites had 0.75 FTE allocation and one urban full-time position is split into two part-time positions to cover different areas. There were five positions vacant. Of these, two were newly allocated positions arising from the formation of a Medicare Local and in early stages of recruitment and two were recent vacancies. Dandenong site also had an IHPO resignation but the DGP continued to undertake the IHPO work at a reduced FTE while recruiting.

Recruitment - Outreach Workers

All Sentinel Sites with a funding allocation for OW positions had at least one position filled. The majority of positions, about 81% (22/27), had been filled and stable since the August 2011 - October 2011 reporting period with only two additional positions recruited to in that period. There were two recent vacancies and one maternity leave absence during this period. The majority of sites have been allocated one FTE OW position per organisation, with exceptions in Darwin, Cairns and North Lakes/Caboolture with 1.5-2 FTE allocation. For reasons of cultural appropriateness two of the sites had appointed both male and female OWs (Darwin and Elizabeth). The latter now has two male OWs and the IHPO fulfils female related culturally appropriate responses with community. The other sites with more than one FTE per organisation (Cairns, Campbelltown and North Lakes/Caboolture) indicated that the OWs are likely to be required to cover a large region, accounting for the need for more than one position.

There were no clear differences in recruitment between urban and regional areas; sites in both types of rurality had few vacancies:

- five out of eight urban sites had full recruitment with three vacancies in the other sites (one maintaining a reduced position time), and two new allocations (four IHPOs and one OW)
- nine out of twelve regional sites had full recruitment with three new vacancies in the other sites (two IHPOs and one OW)
- two out of two remote sites had full recruitment, with both having filled OW positions since the August 2011 - October 2011 period. However, as indicated in the table, none of these positions were within the boundaries of the Sentinel Sites.

In the Sentinel Sites, consistent with the Measure intention that IHPOs are to be recruited earlier than OWs, recruitment to the OW positions lagged behind that of IHPOs. During this reporting period, there were indications of more stability in staffing of OWs compared to the previous reporting period.

TRANSITION TO MEDICARE LOCALS

Funding under the program has been transferred from DGP to Medicare Locals in seven of the twenty-four Sentinel Sites (Table 2). At site level, there were mixed views regarding the anticipation and experience of the transition to Medicare Locals in terms of how this transition affects the ICDP at local level, including the work of the OWs and IHPOs. Some informants saw the transition as an

opportunity allowing greater focus on Aboriginal and Torres Strait Islander health due to the Medicare Local remit to plan for population health needs.

> *'We always knew that we have XX of the population identifying from Census data but it was not until we had dedicated time and a requirement to turn this percentage into numbers and consider what does this mean for service delivery.'* (Interviewee, DGP, program manager)

> *'We see the change to a Medicare Local as a new opportunity and potential. The way we think about what our core business is has shifted. Previously our remit was to support GPs but now we are identifying needs at a local level and then establishing the programs to meet the local needs of the community.'* (Interviewee, DGP, program manager)

Other interviewers were concerned that the organisational changes may be disruptive to the ICDP. Informants cited instances of changes of managers, people having to reapply for positions and realignment of boundaries, as factors that were impacting on their ability to progress ICDP work.

> *'I have had support from IHPO and the OW from the Division through awareness such as posters and education of the item numbers. Had a number of practice visits from the IHPO and OW where they sat and discussed about health assessments. However, this was more focused on last year. Now that the Medicare Local has taken over and reform at the moment there hasn't been too much support from the Medicare Local that the practice has received. But expecting a similar service from these ICDP funded staff. The Division is now at the transition phase, bit of housekeeping is going on. There might be a slight break in getting support from the Division or Medicare Local but I expect to have improved services from the IHPO & OW.'* (Interviewee, private General Practice, GP)

At the same time, as indicated in the quotation above, it was recognised that that the disruptions occurring as a result of organisational changes are likely to be temporary.

Table 16.2: Transition of Divisions of General Practice into Medicare Locals in Sentinel Sites

Division of General Practice	Medicare Local
Flinders and Far North, SA	Country North SA
Brisbane South, Qld	Metro South Brisbane
South East Primary Health Care Network, Qld	Metro South Brisbane
Moreton Bay, Qld	Metro North Brisbane
Goldfields Esperance, WA	Goldfields Mid-West
Mid-West, WA	Goldfields Mid-West
GP South, Tasmania	Tasmania

Source: DoHA, C3 report, 10 January 2012.

AWARENESS OF THE WORKFORCE

Awareness of Indigenous Health Project Officer

In order for IHPOs to work effectively, it is important that health professionals are aware of the presence of these workers. During this reporting period, over 80% (64/75) of interviewees indicated that they were aware of the IHPO positions based in the DGPs (Table 16.3). This varied by rurality,

with awareness highest in regional sites [97% (30/31)], followed by urban [93% (28/30)] and remote sites [43% (6/14)]. The lower awareness of the IHPO DGP in remote sites reflects the tendency of DGPs to be less active in remote areas compared with regional and urban sites, and the vast geographic areas covered by the remote DGPs and Medicare Locals, with the workers not active within the boundaries of the Sentinel Sites.

Some of the IHPOs are based in SBOs and NACCHO state/territory affiliates, and as expected, interviewees, who were predominantly drawn from local level positions, tended to be less aware of these IHPO positions than of those positions based in the DGPs. Remote sites were less aware of the IHPO based in the SBO and NACCHO affiliate than other ruralities (Table 16.3).

Since commencement of the SSE, awareness of the IHPO has increased across all ruralities. In this reporting period there has been a notable increase in awareness of the IHPO in urban sites [93% (28/30) compared to 74% (23/31) in the previous reporting period]. The urban sites are generally more complex service environments than regional sites due to the number of Health Services and stakeholders, and this may be a factor in the relatively later increase in awareness in urban compared to regional sites.

Table 16.3: Awareness of Indigenous Health Project Officer (% who responded 'yes') overall and by rurality

	Rurality	December 2010	June 2011	December 2011	June 2012
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)	85% (n=75)
	Remote	18% (n=11)	44% (n=16)	41% (n=22)	43% (n=14)
	Regional	87% (n=15)	93% (n=40)	94% (n=32)	97% (n=31)
	Urban	85% (n=13)	60% (n=25)	74% (n=31)	93% (n=30)
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)	41% (n=75)
	Remote	45% (n=11)	31% (n=16)	32% (n=22)	7% (n=14)
	Regional	27% (n=15)	35% (n=40)	39% (n=33)	35% (n=31)
	Urban	69% (n=13)	36% (n=25)	39% (n=31)	63% (n=30)
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)	39% (n=75)
	Remote	18% (n=11)	31% (n=16)	36% (n=22)	14% (n=14)
	Regional	13% (n=15)	38% (n=40)	39% (n=33)	32% (n=31)
	Urban	54% (n=13)	44% (n=25)	35% (n=31)	57% (n=30)

[a] Type of interview respondent, see Appendix D for listing of interview and respondent types.
Note: n=number of people who responded to statement.

Awareness of the IHPO based within the DGP across sectors is relevant to the effectiveness of these positions as they have a role in improving links between AHS and the General Practice sector. As expected, a higher proportion of interviewees from the General Practice sector were aware of the IHPOs based in the DGPs than those in the AHS sector [98% (40/41) and 71% (24/34) respectively] (see Figure 16.1). There has been an increase in awareness of these positions overall and across sectors in this reporting period compared to the previous period.

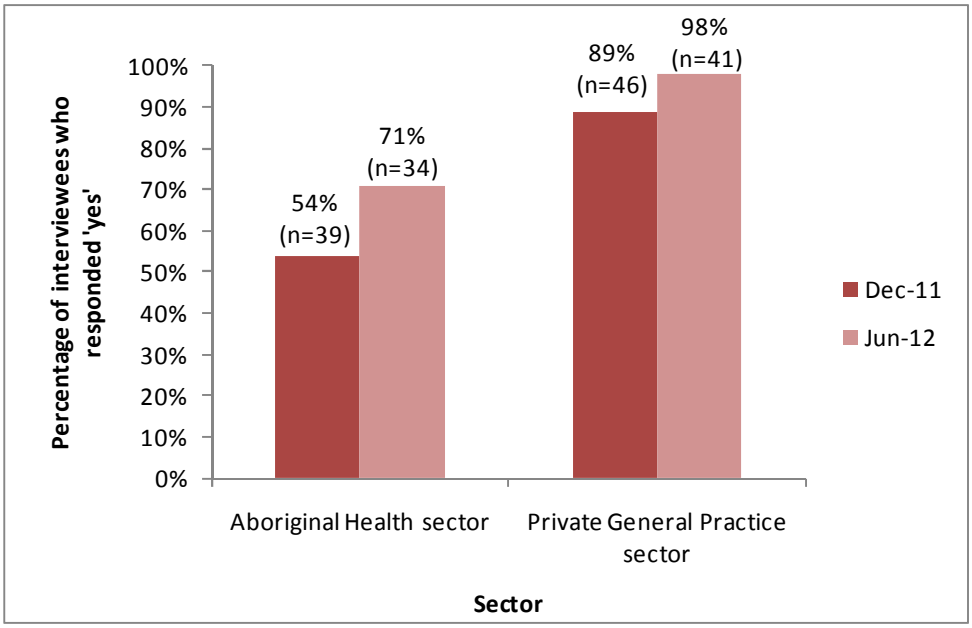


Figure 16.1: Awareness of Indigenous Health Project Officer (% who responded 'yes') by sector

Awareness of the IHPO differed by respondent type, with practice managers more likely than clinicians to be aware of the IHPO. This was supported by interview data indicating that the IHPO was more likely to communicate with practice managers, rather than with clinicians in the course of their work. However, awareness of the IHPO position amongst clinicians has increased [81% (22/27) compared to 63% (19/30) in the previous reporting period].

When interviewees who indicated an awareness of an IHPO were asked which IHPO they had the most communication with, 86% (55/64) nominated the IHPO based at the DGP, 8% (5/64) nominated the IHPO based in the NACCHO State/Territory affiliate and 6% (4/64) the IHPO at the Divisions SBO. 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.

Awareness of Outreach Workers

Around three quarters (55/74) of interviewees in Sentinel Sites were aware of the OW based in the DGP. Awareness has increased steadily since June 2011 (Table 4). Levels of awareness continue to be relatively high in regional sites, with a steady increase in awareness in urban sites. However, awareness of OW positions amongst interviewees in remote sites remained low and may have declined since June 2011. Some of this may be due to the lower involvement of DGPs and lower numbers of GPs in remote areas.

Table 16.4: Awareness of Outreach Worker (% who responded 'yes') overall and by rurality

	Rurality	June 2011	December 2011	June 2012
Are you aware of an Outreach Worker based at the Division of General Practice in the Sentinel Site? MS, CS, PM[a]	Overall	57% (n=81)	70% (n=86)	74% (n=74)
	Remote	38% (n=16)	32% (n=22)	27% (n=15)
	Regional	60% (n=40)	94% (n=33)	93% (n=29)
	Urban	64% (n=25)	71% (n=31)	80% (n=30)

[a] Type of interview respondents, see Appendix D for listing of interview and respondent types.
Note: n=number of people who responded to statement.

ROLES OF INDIGENOUS HEALTH PROJECT OFFICERS AND OUTREACH WORKERS

The main roles of ICDP and OW that were evident at local level in the Sentinel Sites generally correspond well with those described in the DoHA policy documents for this measure. Roles of IHPOs that were identified and explained by informants at site level included: creating awareness and uptake of ICDP measures in the community, and within General Practice; increased demand for certain services offered by private GPs out in the community (with community members then coming in to the practice to ask for these services); acting as a cultural broker, such as making appointments, explaining cultural differences to Aboriginal patients and assisting non-Aboriginal service providers to be more 'Aboriginal friendly'. OWs also took on advocacy roles on behalf of patients for provision of certain key services or types of service delivery such as encouraging providers to bulk-bill for services where possible. There was little evidence of roles in assisting services to enhance delivery of the types of services that would trigger Tier 1 payments for PIP Indigenous Health Incentive registered patients. This area may require further consideration by the DoHA.

Overall, there were high levels of agreement with the statement that the IHPOs were contributing to a raised awareness of the ICDP measures and less high levels of agreement that they contributed to improving access, developing stronger links between primary care providers and improving identification of Aboriginal and Torres Strait Islander people attending General Practices. Agreement with statements relating to the role of the IHPO (Table 16.5) was strong across ruralities, with agreement for all statements being highest in urban, followed by regional and then remote sites. Interviewees from the General Practice sector had a markedly higher agreement with the statements regarding contributions of the IHPOs than interviewees from the Aboriginal Health sector. The practice managers continued to be generally more positive about the role of the IHPO than clinicians. This may be because of a greater awareness amongst practice managers of the role and contribution of IHPOs as a result of them having more contact with these workers. Table 5 illustrates the varying responses from respondents in different positions. Managers tended to be more positive about the role of the IHPO.

Table 16.5: Perceptions of the role and contributions of the Indigenous Health Project Officer (% who responded 'strongly agree' or 'partly agree') by job category

	Managers, Practice managers & clinicians	Practice managers & clinicians	Practice managers	Clinicians	Managers
The IHPO has contributed to improved access to Health Services.	76%(n=63)	68%(n=35)	69%(n=13)	68%(n=22)	86%(n=28)
The IHPO has been helpful in assisting to raise awareness of the new measures being implemented under the ICDP.	80%(n=64)	71% n=35)	69%(n=13)	73%(n=22)	89%(n=29)
The IHPO has contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practice.	66%(n=64)	63%(n=35)	54%(n=13)	68%(n=22)	69%(n=29)
The employment of IHPOs has helped to develop stronger links between Primary Health Care services.	76%(n=64)	74%(n=35)	69%(n=13)	77%(n=22)	79%(n=29)

For interview and respondent types, see Appendix D.

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

Findings from the Sentinel Sites in relation to each of the main roles of the DGP IHPO and OWs are outlined below.

Promoting awareness and uptake of ICDP measures

One of the key roles envisaged for OWs and IHPOs at local level was to assist in creating awareness and uptake of the various ICDP measures available. The effectiveness of OWs and IHPOs in achieving increased awareness and uptake was difficult to ascertain quantitatively in the SSE, as there were no 'unexposed' comparator groups; almost all sites had ICDP workforce in place. However, as workers were appointed at different times, it is informative to look at the timelines of implementation and uptake of ICDP and other contextual factors that have been developed for each of the case study sites. These are described in Section 20.

Similar to the previous reporting period 80% (51/64) of interviewees 'strongly or partly agreed' that the IHPO had been helpful in raising awareness of the new measures available under the ICDP (Figure 16.2).

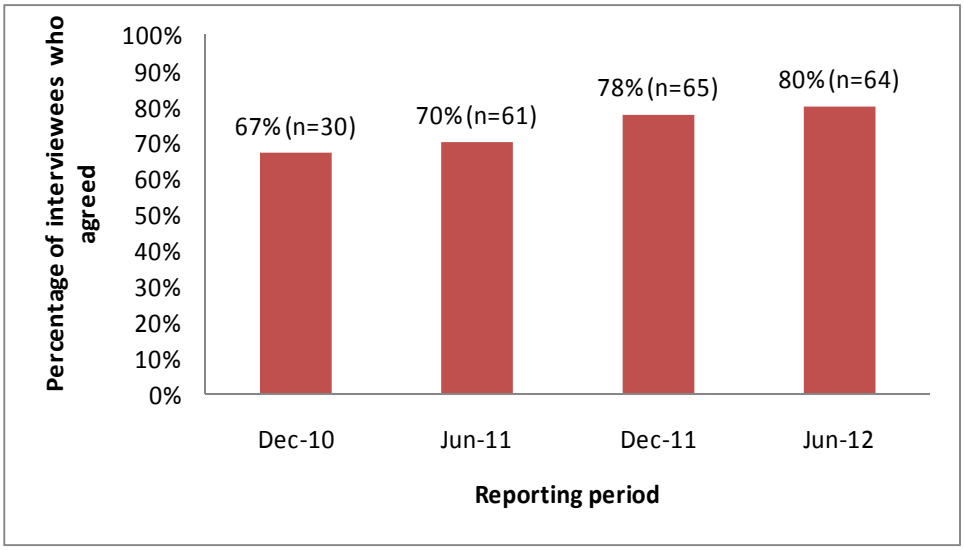


Figure 16.2: Interviewees' responses to the statement: 'The IHPO has been helpful in assisting to raise awareness of the new measures being implemented under the ICDP' (% who responded 'strongly agree' or 'partly agree'), overall and by report period

Interviewees across all sites spoke about the role of the IHPO in raising awareness of the ICDP measures. In this reporting period there were a number of interviewees who felt that the IHPO had achieved good general awareness of the ICDP and there was now a slight change in emphasis to provide more detailed information on measures such as requirements to trigger Tier 1 payments through the PIP Indigenous Health Incentive.

> *'The CtG team from the Medicare Local just pop in intermittently to check how the practice is going and drop off information and just to have a chat with us to see how we are going with everything. They seem to be doing a pretty good job. They have always got time to talk if I have any problem so I am happy with that.'* (Interviewee, private General Practice, practice manager)

A number of stakeholders talked about how the work of their IHPOs and OWs in increasing uptake of ICDP measures targeted both practice and community levels.

General Practice approach

Whilst initial work of IHPOs, and to a lesser extent of OWs, tended to focus on increasing awareness of General Practices, during this reporting period stakeholders indicated that to a large extent this had been achieved and now there was a slight change in emphasis of work, including:

- attempting engagement of General Practices that had shown initial reluctance
- working with the ICDP funded CCs to assist in access to private General Practice, often by way of facilitating introduction of the CCs to the Health Service staff (Section 10)
- increasing awareness within the DGP (and/or emerging Medicare Locals) about the ICDP.

In some General Practices, the IHPOs and OWs worked together with the practice support team and were able to introduce Aboriginal components into events, such as GP and practice staff education sessions, hosted by the team. Other specific activities in General Practices included a range of activities related to increasing identification of Aboriginal and Torres Strait Islander patients; these

are described in more detail below in the section 'Facilitating improvements in Aboriginal and Torres Strait Islander identification in General Practices.'

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 as Aboriginal or Torres Strait Islander people at Health Services. Relevant activities undertaken by the OW at site level identified in this reporting period included: consultations with individuals and families; organisation of presentations about the ICDP at community groups, events and in public spaces and organisation of specific community events to promote the ICDP measures.

> *'OW has assisted to raise that awareness by participating in information sessions at stall set up in local shopping centres.'*(Interviewee, DGP, IHPO)
>
> *'Information days have been held which has established links between services and community. Also visited many organisations in [site name] to talk about the CtG program.'* (Interviewee, DGP, OW)
>
> *'The CtG team goes out there and creates community awareness. The team has been networking with the Aboriginal staff and community to raise awareness on stuff.* (Interviewee, AHS, practice manager)

One factor that seemed to contribute to the ability of the IHPO and OW workforce to effectively assist roll-out of ICDP measures in some of the sites was the formation of Aboriginal Health teams. Examples of how these teams have been organised are described further below in emerging management and organisational factors. The contribution of Aboriginal health teams to increasing the uptake of health assessments is briefly expanded upon here. We noted in Section 7 that one of the common characteristics of those sites that achieved high population coverage of adult health assessments, particularly in urban areas, was that there was a high number of GPs engaged in doing adult health assessments, in addition to high numbers of adult health assessments per GP. Of relevance to the work of OWs and IHPOs, we noted that for many of the sites that achieved good population coverage of health assessments, there was an Aboriginal health team support structure in place. This team structure was described as a support to IHPOs and OWs, and is likely to have contributed to their ability to expand the base of practices engaging in adult health assessments.

Whilst IHPOs (and OWs) described activities consistent with facilitating uptake of some measures (for example, through provision of information and support to enable access of PIP Indigenous Health Incentives and PBS Co-payments and encouraging community members to undergo health assessments), there was a notable gap in activities to enhance care in a way that promoted delivery of the types of services required to trigger Tier 1 payments for PIP Indigenous Health Incentive registered patients. IHPOs do not currently have a well-developed role in respect to assisting Health Services to access these Tier 1 payments. The generally low numbers of patients for whom Tier 1 payments are triggered is consistent with the paucity of Aboriginal patients identified on chronic disease registers (see Sections 9 and 19). This may reflect a more general lack of systems orientation to provision of chronic disease care for Aboriginal and Torres Strait Islander people within the Health Services. A future role of IHPOs in this regard may be to work with practice support teams to develop systems able to deliver and appropriately document the services required for Tier 1 payments.

Vignette – the evolving IHPO role

The work of an IHPO based in a DGP in a regional site has evolved as the ICDP program has become established. When she started in the role, the main focus of IHPO work was informing the community and private General Practices about the new measures.

The IHPO worked in partnership with the DGP based OW to raise awareness and generate community interest in the program. They presented information about the Closing the Gap program at meetings of community groups, combining it with heath education sessions whenever possible. For example, the IHPO arranged for the National Prescribing Service team member employed at the DGP to give a talk on safe medication use at an Elders meeting, where the IHPO also informed the group about assistance available through the new Care Coordination and Supplementary Services program. Community members increasingly asked about access to private General Practices.

In this early phase, information was disseminated to private General Practices through visits, memos and by incorporating information into education events organised by the DGP for GPs and General Practice staff. Links were made with the practice support team based in the DGP to ensure they were aware of the new measures and how they were administered.

Now that most General Practices and community are aware of the ICDP the IHPO role is supporting General Practices to implement relevant measures, raise cultural awareness and improve cultural safety. Community awareness raising activities are ongoing, and work is being done to integrate the ICDP into other DGP programs.

Facilitating improvements in Aboriginal and Torres Strait Islander identification at General Practices

An important factor in enabling the delivery of ICDP measures is that Aboriginal and Torres Strait Islander peoples are identified and that Indigenous status is appropriately recorded in Patient Information Recall Systems (PIRS). Improvement in identification of Aboriginal and Torres Strait Islander patients at General Practices was consistently noted as being a major focus of the program of work of IHPOs and OWs. Appropriately identifying Aboriginal status was found to include the following aspects of work for OWs and IHPOs at local level:

- supporting General Practices to create ‘Aboriginal-friendly environments’
- reminding practices that documentation of Aboriginality is important because of the differing best practice clinical guidelines recommended for Aboriginal and Torres Strait Islander people and others at high risk of certain conditions, for example highlighting that recommended screening intervals for certain conditions may differ because of varying risk profiles
- supporting practices to organise systems to embed routine identification by provision of examples and training of staff (particularly reception staff) on how and why to ask about Aboriginal or Torres Strait Islander status
- encouraging community members to self-identify

- promoting the financial benefits to practices of identifying Aboriginal and Torres Strait Islander patients and service delivery to these patients.

The role of IHPOs in contributing to improved identification of Aboriginal and Torres Strait Islander patients was recognised by interviewees. Two thirds (42/64) of interviewees 'strongly or partly agreed' that the IHPO had contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practices (Figure 16.3). There has been a steady increase in the proportion of interviewees agreeing with this statement since the first evaluation period.

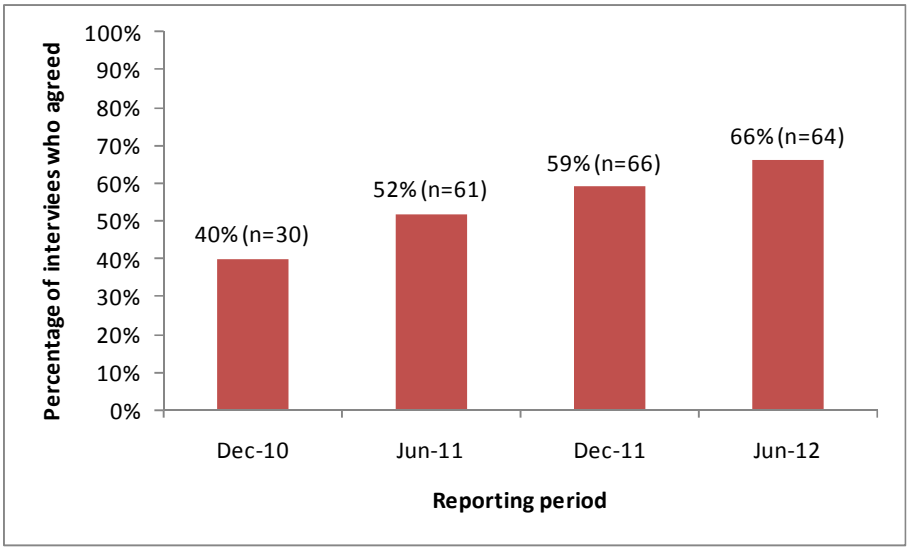


Figure 16.3: Interviewees' responses to the statement: 'The IHPO has contributed to improvements in Aboriginal and Torres Strait Islander identification at General Practice' (% who responded 'strongly agree' or 'partly agree'), overall and by report period

In this reporting period twenty General Practices provided clinical indicator data that included numbers of patients identified as Aboriginal or Torres Strait Islander. This was an increase over the previous reporting period, in which sixteen General Practices provided these data. For General Practices that provided clinical indicator data, the number of regular patients identified in the General Practice information system as Aboriginal or Torres Strait Islander ranged from 19 to 855. Sixteen of the twenty General Practices had more than 50 patients identified as Aboriginal or Torres Strait Islander, twelve had more than 100, and ten had more than 200.

Amongst General Practices that provided data for both this and the last reporting period, two practices showed increases of 50 or more identified Aboriginal and Torres Strait Islander patients since the previous reporting period, and a further five General Practices showed increases of 20 or more patients identified as Aboriginal or Torres Strait Islander (Figure 16.4). Almost all General Practices showed some increase in the number of patients identified as Aboriginal or Torres Strait Islander, with an overall increase of about 10% across the General Practices that provided relevant clinical data over this and the previous reporting period.

For most General Practices, the proportion of all regular patients who identified as Aboriginal and Torres Strait Islander was fairly low, ranging from 0.4% to 7%. For four General Practices this percentage was equivalent to or higher than the percentage of Aboriginal and Torres Strait Islander people in the total population for the site. For the majority of practices (16/20) Aboriginal and Torres Strait Islander people made up a smaller proportion of regular patients than the proportion of the total site population who were identified as Aboriginal and Torres Strait Islander. This does not

necessarily reflect under-documentation of Aboriginal status; it may reflect different service use patterns in different areas.

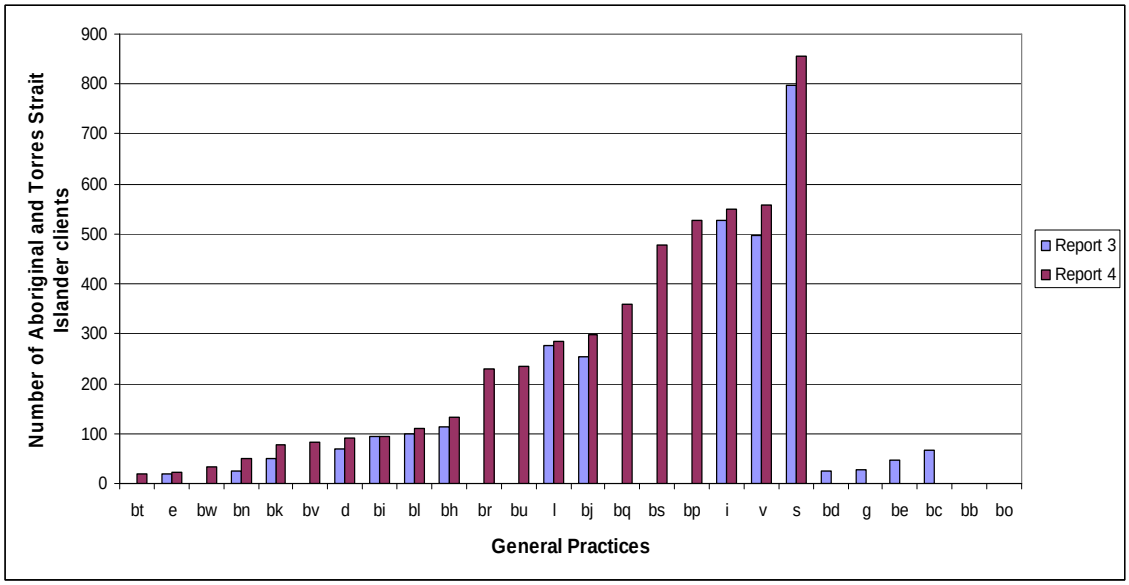


Figure 16.4: Number of patients on the patient information system identified as Aboriginal and Torres Strait Islander by General Practice

AHSs, which by definition have a predominantly Aboriginal or Torres Strait Islander patients, have not, in general, had a focus on recording of Aboriginal and/or Torres Strait Islander status previously. However, with the implementation of ICDP and other reporting requirements, some AHSs, particularly those that have significant numbers of non-Indigenous patients, face the need to establish systems to identify and record Indigenous status. Informants across both General Practices and AHSs indicated the need for further development of systems to support identification of Aboriginal and Torres Strait Islander patients. However, whilst IHPOs have a role in private General Practices to facilitate identification, they do not have a similar role in AHSs. Interviewees from AHSs in Sentinel Sites did not indicate a need for this kind of support from IHPOs.

Improving access to Health Services

OWs and IHPOs worked in a number of ways to increase access to Health Services. There was evidence of OWs working to provide a cultural brokerage service between health professionals and the patients. This role included accompanying patients to appointments, and acting as a '*buffer between [patients and] reception staff, especially at specialists and at doctors'* and providing advice to Health Services about how to be culturally appropriate.

> *'The OW also acknowledges that the patients are often 'hypersensitive' to side-way glances and attend thinking they are going to be discriminated against where in fact the staff may be just busy. The OW points out to the person, 'they are just busy and not ignoring you so you must wait'.'* (Interviewee, DGP, program manager)

> *'One Outreach Worker stated that she had been able to improve access for patients and that ... making a contact with a patient was important and making them feel comfortable enough to open up to me. In my first interview we would talk about everything else except why I was there, so I have found my approach has been spot on and gaining my patient's*

trust which I have, they have actually spoken about other members of the family that may be able to benefit from our services.' (Interviewee, DGP, OW)

The role of OWs in facilitating greater cultural appropriateness of care was recognised by some, but not by the majority of the General Practice interviewees. This may be because in some areas OWs tend to work more with communities and individuals and the IHPO taking the lead in working with practice staff. Eight of the eighteen informants interviewed from the General Practice sector, including practice managers and clinicians, agreed that the OW had assisted the practice with providing more culturally appropriate care (compared to five of seventeen interviewees in the last reporting period). In addition to the role of 'cultural broker', OWs facilitated increased access to health services through assisting patients with making appointments and navigating the health system, including follow-up and specialist appointments. In some situations OWs reportedly took on other roles such as supporting patients with broader social concerns such as assistance with housing or social supports.

Over half of interviewees in this reporting period [55% (43/79)] 'strongly agreed or partly 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 was an increase from 46% (36/78) in the previous reporting period (Table 16.5). The proportion of interviewees who either strongly or partly agreed that the IHPO had improved access to Health Services was higher than that for OWs at 76% (48/63) for this reporting period (Figure 16.5). As indicated above in relation to perceptions of the role of OWs in assisting the practice to provide more culturally appropriate care, this may be related to interviewees having better knowledge of the work of the IHPO than of the OWS because of the types of tasks typically performed by IHPOs, which are more likely to bring them into direct contact with service providers and managers.

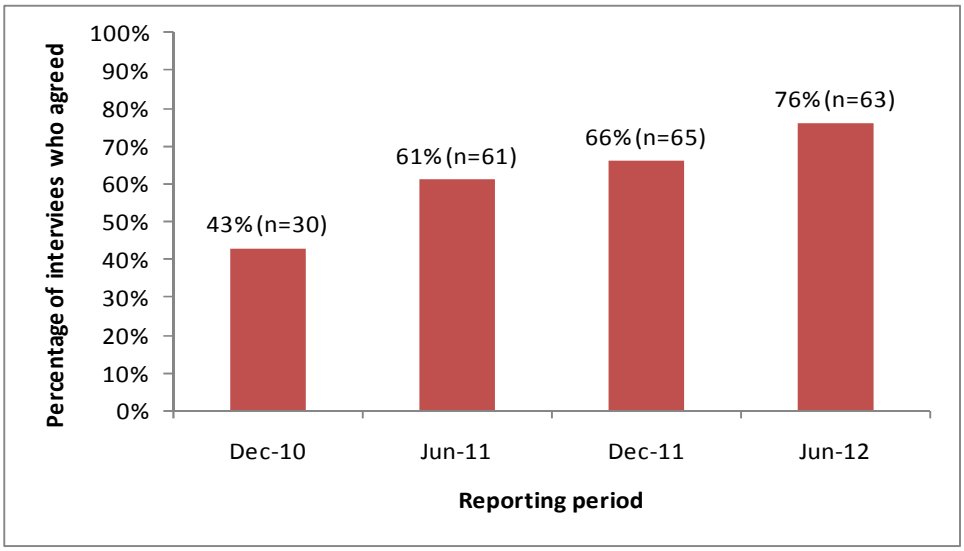


Figure 16.5: Interviewees' responses to the statement: 'The IHPO has contributed to improved access to Health Services' (% who responded 'strongly agree' or 'partly agree'), overall and by report period

Different ways of working

IHPOs and OWs worked in different ways in different sites. This variation was generally in terms of the relative 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 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.

Comparisons of the data on uptake of ICDP items (such as PIP Indigenous Health Incentive or adult health assessments) in relation to the approaches used in different sites do not provide clear insight into the most optimal approach in terms of increasing uptake of the measures. It seems likely that different contexts may require different types of approaches.

DIFFERENCES IN UNDERSTANDING OF ROLES BY RURALITY AND SECTOR

Differences in understanding of the roles of IHPOs and OWs based at DGPs were evident by rurality and by sector. To a large extent these two factors were inter-linked. Interviewees in remote sites and in the AHS sector generally showed lower awareness of DGP IHPOs and OWs and less understanding of their roles compared to urban and regional, and private General Practice.

In remote sites, interviewee awareness of the DGP IHPOs and OWs remained low overall in this reporting period. This may have been because individual IHPOs and OWs need to cover the entire geographical area of a DGP, which in some cases, particularly in remote sites, is larger than the Sentinel Sites boundary. In remote sites, IHPOs/OWs in the relevant DGPs were focusing their work on areas that are not within the Sentinel Site boundaries. There are also few private GPs in remote areas, with AHSs playing a relatively greater role in service provision in remote areas, with a smaller role for the DGP.

In urban and regional areas, some IHPOs indicated a shift in focus of their work during this reporting period, to engage General Practices that were motivated to participate in the ICDP, rather than expending time on ones that, on the basis of initial visits, did not wish to engage.

In the General Practice sector, 60% (25/42) of interviewees agreed that Aboriginal and Torres Strait Islander people were attending Health Services more regularly as a result of the work of the OW (Table 16.6). This proportion was higher than that in the AHS sector, where 49% (18/37) of interviewees agreed with this statement.

Table 16.6: Responses to the statement 'Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker' (% who responded 'strongly agree' or 'partly agree'), by sector

	Sector	December 2011	June 2012
Local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the Outreach Worker. MS, CS, PM, OW[a]	Overall	46% (n=78)	55% (n=79)
	Aboriginal Health Sector	40% (n=35)	49% (n=37)
	General Practice Sector	51% (n=43)	60% (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 numerator are the respondents who indicated 'don't know/can't say'.
Aboriginal Health Sector includes: AHSs, NACCHO State and Territory affiliates.
General Practice Sector includes: private General Practice, DGPs and Division SBOs.

Data from this reporting period also showed an increase in the proportion of respondents agreeing that local Aboriginal and Torres Strait Islander people are attending Health Services more regularly as a result of the work of the OW. This increase was evident in the AHS and in the private General Practice sector (and it is also evident among clinician and practice manager interviewees). The increase may be due to the closer collaboration between OW and ICDP funded CCs in some sites, and/or it may reflect growing confidence of OWs in their role meaning that they can work more comfortably and be more visible within practices, not just in communities.

Developing stronger links between primary health care services

Overall, three quarters (49/64) of interviewees 'strongly or partly agreed' that the employment of the IHPO had helped develop stronger links between primary health care services (Figure 16.6). In this reporting period clinicians were more like to agree to the statement '*the employment of IHPOs has helped develop stronger links between primary health care services'* [77% (17/22) compared to 38% (8/21) in the previous reporting period]. Interviewees described both the OWs and the IHPOs as spending time establishing partnerships with primary health care services such as community Health Services and allied health providers.

> *'The IHPO provides information about their role and Closing the Gap program to organisations and has established referral pathways between the hospital and IHPO for follow-up of patients after their discharge from hospital. Liaison Officer at hospital with the consent of the patient will refer patients to the IHPO. This also enables IHPO to gauge the types of support required by community.'* (Interviewee, DGP, program manager)

The extent of interaction between OWs in the AHS and in the DGP varied across the Sentinel Sites. Some OWs collaborated, conducting joint planning of service provision and others reported no contact. In one site there was concern that a lack of collaboration may be leading to a duplication of services to one subset of the population.

> *'The OWs and the DGP and the AHS don't interact. The OWs in the DGP are focused on providing information to homeless people and people in crisis about where to access health services. There is the possibility this is occurring also with team at AHS.'* (Interviewee, DGP, program manager)

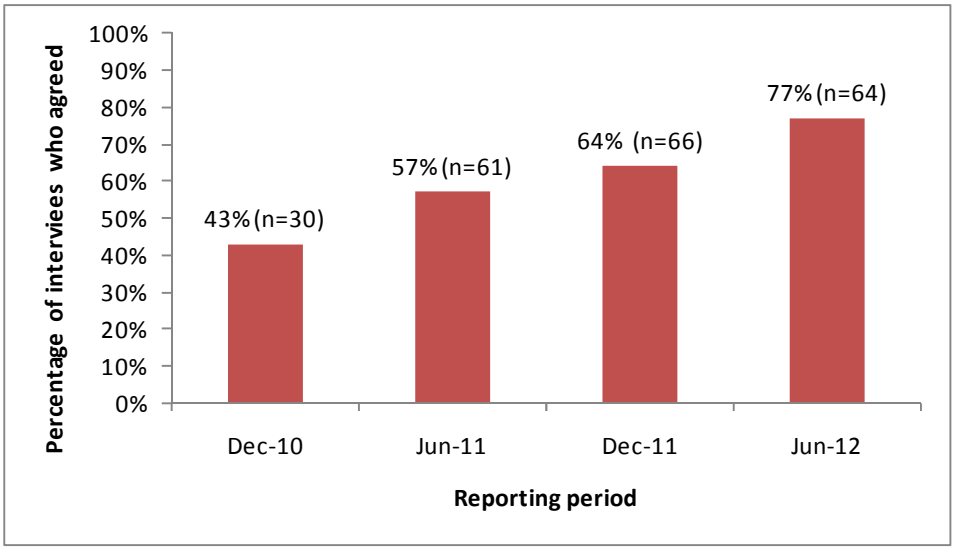


Figure 16.6: Interviewees' responses to the statement: 'The employment of IHPOs has helped to develop stronger links between primary health care services' (% who responded 'strongly agree' or 'partly agree'), overall and by report period

A greater understanding of the role of the OW was evident during site visits during this evaluation cycle compared to previous cycles. Confusion between OWs and other workers (such as AHWs) was less apparent in this round.

The role of the IHPO based in the DGP has been primarily on increasing access to private General Practice and raising awareness of the private General Practices on the ICDP measures. There have been examples of the IHPO wanting to establish links and work with the AHS on raising awareness, but the AHS at the time gave the impression they had this in hand and were not in need of support from the IHPO based in the DGP.

EMERGING ORGANISATIONAL AND MANAGEMENT FACTORS

A number of key factors emerged as important for the ability of IHPOs and OWs to work effectively within DGPs and SBOs. These included development of culturally safe team-based approaches, networking, collaboration and the critical role of organisational support provided by the SBOs.

Culturally safe team-based approaches

In previous reporting periods, considerable concerns had been expressed regarding the difficulties of integrating an Aboriginal workforce into DGPs. During this reporting period, these concerns were less evident. It seemed that local solutions had been developed in a number of areas. A number of sites had developed Aboriginal health teams and these were spoken of highly by interviewees who felt that they provided Aboriginal staff with peer support and the ability to assert their roles more effectively. Other factors such as clearer definition of roles and larger numbers of non-Aboriginal staff in DGPs having undertaken cultural awareness training are also likely to have played a role in successful integration.

Interviewees across a number of sites indicated that building Aboriginal health teams helps to overcome a sense of isolation among Aboriginal and Torres Strait Islander staff employed within DGPs and to 'share the load of Aboriginal Health' within organisations.

> *'Talking about management support structure at the Divisions. Some Divisions do it well and others don't … where you have an Aboriginal Health team, you've got Aboriginal people working in a team with non-Aboriginal people, it works well … if we look at our workforce recruitment and retention over time ... we haven't had the turnover that we thought we'd have … we are looking … to see what works and what doesn't.'* (Interviewee, SBO)

The value of building Aboriginal health teams to provide peer support was highlighted by site level interviewees in this reporting period. Two examples from the Sentinel Sites below illustrate how this can work in practice.

Vignette - Support structures and processes for Aboriginal and Torres Strait Islander staff in DGPs

One DGP that has a number of funded Aboriginal health programs has these programs managed by an overarching Aboriginal Health Manager. The teams work together and cross roles between programs to ensure they are not siloed. They recognise that there are numerous synergies across the programs and feel that the programs are better integrated as a result of this management structure. Benefits of working within the team, as noted by the IHPO, included:

- advocacy by the Aboriginal Health manager, who is able to advocate upwards to the DGP management and board in regard to program direction and implementation, rather than IHPO advocating as a 'lone voice in the team'
- support and networking between OWs and IHPOs
- pooled funding for items such as vehicles
- a sense of having greater influence and being more valued because of team membership.

Another DGP recognised the support needs of Aboriginal health team members and established a system of debriefing and counselling through the DGP-funded mental health team. The team manager indicated that, although time-consuming, additional debriefing opportunities were necessary for staff. She described taking the role of 'accidental counsellor' on many occasions. In recognition of the need for peer support, and of the support role staff members have with patients, this DGP organised 'accidental counsellor' training for all members of their Aboriginal health team.

Not all organisations were able to create such teams. One interviewee indicated frustration that the funding for the IHPO, OW and CC has come into the organisation and they recognise a need to create a management structure. This interviewee believed that the roll-out of the funding did not support the creation of teams as the vision was not there from DoHA to fund middle managers and DGPs have been left to integrate management into existing structures.

> *'The fact they have rolled out separate packages that don't necessarily link together is an issue … the team here at the Division have three programs [IHPO, CC and OW] but they have no manager. I am a division manager; I have spent 15% of my time being a team leader to these people. For them to work as a team and work together is difficult without somebody helping.'* (Interviewee, DGP, program manager)

Some interviewees indicated the need for training for middle managers on how to support the Aboriginal workforce.

Networking and sharing of information

Interviewees in this reporting period continued to highlight the importance of the networking and sharing of information that is facilitated by the SBOs and identified that these roles have evolved and strengthened over time. The email communication and meetings facilitated by SBOs were seen to encourage sharing and collaboration between IHPOs based in the DGPs, avoid duplication of effort in developing resources and provide support to staff. One interviewee spoke about the support received from the SBO and networking opportunities offered through the state-wide networking events which occur twice a year and are coordinated by the SBO. The interviewee perceived that the support and understanding of the program has matured, not only amongst IHPO and OWs, but also amongst the support organisations.

> *'The first twelve months of the program were shaky. The meetings at SBOs with IHPOs were challenging as there were tensions amongst IHPOs and OWs working in DGPs from different models. It was perceived that there was a cultural imbalance between non-Indigenous and Indigenous IHPOs, differing views on the amount that should be invested in time and energy on developing cultural security within DGP and community approach for IHPOs rather than only focusing on GPs. There was a lot of animosity at meetings about the approaches being used and people felt culturally unsafe. [SBO name] developed a working group to bring together an agenda and to work towards making network meetings constructive. The working group organised a healing session and as an outcome developed a mural. We have grown and strengthened and we are one mob now. Care Coordinators join the meeting too now.'* (Interviewee, DGP, IHPO)

An additional aspect to information sharing was the presence of favourable pre-existing collaborative relationships. In particular, strong relationships between DGPs and General Practices were identified by informants as being particularly important for enabling roll-out of the ICDP measures, including Measure C3. This suggests that the ability of the developing Medicare Locals to retain and build on DGP-GP relationships is likely to continue to be important.

Organisational leadership

Interviewees highlighted that where there was strong organisational leadership for Aboriginal Health and a clear strategic direction, IHPOs and OWs were able to work more effectively with staff at different levels.

> *'The DGP as an organisation has been very supportive in making Aboriginal Health a priority and this has filtered down to DGP staff.'* (Interviewee, DGP, IHPO)

Without this 'mainstreaming' of Aboriginal health into management, the IHPO and/or OW were left trying to advocate for Aboriginal health matters to be given higher priority. The effectiveness of this advocacy role varied widely and was largely dependent on the experience and confidence of the IHPO.

> *'[Where there is] a more experienced IHPO that can act as a mentor within the organisation and is able to advocate for Aboriginal health was where there were gains. The younger Aboriginal staff struggle with this advocacy role which they adopt.'* (Interviewee, SBO)

16.5. Summary

1. Overall, data from Sentinel Sites indicate that the DGPs have been successful in recruiting and, to a large extent, retaining IPHO and OW workforce across urban, regional and remote sites. Indications are that within the sites recruitment of workers is on track and retention has been reasonable (with twenty-two of the twenty-four sites having IHPO and OW positions allocated, 89% of positions filled and around three in four of the same job incumbents in their positions for at least six months).
2. Remote areas faced particular challenges in terms of coverage by the DGP IHPO and OW workforce, including vast geographic areas covered per DGP/Medicare Local and the lack of General Practices in remote areas. Although DGP IHPO and OWs were allocated to DGPs that covered the remote Sentinel Sites, the workers were not active within the boundaries of the Sentinel Sites. It was therefore not possible to explore how well these positions were working in remote areas more generally.
3. The main roles of the IHPO and OW at local level broadly correspond to those envisaged in the DoHA policy documents for this measure.
    - 3.1. OW roles that were identified and explained by informants included: increasing demand and expectation among community members for certain services offered by private GPs and encouraging community members to attend General Practices to ask for these services; acting as a cultural broker, such as making appointments, explaining cultural differences to Aboriginal patients and assisting non-Aboriginal service providers to be more 'Aboriginal friendly' and advocating on behalf of patients for access to key services. IHPOs were involved in increasing awareness of the ICDP across the General Practice network.
    - 3.2. There is some evidence to indicate that IHPOs and OWs provided support to General Practices in uptake of some ICDP measures, including MBS items, adult health assessments, and access to PBS Co-payments and PIP registrations.
    - 3.3. There was evidence in this reporting period of a changing emphasis in the work of IHPOs in particular, with greater detail and specific information about ICDP being requested and provided.
4. In some areas, the main role of IHPOs and OWs was seen to be related to improving the identification of Aboriginal and Torres Strait Islander patients at General Practices. This included work with General Practices and with communities to encourage Aboriginal and Torres Strait Islander patients to self-identify. There have been some positive indications from the clinical indicator data that identification of Aboriginal and Torres Strait Islander people at Health Services is improving.
5. There were some apparent differences between urban, regional and remote sites and between the AHS and private General Practice sectors in understanding of the roles of IHPOs and OWs based at DGPs. To a large extent these two factors were inter-linked. Overall, interviewees in remote sites and in the AHS sector showed lower awareness of IHPOs and OWs based in the DGP and less understanding of their roles compared to interviewees in urban and regional sites and in private General Practice. Lower awareness in remote areas may indicate different types of roles fulfilled by the workforce (and limited deployment) in these areas, but it is also likely to be at least partly due to the vast geographical areas covered by the DGPs and Medicare Locals in remote areas.

6. The range of activities undertaken to fulfil IHPO and OW roles together with concerns reported by DGPs both in Sentinel Sites and to DoHA, suggest that the current performance indicators are unlikely to capture the full range of activities of the IHPO and OWs. Some consideration may need to be given to revising these as the roles develop. At the same time, wide variation in roles and community needs means the performance and reporting framework will need to be designed to accommodate the variation and to reflect the range of valuable roles that may be played by these workers. There is also a need to ensure that reporting requirements are realistic and are not so onerous as to detract from the actual work or the quality of reporting.

7. Development of culturally safe team-based approaches, networking, collaboration and organisational support provided by the SBOs are emerging as critical enabling factors for the effectiveness of the IHPO and OWs based in DGPs.

8. With specific exceptions in some sites, there was a lack of evidence of OWs and IHPOs in the two sectors working collaboratively.

9. The IHPO and OW based in the DGP sector have played a role in supporting cultural awareness raising and training of General Practice.

10. At site level, there were mixed views regarding how the transition to Medicare Locals may affect the ICDP including the work of the OWs and IHPOs.

    10.1. Some informants saw the transition as an opportunity for greater focus on Aboriginal Health, due to the increased focus on planning for population health needs. However, others identified potential disruptions resulting from new appointments and requirements for reapplication for positions.

    10.2. Amongst the seven Sentinel Sites that had already transitioned to Medicare Locals, there is some evidence of the transition causing temporary disruption to ICDP implementation in some sites, but longer term effects are not yet clear.

17. ATTRACTING MORE PEOPLE TO WORK IN INDIGENOUS HEALTH (*MEASURE C4*)

This measure is not covered by the scope of the SSE, however, the description and general implementation have been included in this report to reflect its role within the ICDP.

17.1. 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.[190]

[190] DoHA, Attracting more people to work in Indigenous Health – Factsheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/attracting-indigenous-health/$file/Copy%20of%20DHA6136%20C4%20Factsheet.pdf> (accessed 1 June 2012).

18. CLINICAL PRACTICE AND DECISION SUPPORT GUIDELINES (*MEASURE C5*)

This measure has not been included in the scope of the SSE. The information is included below to describe the role this measure within the broader ICDP.

18.1. 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 peoples 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 peoples. In addition, mainstream chronic disease guidelines are to be amended to include information specific to Aboriginal and Torres Strait Islander people.[191]

[191] DoHA, Clinical Practice and Decision Support Guidelines – Fact Sheet, <http://www.health.gov.au/internet/ctg/publishing.nsf/Content/clinical-practice/$file/DHA6136%20C5%20Factsheet.pdf> (accessed 1 June 2012).

19. CLINICAL INDICATORS

19.1. 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 continued emphasis on working with practice support teams based within DGPs to either collect clinical indicator data directly from General Practices or to provide contact details to the SSE team.

19.2. Ability of services to provide data

In this and the previous reporting period the SSE team focused on encouraging private General Practices to provide the standard Australian Primary Care Collaborative (APCC)[192] reports that can be generated by the PEN CAT.[193] 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. As previously reported, 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.

About two-thirds of the AHSs (10/15) and General Practices (22/30) approached actually provided clinical indicator data. Many AHSs had access to the PEN CAT tool as a result of their involvement in the Healthy for Life program and the roll-out of this software funded by

[192] Australian Primary Care Collaborative [website], <http://www.apcc.org.au/> (accessed 5 April 2012).
[193] Clinical Audit Tool [website], <http://www.clinicalaudit.com.au/> (accessed 5 April 2012).

OATSIH. Some of the clinical indicators that were reported on by AHSs as part of the Healthy for Life program have now been incorporated into the National Key Performance Indicators.

In this reporting period, there continued to be concern raised, especially by AHSs that the clinical information systems were not adequately functional and/or there was limited capability amongst staff to use the clinical information systems to generate reports through electronic extraction. Reservations about the quality of clinical data and about the potential to provide data that was a fair reflection of clinical performance continued to be a concern for some services that provided clinical indicator data for the purpose of the SSE.

Services identified a range of difficulties and concerns relating to their ability to report clinical indicator data, including:

- Recognition from a number of AHS and private General Practices that they are not consistently identifying Aboriginal and Torres Strait Islander people on the clinical information system. The data reported through the electronic clinical information systems are therefore not a true reflection of the work being done with Aboriginal patients.
- One AHS had a GP continuing to insist on working on a paper-based system and they do not have a well-functioning patient information system (they are using paper in conjunction with the computer). The nurse indicated that the APCC report contained data on a lot less patients than they had on their chronic disease registers. The nurse was reluctant to provide the APCC report because of the “enormous under-reporting”.
- Another AHS reported that they are fully electronic and had a good functioning clinic. However, they did not believe the APCC report was a fair reflection of the number of patients they manage with a chronic disease and were reluctant to provide the report for the purposes of the SSE. This service was using an Excel spreadsheet to manage the PIP Indigenous Health Incentive and marking the patients registered on this spreadsheet. This reflected a potential duplication of effort and was seen to be a barrier to entering the data on the clinical information system. We heard similar reports about using Excel spreadsheets for recording of PIP registrations from services in other sites.
- At least two AHSs that operate satellite clinics located outside the Sentinel Site (or vice versa) provided clinical indicator data, but they were unable to provide the data disaggregated by clinics. Their data therefore reflect information on the whole service population rather than for the service population for the clinic within the site. Further efforts will be made to obtain data that are specific to the clinic within these sites in the final reporting cycle. For this reporting cycle the clinical indicator data include data from at least one AHS that covers a wider area than the Sentinel Site.
- There were numerous instances of the General Practice staff requiring assistance from the DGP to extract the data from their system as they did not know how to use the PEN CAT despite it being installed on their system. In some instances the pass codes had been forgotten and in others the staff did not know on whose computer the extraction software was loaded.
- One AHS that has been fully electronic for a number of years reported they were now spending time to ‘clean’ their data, and had a dedicated staff member identifying active patients and removing the records of the many patients on the system who had not been seen at the service for many years.
- One AHS had recently changed clinical information systems. The GPs felt that this change-over had resulted in the loss of data during the data migration process, and that

GPs were now entering more free text rather than coding data as previously. Interestingly, comparison of the clinical indicator data provided by this service for this reporting period compared to the previous reporting period shows no clear evidence of loss of data between these periods.

- One AHS reported that the PEN CAT tool does not work effectively with their PIRS, which is PRACTIX. The PEN CAT tool, though compatible with a number of patient information systems, is not compatible with all. This service chose to provide their One21seventy reports as the service staff believed these reports provided more accurate clinical indicator data.

Reasons for not providing clinical indicator data included not being able to disaggregate data for clinics in order to provide a report that was specific to the service in the Sentinel Site boundary. General Practices that were part of corporate chains had a similar issue with the data being processed centrally at another location on a central server and no one at the service being able to extract data (or felt they did not have the authority to do so).

Despite assurances that data would be extracted and sent for the SSE, and despite reminders and follow-up email and telephone contact by SSE staff, some Health Services did not send data within the timeframes required for this report. Competing demands appear to be the main reason for these services not sending clinical indicator data within the required timeframes.

Although the DGP staff has a role in extracting data from General Practices in some of the Sentinel Sites and evidence of good processes by which this could be done, there is little indication that clinical indicator data are being extracted and used in a meaningful way at a DGP level for planning, priority setting, performance monitoring or quality improvement purposes. There was a sense that the DGP teams are extracting the data from practices as per reporting requirements (at least in some locations and with some practices), but there was no meaningful use of the data. It appears that a number of DGPs have developed good relationships with practices, which may be why practices are willing to provide data on a regular basis. However, the processes and capabilities required to support effective use of these data has yet to be developed.

19.3. Characteristics of Health Services that provided clinical indicator data

The size of the Health Services in terms of their total numbers of patients, as well as, the number of patients identified as Aboriginal or Torres Strait Islander, varied widely between the Health Services that provided clinical indicator data, as did the number of patients on various disease registers. The focus of the analysis presented below is on diabetes and 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 patients between these two types of services and general differences in terms of relative focus on care for Aboriginal and Torres Strait Islander peoples. The differences are reflected in Table 19.1 and in further discussion of the findings of the analysis of clinical indicator data reported below.

The data in Table 19.1 show that the majority of AHSs that reported clinical indicator data had:

- significant numbers of patients identified as Aboriginal and Torres Strait Islander people
- a higher proportion of patients identified as Aboriginal and Torres Strait Islander than the proportion of Aboriginal and Torres Strait Islander peoples in the site population
- more than ten Aboriginal and Torres Strait Islander patients on their diabetes and 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 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.

Fewer services were requested to provide clinical indicator data for this reporting cycle than for the previous one. This was because some services approached in the previous cycle had made it clear that they were not willing or able to provide clinical indicator data. Despite fewer services being requested to provide clinical indicator data there was an increase in the number of services that actually provided data for this reporting cycle than for the previous cycle, primarily because of an increase in understanding in the SSE team and DGPs of which services were likely to be willing and able to provide data.

Table 19.1: Characteristics of Health Services that provided clinical indicator data overall and by sector

	Round 3			Round 4		
	General Practice	**AHS**	**Total**	**General Practice**	**AHS**	**Total**
No. of services requested to provide clinical indicator data	32	21	53	30	15	45
No. of services that provided clinical indicator data	17	12	29	22	10	32
No. of services with >50 patients identified as Aboriginal and/or Torres Strait Islander	10	12	22	16	10	26
No. of services with >100 patients identified as Aboriginal and/or Torres Strait Islander	7	12	19	12	10	22
No. of services with >200 patients identified as Aboriginal and/or Torres Strait Islander	5	12	17	10	10	20
No. of services where proportion of patients 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	2	10	12
No. of services that report no. of patients on diabetes register	16	8	24	21	8	29
No. of services that report no. of patients on CHD register	16	9	25	21	8	29
No. of services with >10 Aboriginal and Torres Strait Islander patients on the diabetes register	4	8	15	9	8	17
No. of services with >10 Aboriginal and Torres Strait Islander patients on the CHD register	3	9	12	3	3	6

19.4. Analysis of data from Aboriginal Health Services

Ten of the fifteen AHSs approached to provide clinical indicator data actually provided clinical indicator reports. These ten AHSs were located in ten different sites. These same ten AHSs also provided clinical indicator data in the previous reporting period.

One of the AHS Clinical Indicator data sets was omitted due to the fact that it was a combined report that predominantly included data from clinics that were outside of the Sentinel Site boundary. It was not possible to obtain a report that was specific to the clinic in the Sentinel Site boundary. It appears that at least one other service has provided data that includes services provided through a clinic outside the Sentinel Site boundaries. This will be investigated further for the final evaluation cycle.

SOURCE OF REPORTS

In previous rounds some Health Services had provided Healthy for Life reports. However, with the change to reporting requirements with Healthy for Life and the reporting tool for this program changing these Health Services are now generally providing other electronically extracted reports such as National Key Performance Indicators data or APCC reports. One service provided One21seventy[194] audit reports.

REPORTING ON REGULAR PATIENTS

There was a decline in the number of services that reported number of 'regular' patients. Of the ten services that provided clinical indicator reports, five (compared to nine in previous reporting period) reported the total number of all patients on the clinical information system identified as regular patients. Numbers of regular patients per service ranged from 1666 to 11 564. The definition of a 'regular patient' by services that provided clinical indicator data was in many cases not clear, nor was consistency of the application of definitions of regular patients in specific services clear.

REPORTING ON ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS

Of the five AHSs that did report total number of all regular patients, three were able to report on the number of Aboriginal and Torres Strait Islander patients as a percentage of all regular patients (Figure 19.1). The range was 39% (2473/6329), 43% (4953/11 564) and 46% (1017/2197). Of the three AHSs that submitted data for all regular patients, 26% (5289/20 090) did not have their Indigenous status recorded. The range was 48% (3020/6329), 12% (1345/ 11 564) and 42% (924/2197) respectively.

[194] One21seventy [website], <http://www.one21seventy.org.au/> (accessed 5 April 2012).

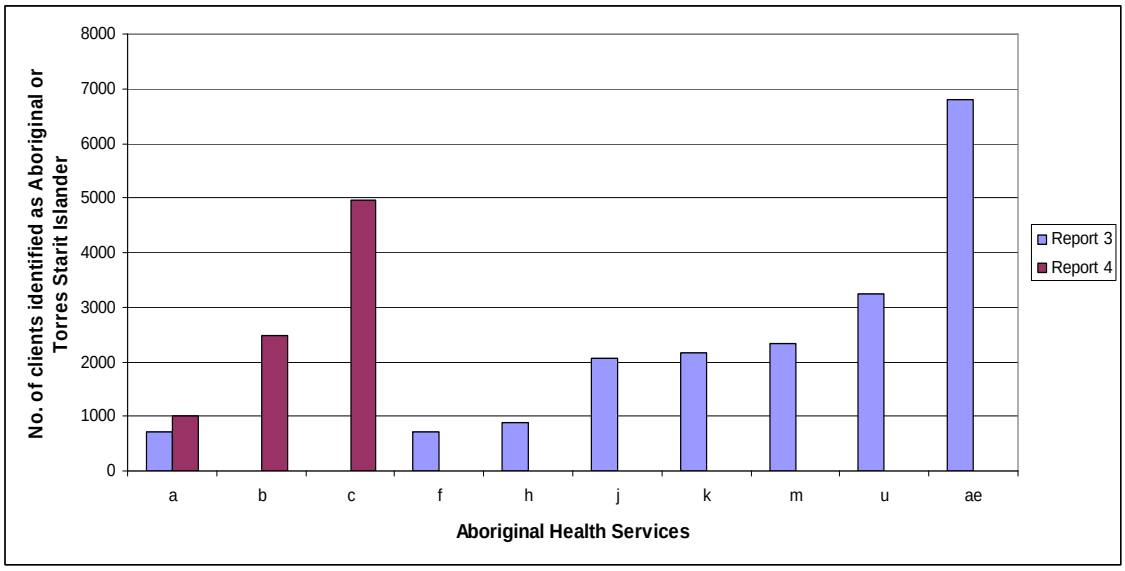


Figure 19.1: Number of patients on the clinical information system identified as Aboriginal or Torres Strait Islander for each Aboriginal Health Service

- There was only one AHS that reported on the number of regular patients that were identified as Aboriginal and Torres Strait Islanders over both reporting periods.
- For the only AHS that reported number of regular patients that were Aboriginal and Torres Strait Islanders for both reporting periods, the number of regular Aboriginal and Torres Strait islander patients increased by around 300 (42%). The AHS also reported a change in the source of data from H4L reports to APCC reports and a change in the PIRS software being used. This increase appears likely to be the result of a change in the way regular patients are counted or defined, as well as, an increase in the identification of Aboriginal and Torres Strait Islander status on the clinical information systems.
- Of the three AHSs that reported the number of all regular patients (Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander) for this reporting period, one of the AHSs reported large numbers with Aboriginal and Torres Strait Islander status 'Not Recorded' (48% of all regular patients).

The changes in the number of all regular patients (Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander) may reflect real changes in the number of regular patients using these services, and/or updating the patient information system to more accurately reflect current regular patients, and/or a change in the definition or improved application of the existing definition of 'regular patient'. Where the status of a patient was 'Not Recorded' it may be a coding problem or failure to determine and/or enter the Indigenous status data.

The less complete nature of clinical indicator data provided for this evaluation cycle compared to the previous cycle can be attributed to a change in the type of reports received, particularly a shortened version of the APCC report generated from Communicare, which was provided this reporting period where services had previously supplied H4L reports. This shortened report that was generated electronically from Communicare did not contain data on the number of patients or the number of patients disaggregated by Indigenous status as a total or on specific disease registers.

DIABETES REGISTER

Eight of the AHSs that provided clinical indicator data reported the number of Aboriginal and Torres Strait Islander people on the diabetes register, the same number that reported on this in the previous reporting period. However, only three of these services reported the number of patients identified as Aboriginal or Torres Strait Islander.

Four of the AHSs reported more than 10 patients on the diabetes register in the previous round, with all eight AHSs reporting more than 10 patients on their diabetes registers in this round. The number of patients on the diabetes registers from all eight AHSs ranged from 67 to 687 (Figure 19.2).

Some AHSs in this reporting round were unable to report on the number of Aboriginal and Torres Strait Islander people on the disease registers due to use this round of an abridged APCC reported generated from Communicare that did not include data on Indigenous status (as opposed to H4L reports).

Because of lack of identification of Indigenous status, only three services reported 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. The range for these services was from 3.0% to 8.3% (150/4953 to 206/2473). These figures are on the low side of prevalence estimates of diabetes in Aboriginal and Torres Strait Islander people,[195] and notably lower than the range reported for the previous reporting period.

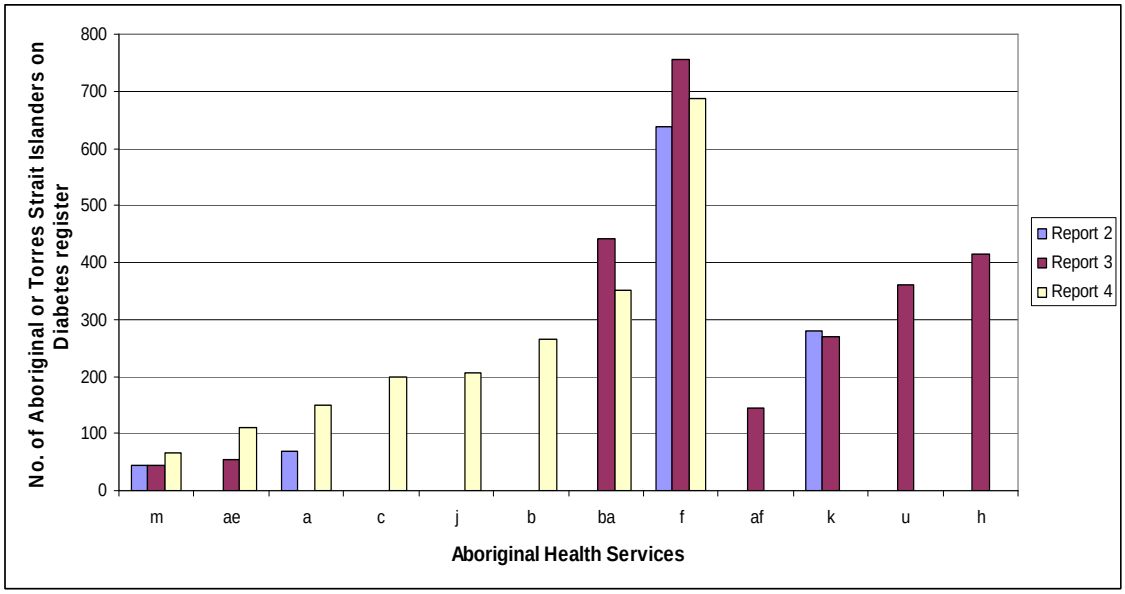


Figure 19.2: Number of Aboriginal and Torres Strait Islander people on the diabetes register in Aboriginal Health Services

The wide range in published prevalence estimates makes it difficult to assess whether the proportion of patients on the diabetes register is a fair reflection of the population prevalence.

The range in the proportion of patients included on the diabetes register is likely to some extent reflect differences in screening, diagnosis and recording of diagnosed patients on the

[195] 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).

diabetes register, in addition to the functional state of registers and the capabilities of Health Service staff to use these registers. These differences are also evident in relation to CHD in AHSs and in relation to both diabetes and CHD in General Practices.

Four of the AHSs reported the number of Aboriginal and Torres Strait Islander patients on the diabetes register for both this reporting period and the previous one. The total number of Aboriginal and Torres Strait Islander patients on the four services' diabetes registers dropped by 6% (81) in the current evaluation cycle (1296 to 1215). In the two AHSs that reported an increase in numbers on the diabetes register the number of patients on the registers was relatively small. In one service the number increased by 52% (44 to 67) and in the other service by 101% (55 to 111). Two AHSs reported decreases: one of -9% (756 to 687) and the other 20% (441 to 350). Significantly, all four AHSs used a different data extraction tool compared to the previous reporting period.

The change in the numbers of Aboriginal and Torres Strait Islander patients on diabetes registers between this and the previous evaluation cycle is likely over time. As will be screening, diagnosis and recording of diagnosed patients on the diabetes register within the individual services in addition to changes in clinical information software systems, changes in the functional state of registers and in the capabilities of Health Service staff to use these registers.

Only two AHSs have reported numbers of Aboriginal and Torres Strait Islander patients on the diabetes register over three reporting periods (Figure 19.2).

CORONARY HEART DISEASE REGISTER

Eight AHSs could provide total number of all patients (Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander) on the CHD register, however, as with the diabetes register, only three of the AHSs could report the number of Aboriginal and Torres Strait Islander people on the CHD register. Only two AHSs provided data on the number of Aboriginal and Torres Strait Islander people on the CHD register for both this and the previous reporting periods.

For the three AHSs that provided data this reporting period the percentage of Aboriginal and Torres Strait Islander people on the CHD register as a percentage of all Aboriginal and Torres Strait Islander regular patients ranged from 1.0% to 3.5%, with the average for the three AHSs for which this proportion could be calculated being 2.6%. This is higher than published estimates of the prevalence of CHD among Aboriginal and Torres Strait Islander people.[196] For the three AHSs the number of patients on the CHD register per service for this reporting period ranged from 34 to 86 (Figure 19.3).

[196] 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.

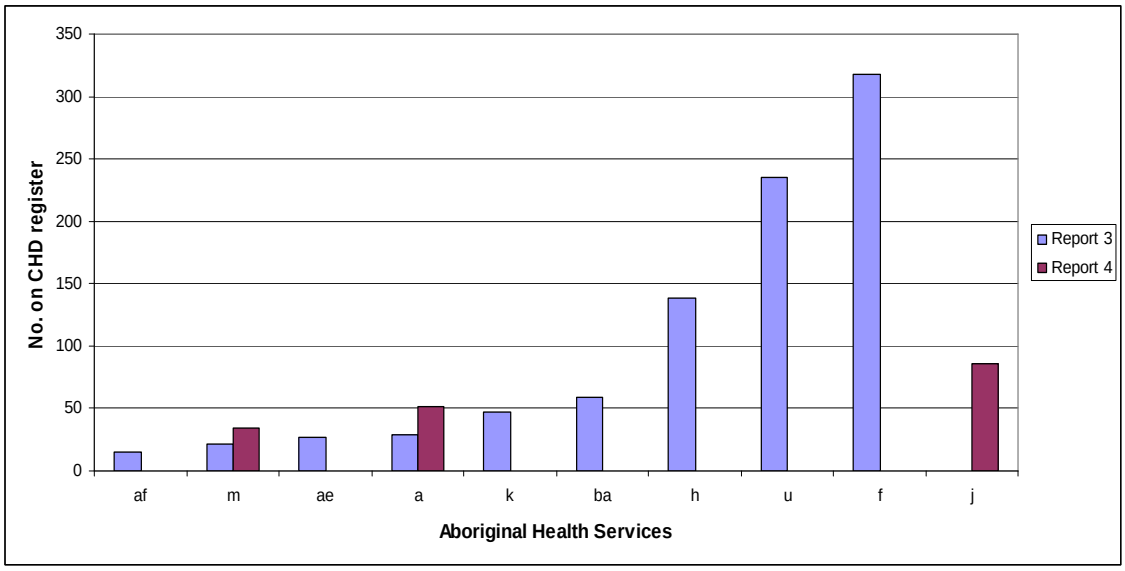


Figure 19.3: Number of Aboriginal and Torres Strait Islander people on the CHD register in Aboriginal Health Services

The number of Aboriginal and Torres Strait islander patients with CHD reported for the current reporting period was 36 patients more than for the previous reporting period (noting that only two services reported relevant data in both this and the previous period). This represents an increase of about 72% of the total number of Aboriginal and Torres Strait Islander patients on the CHD registers for the two services that provided relevant data. One service reported a 79% increase in numbers of Aboriginal and Torres Strait Islander patients on the CHD register (29 to 52) and the other reported a 61% increase (21 to 34).

LIMITATIONS OF THE CLINICAL INDICATOR DATA

While several AHSs provided clinical indicator data for at least ten patients 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 small proportion of the AHSs that provided any data appear to have disease registers through which they could identify Aboriginal and Torres Strait Islander patients 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.

19.5. Analysis of data from private General Practices

Twenty-two General Practices provided clinical indicator reports. These twenty-two practices were in nine different Sentinel Sites. Twenty of the General Practices provided Australian Primary Care Collaborative (APCC) reports generated from the PEN CAT tool and two were 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 the majority 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 indicators for the specific purpose of the SSE.

REPORTING ON REGULAR PATIENTS

All except two General Practices provided data on the number of all regular patients (Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander) of the practice.

The number of all regular patients in each practice ranged between 3339 and 41 836. Two practices had less than 5000 regular patients, eleven practices had between 5000 and 10 000 regular patients, five between 10 000 and 20 000 and two had over 20 000.

Twelve of the General Practices that reported data for the current reporting period also reported the number of all regular patients for the previous reporting period. For seven 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 five practices, there were marked differences between the number of all regular patients reported for this round and the previous round – increases of 25% (2023), 26% (1590), 73% (3465) and decreases of -15% (2605) and -47% (7050).

REPORTING ON ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS

Twenty General Practices submitted data for the number of Aboriginal and Torres Strait Islander regular patients on the clinical information system. Three of these practices reported that the Indigenous status of all patients was recorded. For the remaining nine General Practices 47% (113 173/238 714) of all patients (Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander) were not recorded.

The number of regular patients identified in the practice information system as Aboriginal and Torres Strait Islander ranged from less than 50 to over 850 (Figure 19.4). Sixteen of the 20 General Practices had more than 50 patients identified as Aboriginal and Torres Strait Islander, twelve had more than 100 and ten had more than 200 (Table 19.1). The number of practices with more than 200 patients identified as Aboriginal or Torres Strait Islander is double than for the previous reporting cycle.

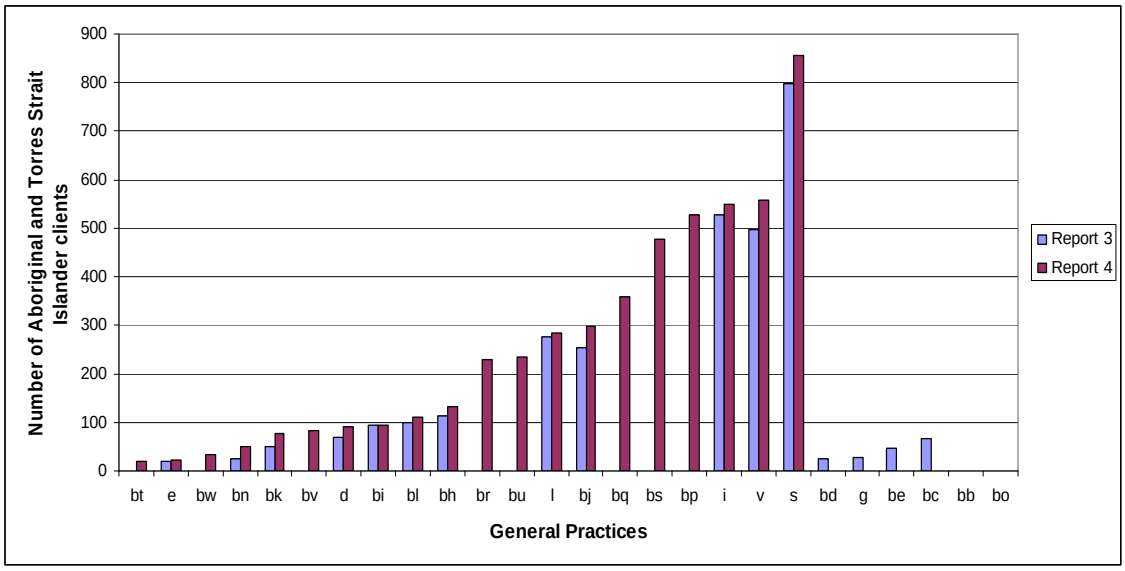


Figure 19.4: Number of patients on the patient information system identified as Aboriginal and Torres Strait Islander for each General Practice

As a proportion of all regular patients (Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander), the range for those identified as Aboriginal and Torres Strait Islander was from 0.4% to 7%. For four 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 (16/20) Aboriginal and Torres Strait Islander people made up a smaller proportion of regular patients than the proportion of the total site population who were identified as Aboriginal and Torres Strait Islander.

- The twelve General Practices that reported data on number of all regular patients for the current and previous reporting period also reported on number of patients identified as Aboriginal and Torres Strait Islander for each of the reporting periods. Eleven of these practices showed an increase and one showed no change. For three of these twelve General 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 nine practices, the proportional increase in the number of patients identified as Aboriginal and Torres Strait Islander was markedly higher for this reporting period compared to the previous reporting period - between 13% (496 to 559) and 88% (26 to 49). The largest proportional increases were seen in smaller practices (Figure 19.6). The twelve General Practices that provided data on number of Aboriginal and Torres Strait Islander patients for both this and the previous reporting period reported an increase of 10.6% (from 2822 to 3122).
- Some private General Practices reported large numbers of 'Not Recorded' for Indigenous status. In one General Practice nearly 1300 'active' patients had Indigenous status as 'Not Recorded'.

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

DIABETES REGISTERS

Twenty-one of the twenty-two General Practices reported the number of patients identified as Aboriginal and Torres Strait Islander on the diabetes register (an increase from sixteen General Practices in the previous reporting cycle). The numbers range between 1 and 88 per General

Practice (Figure 19.5). Half of the practices (11/22) had six or fewer patients identified as Aboriginal and Torres Strait Islander on the diabetes register. Nine practices had ten or more and seven practices had twenty or more patients identified as Aboriginal and Torres Strait Islander on the diabetes register.

All four General Practices that reported more than ten patients on the diabetes register in the previous reporting period also reported more than ten patients in this reporting period. Five additional General Practices that provided clinical indicator data for the SSE for the first time in Round 4 also had more than ten patients 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 2.0% to 25.6%, with the average for the twenty practices being 7.1%. This figure is close to the lower limit of the range of prevalence estimates of diabetes in Aboriginal and Torres Strait Islander people.[197] For the nine practices with ten or more Aboriginal and Torres Strait Islander patients on the diabetes register, the number of Aboriginal and Torres Strait Islander people on the diabetes register as a proportion of all patients identified as Aboriginal and Torres Strait Islander on the practice patient list was 8.6%. As for the figure provided above for all twenty 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 twenty practices that provided relevant data, the number of all people on the diabetes register as a percentage of all regular patients, ranged from 1.6% to 6.6% with the average for the twenty practices being 3.5%. This is lower than national surveys of prevalence of self-reported diagnosis of diabetes in the general population (4.4%).[198]

These findings suggest that diabetes registers are not being well maintained for regular patients of these practices in general or for regular Aboriginal and Torres Strait Islander patients. In addition to the points made above regarding limited identification of Aboriginal and Torres Strait Islander patients in these practices and/or the patients 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.

[197] 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).

[198] AIHW 2011. Diabetes prevalence in Australia: detailed estimates for 2007-08. Diabetes series no. 17. Cat. no. CVD 56. Canberra: AIHW. <http://www.aihw.gov.au/publications>, (accessed 5 April 2012).

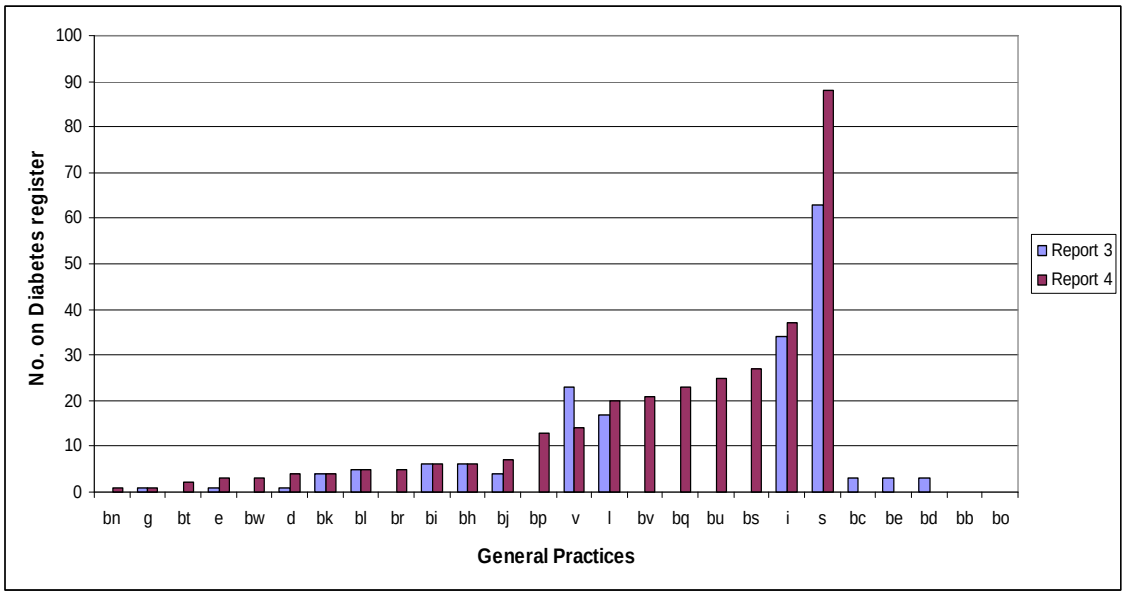


Figure 19.5: Number of Aboriginal and Torres Strait Islander people on diabetes registers for each General Practice

Thirteen practices reported the number of Aboriginal and Torres Strait Islander patients on their diabetes register for both the current and previous reporting periods. Nine of the thirteen practices reported they had less than ten Aboriginal and Torres Strait Islander patients on the register in the current reporting period. One of these practices reported they had a decrease in numbers on the diabetes register of -39% (23 to 14). For the other three practices, the reported number of Aboriginal and Torres Strait Islander patients 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 3,3 and 25 (9%, 17% and 40% increase respectively over the number reported in the previous cycle). These increases are likely to reflect a combination of improved identification of known patients with diabetes as Aboriginal and Torres Strait Islander and new diagnoses of diabetes among regular patients of these practices who are known to be Aboriginal and Torres Strait Islander.

CHD REGISTER

Twenty-one of the twenty-two General Practices reported the number of patients identified as Aboriginal and Torres Strait Islander on the CHD register (Figure 19.6) (an increase from sixteen General Practices in the previous reporting cycle). The numbers range between 0 and 28 per practice. Approximately half of the practices (11/21) had three or fewer Aboriginal and Torres Strait Islander patients on the CHD register. Four practices had ten or more Aboriginal and Torres Strait Islander patients 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 patients ranged from 0% to 10.5%, with the average for twenty practices that provided relevant data being 2.8%. 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%).[199] The small number of

[199] 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.

Aboriginal and Torres Strait Islander patients in most of these practices is a limitation on making meaningful comparison with population estimates of CHD. For the four practices with ten or more Aboriginal and Torres Strait Islander patients on the CHD register, the number of Aboriginal and Torres Strait Islander people on the CHD register as a proportion of all patients identified as Aboriginal and Torres Strait Islander on the practice patient list was 3.2%.

By way of comparison, for the twenty practices that provided relevant data, the number of all people on the CHD register as a percentage of all regular patients ranged from 0.5% to 4.9%, with the average for the twenty practices being 2.0%. The high proportion of Aboriginal and Torres Strait Islander patients diagnosed as having CHD compared to all regular patients is consistent with the higher prevalence of CHD among Aboriginal and Torres Strait Islander people compared to the non-Indigenous Australian population.

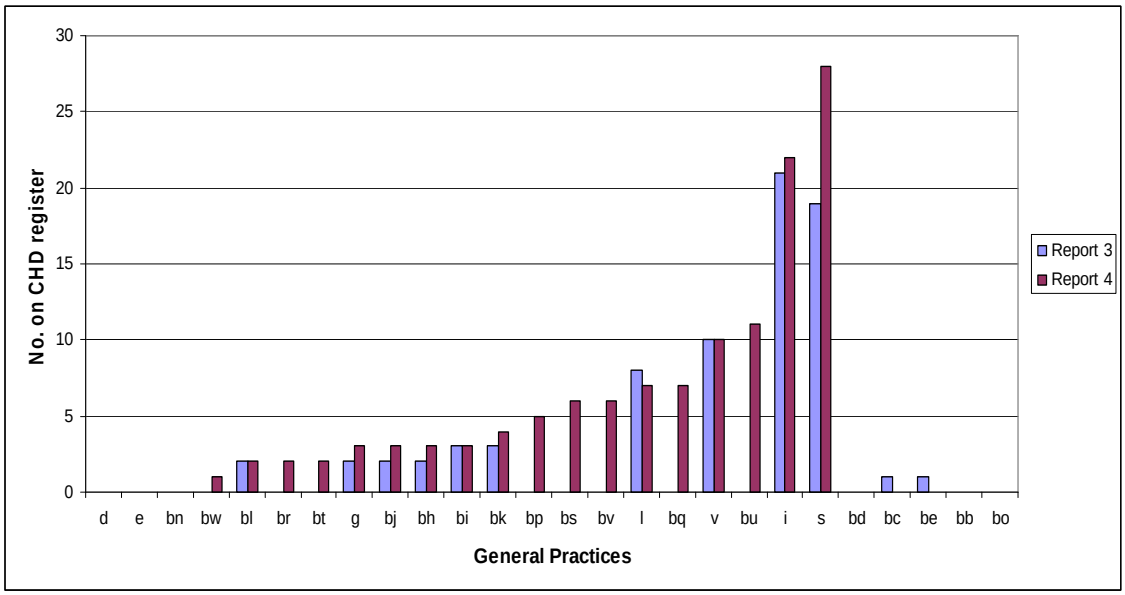


Figure 19.6: Number of Aboriginal and Torres Strait Islander people on the CHD register for each General Practice.

Thirteen practices reported the number of Aboriginal and Torres Strait Islander patients on their CHD register for both the current and previous reporting periods. Three practices reported zero Aboriginal and Torres Strait Islander patients for both reporting periods. Another ten of the practices reported they had less than ten Aboriginal and Torres Strait Islander patients on the register in the current reporting period. Six of the practices showed an increase, three showed no change and one showed a decrease. For the three practices with more than ten CHD patients registered, two reported a higher number of Aboriginal and Torres Strait Islander patients on the CHD register for this reporting period compared to the previous reporting period – more specifically, the increase in numbers for these practices was one and nine (4.8% and 47% increase respectively over number reported in the previous reporting period). One practice reported no change in numbers. The reasons for this general increase in these practices are likely to be similar to the reasons for the increase in numbers on the diabetes registers as described above.

LIMITATIONS OF THE CLINICAL INDICATOR DATA

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 general under-representation of Aboriginal and Torres Strait Islander people among the regular practice patients 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.
- 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 patients in these practices and/or the patients 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 these patients on the diabetes and CHD registers for most of these practices, and the low proportion of regular Aboriginal and Torres Strait Islander patients 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 patients 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.

19.6. 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 identified as being interested in providing care to Aboriginal and Torres Strait Islander people.

19.7. Summary

1. The identification of Aboriginal and Torres Strait islander patients in clinical information systems and the inclusion of patients on diabetes or CHD registers, in both AHSs and General Practices, appears to be far from complete. The small numbers of AHS that have provided clinical indicator data over successive rounds over the SSE to date makes it impossible to discern clear trends in identification of Indigenous status or inclusion of patients on disease registers in AHSs. There were a larger number of General Practices that provided clinical indicator data over successive rounds and these practices almost all show a small increase in the numbers of patients identified as Aboriginal or Torres Strait Islander. There is also some evidence of a trend towards increasing numbers of patients identified as Aboriginal and Torres Strait Islanders on diabetes and CHD registers in General Practices.
2. For this reporting round there has been a change to the clinical software being used by most of the AHSs, most notably, the use of the PEN CAT tool to extract data from their PIRS. From the data supplied to the SSE it is evident that this process has not been straightforward for some AHSs and the validity of the data may be questionable. There are significant irregularities in the total number of regular patients and number of Aboriginal and Torres Strait Islander patients reported in this round compared to the previous one. It appears that these variations are at least in part due to recent changes in the methods used to extract clinical indicator data for reporting to the SSE.
3. The most important issue emerging from this analysis of the clinical indicator data continues to be 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 resulting lack of clinical indicator data of reasonable quality, place 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.
4. Essentially, 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 patients of primary health care services, as well as, any Aboriginal and Torres Strait Islander patients who have a chronic illness or who have risk factors which predispose them to the development of chronic illness.
5. The data from this reporting period further demonstrates the need for stronger and more strategic investment in development of clinical information systems within primary health care services in both AHSs and General Practices to support their effective 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.
6. 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.

20. RELATIONSHIPS BETWEEN USE OF ICDP RELATED SERVICES AND INTENSITY OF INTERVENTION AND CONTEXTUAL FACTORS

The relationship between variables that reflect use of ICDP related services 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 bivariate descriptive statistics. Specifically, we examined the relationships between the number of ICDP workers (end of February 2011 and end of June 2011) and service use variables at the September 2011 - November 2011 quarter. We also examined associations between key contextual variables and service use variables at September 2011 - November 2011.

Service use variables were:

- PIP Indigenous Health Incentive registration per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011 quarter)
- Tier 1 payments per 100 Aboriginal and Torres Strait Islander people (June 2011 - September 2011)
- Tier 2 payments 2010 per 100 Aboriginal and Torres Strait Islander people
- health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011 quarter)
- follow-up allied health services (MBS items 81300-81360) per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011 quarter)
- follow-up services provided by a practice nurse or registered AHW (MBS item 10987) per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011 quarter)
- patients accessing the PBS Co-payment measures per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011 quarter).

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 service use variables identified above. The analysis does not include workers who were recruited after June 2011, as workers employed later than this date are unlikely to have been in the positions long enough to influence health service use within the timeframes of available service use data.

Contextual variables examined were:

- SEIFA average
- per cent of solo practices (2009-2010 and 2010-2011)
- GP to population ratio (2009,2010)
- Enhanced Primary Care[200] items as a proxy measure of use of pre-existing MBS items that have been designed to support preventive care and care for people with complex care needs
- percentage of practices using practice nurse items.

[200] DoHA, MBS Primary Care Items [website], <http://www.health.gov.au/mbsprimarycareitems> (accessed 9 June 2012).

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 percentage 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 relative availability of GPs in each area.

ANALYSIS OF SERVICE USE VARIABLES IN RELATION TO CONTEXTUAL VARIABLES

None of the contextual factors were significantly associated with the service use variables. The lack of statistically significant associations between the contextual variables and service use variables may be a consequence of the small numbers of sites and/or unmeasured and uncontrolled confounding factors.

ANALYSIS OF SERVICE USE VARIABLES IN RELATION TO NUMBER OF ICDP WORKERS

There was a significant correlation between the number of ICDP workers at the end of February 2011 and:

- adult health assessments in September 2011 - November 2011 (r=0.46* p=0.02) (Figure 20.1)
- the number of follow-up services provided by allied health professionals per 100 Aboriginal and Torres Strait Islander people in September 2011 - November 2011 (r=0.53**, p=0.01) (Figure 20.2)
- the number of PBS Co-payments made per 100 Aboriginal and Torres Strait Islander people in September 2011 - November 2011 compared to September 2010 - November 2010 (r=0.45*, p=0.03) (Figure 20.3).

No other correlations between the intensity of the intervention (as reflected by number of ICDP workers) or any of the other service use variables were statistically significant. No significant relationship between the number of ICDP workers by end of June 2011 and any of the service use variables was observed. This indicates the lag time for benefits associated with the employment of workers.

The limited number of sites and the lack of good data on potential confounding factors limit the potential for more sophisticated quantitative analysis and we cannot exclude the possibility that the observed associations are a result of confounding. Nevertheless, the association described above is consistent with the important focus that the IHPOs and OWs have had on promoting uptake of adult health assessments, follow-up services by allied health professionals and PBS Co-payment measure use.

Comment on confounding

Allocation of new worker positions funded through the ICDP has not been random, rather it has been based on a variety of considerations including local needs and service performance and capability. Uptake/delivery of ICDP related services (as described above) is also probably strongly related to local needs and service performance and capability. The various factors that underlie local needs and service performance and capability are therefore almost certainly causing some degree of confounding in the associations that have been examined in this section. Many of these factors are

difficult to define and difficult to measure and therefore cannot be controlled for in a statistical analysis. Even for potential confounders that could be defined and measured, the numbers of Sentinel Sites for which we have data places serious constraints on the potential for multivariate analysis. It is also evident from the other sections of this report that the wide variation between use of ICDP related services between sites is due to local organisational factors, including organisational capability, teamwork, capability of individual staff members and relationships between service organisations and Aboriginal and Torres Strait Islander people in the site population; all factors that are difficult to define and measure and therefore difficult to account for in statistical models.



Figure 20.1: Health assessments (MBS items 704, 706, 710 to 1 May 2010 thereafter 715) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years in the September 2011 - November 2011 quarter in relation to the number of ICDP workers by end of February 2011

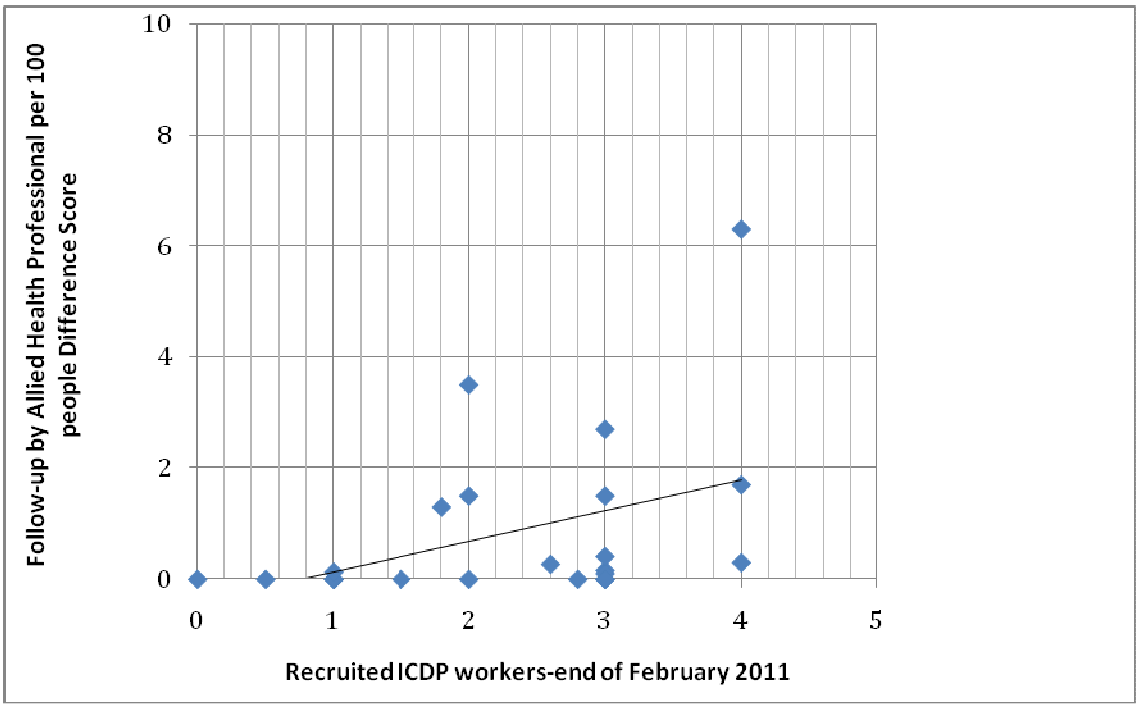


Figure 20.2: Follow-up allied health services (MBS items 81300-81360) per 100 Aboriginal and Torres Strait Islander people aged ≥15 years September 2011 - November 2011 quarter in relation to the number of ICDP workers by end of February 2011

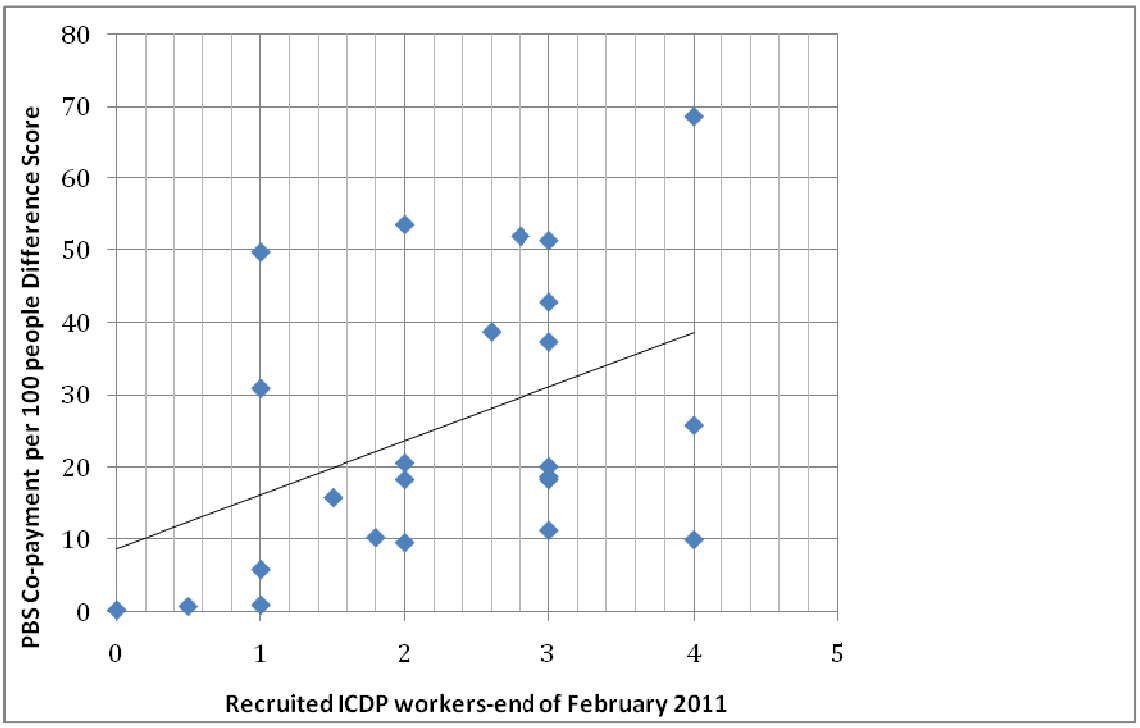


Figure 20.3: Patients accessing the PBS Co-payment measures per 100 Aboriginal and Torres Strait Islander people (September 2011 - November 2011) in relation to the number of ICDP workers by end of February 2011

Analysis of the relationship between different service use variables

Table 20.1 shows the relationships between service use variables for the most recent quarter of available data. The key points that emerge from this analysis include:

- As would be expected, adult health assessments were associated with both types of follow-up services, with number of PIP Indigenous Health Incentive registrations, Tier 1 payments and number of patients accessing the PBS Co-payment.
- Follow-up services by an allied health worker were associated with the PIP Indigenous Health Incentive registrations and Tier 1 payments.
- Follow-up services by a nurse or registered AHW were associated with Tier 1 payments. PIP Indigenous Health Incentive registration was associated with Tier 1 payments but not Tier 2 payments.
- PIP Indigenous Health Incentive registration and Tier 1 payments were not associated with patients using the PBS Co-payment.
- The lack of association between PIP Indigenous Health Incentive registrations and Tier 2 payments may be related to the time periods for data used in this analysis, or because service activity related to Tier 2 payments are less likely to be related to the types of reorientation of primary health care service systems that are associated with increased use of adult health assessments, follow-up items, services associated with Tier 1 payments and PBS Co-payments. Tier 2 payments are for services provided over a full year and are paid annually, subsequently September 2011 - November 2011 PIP Indigenous Health Incentive registrations would be expected to influence Tier 2 payments for 2011. However, this analysis uses Tier 2 payments for 2010 (data on Tier 2 payments for 2011 were not available for this analysis).

Table 20.1: Correlations between services use variables

Number of services per 100 Aboriginal and Torres Strait Islander people	Correlation and significance	Health Assessment (Sep-Nov 2011)	Follow-up allied health professional (Sep-Nov 2011)	Follow-up nurse or registered Aboriginal Health worker (Sep-Nov 2011)	PIP Indigenous Health Incentive registration (Sep-Nov 2011)	Tier2 2010	Tier 1 payments Jun-Nov 2011	Patients accessing PBS Co-payment Sep-Nov 2011
Adult health assessment (Sep-Nov 2011)	r	1.000						
	p	.						
Follow-up allied health professional (Sep-Nov 2011)	r	.690	1.000					
	p	.000	.					
Follow-up nurse or registered Aboriginal Health Worker (Sep-Nov 2011)	r	.491	.346	1.000				
	p	.015	.098	.				
PIP Indigenous Health Incentive registration (Sep-Nov 2011)	r	.468	.466	.281	1.000			
	p	.021	.022	.184	.			
Tier 2 2010	r	.307	-.013	-.292	.191	1.000		
	p	.145	.953	.166	.372	.		
Tier 1 payments (Jun-Nov 2011)	r	.556	.586	.457	.460	.067	1.000	
	p	.005	.003	.025	.024	.757	.	
Patients accessing PBS Co-payment (Sep-Nov 2011)	r	.452	. 301	-.018	.344	.403	.197	1.00
	p	.027	.153	.934	.099	.051	.357	.

21. CASE STUDIES

21.1. Implementation of the ICDP in urban case study sites: Logan/Woodridge, Brisbane South and Campbelltown

The SSE covers eight urban sites. Three are case study sites - Logan/Woodridge, Brisbane South and Campbelltown.

The three sites host a variety of government, community controlled and privately operated Health Services and facilities typical of urban Australia. Suburban regions offer consumers access to public and private health and allied services, multiple private General Practices and many pharmacies. Many Aboriginal and Torres Strait Islander people living in urban areas have a choice of using Aboriginal or general Health Services. A significant factor in urban Sentinel Sites is that access to site-located services by people living outside the site, and access to outside services by site residents, is easier than in regional and especially remote sites. Availability of public transport in urban areas is another factor relevant to accessing services of choice, particularly when compared with the limited transport options in remote sites.

The large number of health service providers, the range of business models and sizes, and the range of other stakeholders in urban sites present a complex setting in which to implement a multi-faceted program targeting a dispersed population group. Urban Sentinel Sites generally have relatively low percentages of Aboriginal and Torres Strait Islander residents compared with regional and remote sites, and the primary health care services and pharmacies used by this population group are spread across metropolitan areas. Therefore, many of the providers who need to engage with the ICDP measures may not previously have considered the specific health and access issues of Aboriginal and Torres Strait Islander people.

ABS Socio-Economic Index of Disadvantage for Areas (SEIFA) scores for these sites are 985 for Logan/Woodridge, 1023 for Brisbane South and 955 for Campbelltown (the only site with a higher SEIFA score than Brisbane South is the Sentinel Site of Canberra with 1067). SEIFA scores reflect the environment generally and do not account for the variation in socio-economic status of sub-populations or households within an area, and do not take Aboriginal and Torres Strait Islander identity into account.[201] With Aboriginal and Torres Strait Islander people making up a low percentage of the population in these sites, the SEIFA scores need to be understood to reflect the socio-economic conditions of the site in general, and that the scores are not necessarily a reflection of the socio-economic conditions of the Aboriginal and Torres Strait Islander people living in the sites.

The Logan/Woodridge Sentinel Site includes outer Brisbane suburbs to the south of the city and has a total population of about 175 000, with 2.5% identifying as Aboriginal and/or Torres Strait Islander (approximately 4400 residents). The Aboriginal and Torres Strait Islander Community Health Service (ATSICHS), based outside the site boundary at Woolloongabba, has operated a health centre in the Logan area for some years and has recently expanded its services with an extended facility in the site. The site includes a number of private General Practices and one public hospital. All ICDP funded

[201] Stratifying SEIFA scores by Indigenous and non-Indigenous households has established that Indigenous populations suffer a high level of social and economic disadvantage regardless of whether they live in high or low socio-economic status areas. (Kennedy B and Firman D, 2004: 1).

positions that have responsibility for the Logan/Woodridge site have been filled, with no change in personnel since the previous SSE report. The Tackling Smoking and Healthy Lifestyle positions (measure A1 and A2) are located off-site, with a regional support organisation (see below).

The Brisbane South Sentinel Site covers a large area of metropolitan Brisbane to the south and west of the city centre, and has a total population of about 300 000 people. Aboriginal and Torres Strait Islander people make up about 1.6% of the total site population (approximately 4770 residents). This is a low percentage compared with other areas in South East Queensland (2006 suburb-by-suburb analysis showed 1-8%). Of the Sentinel Sites, only Dandenong and Canberra have lower percentages of Aboriginal and Torres Strait Islander residents with 0.5% and 1.2% respectively. Inala Indigenous Health Service is a major provider of health services to Aboriginal and Torres Strait Islander people within the site and surrounding areas. There are many private General Practices within the site. One public hospital is located in the site and one nearby. The site also has three private hospitals and two more nearby. The Tackling Smoking and Healthy Lifestyle worker positions are located off-site with a regional support organisation (as for Logan/Woodridge).

The Tackling Smoking and Healthy Lifestyle positions with responsibility for Logan/Woodridge and Brisbane South - the Regional Tobacco Coordinators (RTCs), Tobacco Action Workers (TAWs) and Healthy Lifestyle Workers (HLWs) - are located with the Institute of Urban Indigenous Health (IUIH). The implementation arrangement among Sentinel Sites is unique to South East Queensland, a large and rapidly develop urban region where 38% of the state's Aboriginal and Torres Strait Islanders (and 66% of all Queenslanders) live. The IUIH is a community controlled service established in 2009 as a strategic response to the significant growth and geographic dispersion of Aboriginal and Torres Strait Islander peoples in the region.[202] The IUIH has a role that extends beyond health promotion to support health service development, coordination of community services, conducting research and coordination of the placement of health students in the Aboriginal and Torres Strait Islander health sector.

The Campbelltown Sentinel Site in NSW is approximately 50 kilometres south-west of the Sydney central business district. The total site population is about 145 000 people, 2.7% are Aboriginal and Torres Strait Islanders (approximately 3800 residents). Tharawal Aboriginal Medical Service is an Aboriginal and Torres Strait Islander community controlled provider of health services to residents within the site and surrounding area, which includes many private General Practices and two hospitals. A non-government organisation, 'Marumali', just outside the site boundary provides a health brokerage service that can be used by Aboriginal and Torres Strait Islander patients in the Campbelltown area.[203] The DGP employs a large team, including dieticians and exercise physiologists. The employment arrangement for the Tackling Smoking and Healthy Lifestyle workforce in the Campbelltown site is consistent with other Sentinel Sites, in that the RTC, TAWS and HLWs are located at an Aboriginal or Torres Strait Islander Aboriginal Health Service (AHS) and work within the Sentinel Site boundaries.

[202] IUIH [Website] <http://www.iuih.org.au/> (accessed 9 June 2012).
[203] Marumali Health [Website] < http://www.marumalihealth.com.au/> (accessed 9 June 2012).

CHRONIC DISEASE RISK FACTORS: A MEASURES

Tackling Smoking (Measure A1) and Healthy Lifestyle Promotion (Measure A2), Local campaigns to promote better health (Measure A3)

The three urban case study sites provide examples of how the Tackling Smoking and Healthy Lifestyle workforce may be employed under different service delivery arrangements.

Implementing the A Measures in the Logan/Woodridge and Brisbane South Sentinel Sites

The Tackling Smoking and Healthy Lifestyle workforce based outside the site at the IUIH has responsibility for implementing the measures in Logan/Woodridge and Brisbane South. The workers cover the entire SE Queensland region and acknowledge the limitations this puts on their health promotion program to facilitate change. A second team is being established to extend the activities delivered by the original team of one RTC, one TAW, two HLWs and two trainee HLWs. Two additional HLWs commenced at the start of 2012, and two further TAWs are being recruited (in May 2012). A Healthy Lifestyle Team Manager oversees this ICDP funded workforce, and takes responsibility for mentoring the trainees. The flagship program of the IUIH Tackling Smoking and Healthy Lifestyle team is 'Deadly Choices'.

'Deadly Choices', an eight week secondary school program which uses interactive strategies to engage students in discussion about nutrition, chronic disease, sexual health, substance abuse, physical activity and smoking, and aims to develop mentors and role models. It has been delivered in one Logan/Woodridge school and one Brisbane South school to date and is promoted at Healthy Community Days.

The IUIH's tackling smoking team, in partnership with the ATSICHS Logan clinic, is developing a training model and resources to be trialled in Logan/Woodridge, with the aim of improving patient assistance to quit smoking. All clinic staff will be trained in tobacco cessation support and one staff member supported to deliver other tobacco action program activities. When the trial is completed and the model refined, the program will be replicated in other AHSs in SE Queensland.

IUIH Healthy Community Days are delivered in collaboration with local services. In addition to raising awareness about health and lifestyle issues, they aim to link people to health care and ICDP benefits. *'[Healthy] Community Days are about active involvement and sending health promotion messages. We have access to medical van, we provide a doctor, we use local nurses'* (staff member, IUIH). Health checks are conducted using these resources. It was reported that twenty-three health checks were completed at a recent Health Community Day. No Healthy Community Days have been held in the Brisbane South or Logan/Woodridge sites to date, however one is being planned for mid 2012 in Logan/Woodridge. Some focus group participants in Brisbane South mentioned meeting the IUIH workers at sports events and Healthy Community Days in other areas.

The majority of participants in focus groups in Logan/Woodridge and Brisbane South had some awareness of Healthy Community Days and the 'Deadly Choices' program delivered through the IUIH model of delivery. In some groups the level of awareness did not extend to knowing about the Tackling Smoking and Healthy Lifestyle workforce, although several people in three Brisbane South community focus groups had met TAWs at a nearby Healthy Community Day.

In the focus groups held in these two SE Queensland sites, the IUIH workforce was widely acknowledged to be doing good work. The groups were generally positive about the way young people were being targeted through school and sporting programs, although there were some

concerns that young people who do not attend sporting events are missing out. There is an ongoing community perception in both sites that, because the IUIH workforce has to cover a large area, teams do not have the capacity to engage often enough with people and services, and that they 'set the agenda' rather than support local programs. One participant in an 'under 30' focus group suggested there would be more impact *'if you saw them more in the community doing stuff at the grass root level [rather than] ... promotional events ... They could be coming to youth group here on Friday night … to have a real impact on kids and families … not the one off stuff'* (Community focus group participant).

In Logan/Woodridge, community focus groups participants were aware of the risks associated with smoking, the benefits of giving up and what a healthy life style involves. They spoke about healthy food, being involved in sports, keeping motivated, walking instead of driving everywhere. For the older group (an Elders advisory group to the AHS), being healthy was connected with using will power and living longer. In Brisbane South, most participants had seen smoking related material at the Health Service and agreed that staff were readily available at the Health Service to help people with smoking cessation. In relation to lifestyle modification, an issue raised was the number of fast food outlets in the area, which 'make it difficult to always eat healthy food'. Groups were aware of quit smoking TV commercials on the major TV networks. Overall, there appears to be a reasonable awareness of the factors that contribute to health amongst community focus groups, presenting a sound basis for the delivery of community health promotion activities.

This delivery model, designed to utilise a relatively small team across an extensive urban setting, has strengths in its ability to reach a wide audience with health promotion messages, as well as limitations in its capacity to respond to, and support, community initiatives.

Implementing the A Measures in the Campbelltown site

A different delivery model is use in the Campbelltown site, where the AHS has funding allocation for one RTC, two TAWs and two HLWs. At the time of the evaluation visit, all positions were filled. A busy program of activities and a range of resources have been developed to raise awareness and engage community members in healthy eating and physical activity, and to reduce smoking rates. Strategies are tailored to reflect a local service perspective, such as a strengths based approach to smoking cessation messages. *'Rather than look at the negatives of smoking, [we] focus on the positives of giving up, the benefits like money, live longer, see your kids live longer and close the gap … It's been the norm that Aboriginal people smoke … so we gotta break that cycle …*' (Interviewee, AHS).

The AHS reported that the Tackling Smoking and Healthy Lifestyle workers have recently offered demonstrations and hands-on activities at 15 events attended by a total of 1,690 people. They include a Close the Gap Day event (150 people attended), a Health Community Day event (150 attended), NAIDOC Health Expo (300 attended), a One Deadly Step event (400 attended), 10 Community Kitchen Program sessions (138 attended) and The Biggest Bruiser Program (with 8 participants). Other health promotion activities include 'boot camps' and exercise programs, cooking classes, a community garden project, smoking cessation activities and delivery of fruits and vegetables to households. It is not clear how many of these activities took place during the current reporting period.

In 2011, COAG Indigenous Health Partnerships funds were used to buy a yellow Holden utility and a trailer, which is filled with gym equipment. The ute and trailer are decorated to promote healthy lifestyle messages and are used by the Tackling Smoking and Healthy Lifestyle team and other AHS

staff who deliver health promotion activities. ICDP funding was recently used to buy a second vehicle to extend the program's reach.

A community focus group drawn from an exercise class talked about the success of the AHS program. They enjoyed the exercises and were positive about the healthy lifestyle sessions and level of support. '*The HLW learns you about salt and sugar and things not to have - she gives you a program. If you want to do it you'll get plenty of support*'. Most were aware of the support to give up smoking offered through the program at the AHS; however, many described how they and family members had given up smoking without assistance, for example '*The doctor said it would stop the pain so I gave up that day*' and '*My grand-daughter just gave up, she was having a baby'.* Another focus group comprised chronic disease patients; one participant was able to describe a patient journey that included ICDP funded positions with clarity, recounting the point of contact with HLWs and clinical staff at a Healthy Community Day, the follow up phone call, appointment, sign-up to PIP Indigenous Health Incentive, adult health assessment, access to subsidised medicines through a PBS Co-payment script and referral to a specialist. This example from Campbelltown provides evidence of how A Measure activities can be integrated successfully with other measures and in a way that provides a supportive environment for community level activity.

The site has recently experienced some changes in the Tackling Smoking and Healthy Lifestyle workforce. The RTC position was vacated when the incumbent took up a (non ICDP) tobacco position elsewhere; a new RTC has since been appointed. The two TAW positions also became vacant. These disruptions appear to have had minimal impact on program continuity, indicating well established systems to support health promotion within the organisation. Another factor likely to be contributing to success in the Campbelltown site is that the Tackling Smoking and Healthy Lifestyle workforce are building on an established health promotion program. In addition, one of the two HLWs is a dietitian; this appears to have been another positive factor in supporting patients to make lifestyle changes, and complements the work of the other HLW, whose area of expertise is exercise.

Findings from the Campbelltown site suggest that where there is a strong foundation of community engagement within the AHS, it enables a solid level of community engagement in the activities of the service-based Tackling Smoking and Healthy Lifestyle workforce. It appears to enable the linking of participants with clinical staff and services. When talking about the Tackling Smoking and Healthy Lifestyle workforce, one Campbelltown clinician commented on the way the programs under the ICDP complement each other *' … [an] effective model with flow on from clinical care to prevention and healthy lifestyle, and that's how it should ideally be. The model is working, when we have the level of expertise meeting our expectations and the programs flow, it's perfect'.* This positive experience is no doubt contributing to concern about the future of funding. '*When the funding ends what is going to happen with the healthy lifestyle and tackling smoking programs? I was hoping these healthy lifestyle trends will flow on to the generations to come*.' (Interviewee, AHS)

It appears that the resources, existing programs and links available in this urban setting provide a solid foundation on which to deliver effective health promotion and integrate health promotion activities with clinical health services.

Recruitment and training of the Tackling Smoking and Healthy Lifestyle workforce in the three urban case study sites

In comparison with remote sites, the three urban sites have experienced minimal problems recruiting and retaining or replacing Tackling Smoking and Healthy Lifestyle workforce. Finding workers with adequate qualifications and skills to deliver a quit smoking program was raised as a challenge in one site, and a manager in another site commented on the *'small pool of skilled*

personnel' from which the Tackling Smoking and Healthy Lifestyle workforce is drawn. However, some workers hold qualifications higher than is required by their job descriptions. For example, one HLW in Campbelltown has a Masters of Applied Science in Nutrition and Dietetics; a member of the IUIH team in Queensland has a Bachelor of Health Promotion and a Diploma of Community Services.

Access to quality training and workplace support has not presented as a problem in the three urban case study sites. Teams in SE Queensland have attended ICDP workshops, seminars and other training, such as brief intervention training (TAWs). Workers commented favourably about the ICDP training received, although there was a suggestion that presentations could have grouped workers to focus on the different issues and challenges experienced in regional, remote and urban settings. Individualised training plans have been developed for the IUIH workforce, including Aboriginal Health Worker training for trainees and further courses for those with tertiary qualifications. A systematic process involving team members and coordinators is used to determine who takes up particular training opportunities '*It's not just where your vested interest is, but what is relevant and useful, or closely matches to your role'* (RTC). The management approach at IUIH is also strategic and supports staff development - one RTC has been allocated to coordinate two TAW teams, while an overall program manager coordinates the HLW teams and programs, including the mentoring of trainees. The structure enables coordinators to work together to avoid overlap or duplication of work planning, programs or resources. RTCs in Queensland meet bi-annually at the regional level, attend quarterly affiliate meetings and network through emails and phone conversations. This supports professional development.

In summary, different employment arrangements are in place for the Tackling Smoking and Healthy Lifestyle workforce; this impacts significantly on strategies, resources and community involvement at the site level. It is evident that there is access to relevant training and support for the Tackling Smoking and Healthy Lifestyle workforce in the three urban case study sites, regardless of the service delivery model being used. There is stated management commitment to, and investment in, professional development of staff – particularly at the IUIH. Data collection across all sites indicates that it is easier to access training in urban settings than in remote and regional settings. There are more choices and delivery modes available; logistically, it is easier to arrange; it involves less travel, resulting in lower cost and less time away from the workplace or home for staff; training is also more accessible for workers who have English literacy skills and prior experience in mainstream education.

CHRONIC DISEASE MANAGEMENT AND FOLLOW-UP CARE: B MEASURES

PIP Indigenous Health Incentive (Measure B3 Part A) and PBS Co-payments (Measure B1)

The three sites provide a 'snapshot' of B Measure implementation in urban settings, and the opportunity to consider how local circumstances influence implementation of various aspects of the ICDP.

In general, urban sites have lower numbers of Aboriginal and Torres Strait Islander patients registered for the PIP Indigenous Health Incentive than regional sites. As would be expected, registrations for the PIP Indigenous Health Incentive have increased in each site.

A case study in the previous reporting period highlighted the way the IHPO and OWs based in the DGP were using a community empowerment strategy in Logan/Woodridge, actively encouraging people to identify as Aboriginal and Torres Strait Islander and request an adult health assessment at Health Services not yet involved in the ICDP. This strategy appears to have been rewarded. The site has registered more patients for the PIP Indigenous Health Incentive per 100 Aboriginal and Torres

Strait Islander people than any other urban Sentinel Site. In the period up to November 2011 the cumulative registration per 100 Aboriginal and Torres Strait Islander people in Logan/Woodridge was 20 patients, while in Brisbane South and Campbelltown the corresponding figure was approximately 11 registrations per 100 Aboriginal and Torres Strait Islander people, similar to the rest of urban Australia.

Finding out if and where patients are currently registered continues to be of concern for GPs in urban case study sites, where '*transient patients come to the practice and tell us [they are] registered and ask for CtG scripts ... [there is] nowhere to check or confirm this'* (Interviewee, private General Practice). This is an issue for patients as well *'QAIHC is looking at introducing a business card concept for patients to carry. This would state whether they are PIP registered, PBS Co-payment registered and which Health Service registered them'* (Interviewee, NACCHO affiliate).

In relation to the number of adult health assessments, the number of GP providers claiming adult health assessments and the average number performed per GP, the three urban case study sites all stand out among urban sites over the most recently reported quarters.

Logan/Woodridge has shown an increase in adult health assessments over the period of ICDP implementation that is eight times higher than the rest of urban Australia. In September 2010 - November 2010, Logan/Woodridge recorded over 15 adult health assessments per 100 Aboriginal and Torres Strait Islander people, figures similar to the best performing regional and remote sites which have higher percentages of Aboriginal and Torres Strait Islander people. There has been an upward trend in Logan/Woodridge since then, to 21.7 per 100 people in the corresponding quarter a year later (Figure 21.1). The other stand out factor in Logan/Woodridge is a significantly higher number of GPs claiming health assessments compared to other sites (almost 4.5 GPs per 100 Aboriginal and Torres Strait Islander people in the September 2010 - November 2011 quarter, when the average across Australia was 0.8 claiming GPs per 100 Aboriginal and Torres Strait Islander people). The high number of health assessments relative to other urban sites is probably related to a high level of commitment to Aboriginal and Torres Strait Islander health that preceded the ICDP, and as a consequence a high number of private GPs willing to register for the PIP Indigenous Health Incentive and to engage in ICDP related programs (including conducting health assessments) in addition to significant developments in the AHS in this site.

Brisbane South has consistently shown the highest number of adult health assessments per GP. In the September 2010 - November 2011 quarter, the average number of adult health assessments per GP in the site was 12 (when Logan/Woodridge and Campbelltown were more aligned with the rest of Australia, which averaged 6). Brisbane South achieved an average of 22 health assessments per GP in the June 2010 - August 2010 quarter. The probable reason for these figures is the effort Inala Indigenous Health Services has invested in performing adult health assessments for some time. Inala is well established and respected as the health service provider for the majority of Aboriginal and Torres Strait Islander people in the area. This explanation suggests there is little scope for further increase in health assessments per 100 people in the Brisbane South site, unless more private General Practices engage in the ICDP and conduct health assessments and/or Inala employs more doctors to do health assessments.

The Campbelltown site has recorded the second highest number of adult health assessments per GP over most of the period of ICDP implementation. There was an average of 7 adult health assessments per GP in the September 2011 - November 2011 quarter, when there were approximately 4 health assessments per 100 Aboriginal and Torres Strait Islander people, and 8 adult health assessments per GP in the previous quarter. This is likely to largely reflect figures from Tharawal Aboriginal Medical Service which, similar to Inala Health Service in Brisbane South, is well

established and attended. Good clinical leadership is evident, and the service has expressed the aim to engage fully with ICDP measures.

As would be expected, the number of Aboriginal and Torres Strait Islander people accessing the PBS Co-payment in the three sites has increased steadily over the period of the evaluation. In Logan/Woodridge the number of people accessing medicines through the PBS Co-payment had more than doubled in the September 2011 - November 2011 quarter (to about 69 per 100 people), compared to the same quarter in 2010 (Figure 21.1), while in the Brisbane South and Campbelltown sites the rates of increase over the year were similar - one third to double respectively (although the actual numbers were considerably less) (Figure 21.2 and 21.3). The high uptake in Logan/Woodridge is possibly linked to high PIP Indigenous Health Incentive registration coverage in this site.

Focus group participants in the three urban sites identified the same ICDP benefits as those in other site types - improved access to medications through lower costs and better medication adherence as a result, because *'… you don't have to worry about how you will pay for it'*. Some participants talked about previously sharing medication because they could not afford to pay for prescriptions. Clinicians also identified improved medication compliance, especially for patients taking multiple medications, and increased patient engagement as benefits of the PIP Indigenous Health Incentive and PBS Co-payment measures. '*The patients now tend to stick to the one practice as a main service provider - before they would go from doctor to doctor … '* (Interviewee, AHS). This feedback has not occurred in regional sites. A commonly raised issue is delay in treatment brought about when eligible patients get non-annotated scripts from doctors in hospital accident and emergency departments. *' … often patients will not fill those scripts until they have come to the AMS clinic and changed [them] … '* (Interviewee, AHS).

In relation to the successful implementation of B measures, as demonstrated in the case study sites, several issues are highlighted in urban environments.

Access to ICDP benefits and equity in urban Aboriginal and Torres Strait Islander residents

In these urban sites, where a large number of private General Practices have a small number of Aboriginal and Torres Strait Islander patients, differential access to the benefits of the ICDP has been described as an equity issue. *'I have heard of GPs saying that they have only one or two Indigenous clients so why register as a PIP practice? This means that their Indigenous patients may be missing out on accessing the ICDP measures'* (Interviewee, NACCHO affiliate). A similar issue has been raised by staff in one DGP, *'Some doctors said they don't want any Aboriginal and Torres Strait Islander patients as they have heard they take up a lot of time. [They say that] GPs and practice nurses are time poor and mainstream GPs are running businesses'* (Interviewee, DGP).

A number of private General Practices with few Aboriginal and Torres Strait Islander clients remain unaware of the program until it becomes directly relevant. An example comes from the Brisbane South site where an Aboriginal patient was sent back to a local GP to have a prescription annotated, to discover the GP concerned was not aware of the PBS Co-payment measure. According to a pharmacist in the Campbelltown site *'a lot of [doctors] haven't heard of [the PBS Co-payment measure], particularly in these big medical centres.*' General Practices in urban areas are less likely to have direct contact with DGP based ICDP workers than those in regional and remote towns, and this is likely to influence knowledge about the ICDP measures.

Some urban community focus group participants talked about being reluctant to leave their long term Health Service of choice, which is not registered with the PIP Indigenous Health Incentive

(which meant they could not access PBS Co-payment annotated scripts), and were consequently having to pay the higher cost of medication. Also, *'There are still pharmacists who don't dispense on CtG scripts'* (Interviewee, NACCHO affiliate).

Pharmacist engagement and education in urban areas

A few urban pharmacy businesses that dispense prescriptions under the PBS Co-payment measure are located close to AHSs and have a reasonably large proportion of Aboriginal and Torres Strait Islander clientele; most pharmacies are located in shopping precincts across site suburbs. Business models and sizes vary; however, a large number of highly privatised and 'individualised' providers presents a challenging scenario for dissemination of information. This observation is reinforced by comments from one IHPO, who highlighted in their interview that there are *'so many [pharmacists] to educate'*. IHPOs and OWs in DGPs have, in some instances, provided information and education to pharmacists about the ICDP.

Pharmacies located close to the AHSs in each site appear to be well informed and have well developed systems to process CtG scripts. *'Local pharmacies are excellent … '* (Interviewee, AHS), however, it is also observed that *'pharmacies in different suburbs … refuse … or are unaware'* (ibid). Lack of knowledge by some locum pharmacists persists and the transfer of PBS Co-payment annotation to repeat prescriptions can be overlooked. It is acknowledged that *'It has gotten better since Medicare has gone out to pharmacies'* (Interviewee, DGP). Nevertheless, it is clear that some managers are not embedding procedures in systems, nor educating staff. *'One pharmacist ... said yes I know about it, but could you please ask people not to come in on the weekend. Because I don't work on the weekend'* (Interviewee, NACCHO affiliate). While there has been some progress with improving cultural safety in pharmacies, focus group feedback continues to indicate further action is needed.

It appears some urban pharmacists do not understand that their role in dispensing PBS Co-payment prescriptions is not discretionary. At least two pharmacies in neighbouring suburbs within one site refused to dispense medication on PBS Co-payment annotated scripts, responding with *'we are not a part of that'* when handed the prescription. An interviewee within the NACCHO affiliate regularly advocates to explain that '*PBS Co-payment is a national program, and eligible [Aboriginal and Torres Strait Islander people] shouldn't have to pharmacy shop'.*

Awareness of the social determinants of health and equity

Lack of understanding of the social origins of disease, and of Indigenous status as a risk factor, continues to negatively influence the way some GPs interpret eligibility criteria for then PBS Co-payment. *'There may be clients who [are] quite well and they come in and want to be part of it. I wouldn't write a CtG script for antibiotics for an acute infection as I don't consider that part of a chronic condition. All you're doing if you give it to them is creating a sense of entitlement … So how can they get themselves better if everything is so freely available?'* (Interviewee, private General Practice). A practitioner in an urban practice who lacks relevant background and has few Aboriginal and Torres Strait Islander patients may not be sufficiently motivated to engage in the issues or the ICDP.

Care Coordination and Supplementary Services (CCSS) (Measure B3 Part B)

The Campbelltown site has an appointed ICDP Care Coordinator, employed in the local DGP. With AHS endorsement, her work is focused on assisting coordinated care for patients of private General Practices in the site – this may explain a higher rate of follow-up claims by GPs in Campbelltown. The

Care Coordinator's first referral was in May 2011. At the time of interview in late April 2012, her workload comprised 5 referrals from state based Care Coordinators, 25 referrals from private General Practices, and 2 from AHS, where she is regarded as *'a wonderful resource … [with] lots of contacts … knows who does what'* (Interviewee, AHS). The AHS (Tharawal) has in-house allied health specialists and accesses Medicare funding for this program. However, it is finding the CCSS measure helpful to fast track acute clients who need immediate care. The IUIH fund holds the CCSS funding in SE Queensland. At the time of the evaluation visit the Care Coordinators based at the IUIH were not working with Health Services in the Logan/Woodridge and Brisbane South sites.

The high rate of referrals and positive feedback is likely to reflect the Care Coordinator's competence and local knowledge, and not necessarily the service model or environment.

Urban Outreach – USOAP (Measure B5 Part A)

In Logan/Woodridge, specialists for the outreach program, USOAP, are organised for the AHS by the IUIH; *'IUIH [works] in collaboration with us in terms of making the relationship, scheduling the time, and coordinating all these with the clinic staff including the Care Coordinator …'* (Interviewee, AHS). The current low number of referrals to specialist services has been attributed to the recent establishment of the USOAP service, high number of locum doctors and established referral pathways with existing providers. '*When you have a high turnover of doctors they do not have an understanding of the system, and the referrals tend to drop off'* (Interviewee, AHS). Poor patient attendance at specialist appointments is a problem. *'We may still have about 50% turnout and lot of specialists would say they are not going to come back because patients miss the appointments … they are maybe getting two clients per day'* (ibid). However, GPQ staff reported there are *'positive stories coming through that specialists are seeing people who they wouldn't normally see'* (Interviewee, SBO). It is early to determine the success of the USOAP delivery model in these urban sites.

There is no USOAP host organisation located within the Brisbane South site boundary. However, a nearby USOAP host organisation at Woolloongabba makes a range of specialist services available to Brisbane South residents. Staff at GPQ reported that factors such as the length of time a facility or GP has been established, systems establishment and 'word of mouth' in the community affected the number of specialist referrals, and reported that *'We actually have more [specialists] than we can place at the moment. In SE Queensland we work with the key stakeholders – such as the Institute [IUIH], AMSs and QAIHC - to get a good picture of whole service needs'* (Interviewee, SBO). Good availability of specialists and a coordinated approach to determining needs and allocating specialist services indicate that these urban areas will be adequately served when referral pathways and systems are established.

AHS staff in the Campbelltown site report a 60-70% patient turn-up rate for outreach specialist services. It is clear from patient feedback that the service has made a difference to wait times. *'I'm on the waitlist for six months to have a cortisone injection at the hospital. Here I saw Dr XXX … and he referred me straight away for [an injection] at the ultrasound place'* (Community focus group). The USOAP has also made specialist consultations accessible to those who cannot afford up-front payments and/or private specialists' fees. *'Last time I saw my other bone doctor, I had to pay $180 and got [back] $80 and I can't afford that'* (Community focus group).

Specialists have a variety of arrangements and expectations in regard to billing, and this is presenting some challenges for host services in these urban sites. 'Some processing protocols around Medicare claiming and billing [are] needed' (Interviewee, NACCHO affiliate).

In summary, the uptake of health assessments, PIP Indigenous Health Incentive registration and the PBS Co-payment has continued to increase in the three urban sites. Areas and rate of increase appear to be determined by the number of GPs engaged in the ICDP, the population reach and priorities of the site AHS, and local Aboriginal and Torres Strait Islander community advocacy with local providers. Several issues emerge in relation to urban case study sites and successful implementation of B Measures including access to ICDP benefits and equity; pharmacist engagement, and GP understanding of the social and economic determinants of health. The use of CCSS funding varies in sites according to need, determined by ongoing systems established prior to the introduction of the ICDP. The role of the ICDP funded Care Coordinator employed in one site (to date) is being successfully carried out with the support of various site health service providers. Management arrangements for the USOAP vary across the sites and may provide valuable insights into successful models for specialist service delivery in urban sites as ICDP implementation continues. Patient turn-up rates for appointments continues to be an issue for specialists providing outreach services in urban areas, while, as in non-urban sites, patients report positive experiences regarding wait times and affordability.

WORKFORCE EXPANSION AND SUPPORT: C MEASURES

Each of these three urban sites has full recruitment to funded IHPO and OW positions in both the DGP and the AHS.

Workforce support and training (Measure C1)

The OW based at the AHS in the Campbelltown site has been working there for seventeen years, including for 2.5 years in a role perceived to be similar to her current OW role prior to ICDP funding (Figure 21.3). A qualified Aboriginal Health Worker from the local community, she found the OW training delivered through the ICDP to be very useful and conducive to good networking with other OWs.

In Logan/Woodridge, where two OWs are based in the AHS (Figure 21.1), the OW training experience has been less positive *'[One] OW has been employed since [September] 2010 and is only just going to orientation training [in February 2012].'* The service used its own resources to develop an orientation and professional development package, drawing on ICDP program information. Concern previously raised in Logan/Woodridge, about the selection criteria for OW positions, remains. *'[The position] needs to be more than entry level because of the nature of the role in practice. For example, transporting patients raises privacy/confidentiality issues as well as health assistance [needs] …. It needs to have a strong health focus'* (Interviewee, NACCHO affiliate). One OW talked about a different dimension of skill development, identifying the need for *'good communication [skills], knowledge of people and community, being able to feel at ease going into homes to give information'.*

OW in AHS (Measure C2), OW and IHPO in DGP (Measure C3)

In the Logan/Woodridge site, the IHPO and OW based at the DGP (Figure 21.1) have been employed since March 2010 and have been effective in raising awareness of the ICDP measures in private General Practices, other Health Services and in the community. Aboriginal and Torres Strait Islander community engagement is a DGP priority and the IHPO, a well respected Aboriginal woman, has been a driving force behind the strengthening of networks by the DGP and in encouraging people to identify as Aboriginal or Torres Strait Islander and sign up to receive program benefits. It is evident from community focus group feedback that the IHPO and OW are known in the community for *'making [services] a lot more friendly or feeling, and a bit more comfortable'*. The cultural awareness

training they have delivered through the DGP has been effective in improving cultural safety. '*The staff [are]... not frightened to approach you and more open to talk to you … [and] now they know we come in every shape, size, colour, everything … [they] used to ask me are you sure that you're Aboriginal? … now they get it'* (Community focus group participant). Clinicians are also positive about these roles, identifying improved attendance at appointments and improved medication compliance as benefits. The IHPO and OW regard ongoing support in practices as important follow up to the cultural awareness training course, reporting that staff frequently want to engage in further discussion about improving cultural safety.

Several clinicians described the value of the OWs visiting patients in their homes to inform them of abnormal test results, to drop in information, arrange an appointment when there is no response to follow-up calls, or accompany the pharmacist doing a home medication review. Patient transport to health services is also provided. Similar OW support was described by patients in the Campbelltown site. *'[Name] the Outreach Worker picked me up this morning and [she] brings me my medication in a Webster pack'* (Community focus group). Another service undertaken by the OW at one AHS is to follow up patients who need prescriptions renewed, based on a list that is regularly generated by a local pharmacy. The OW sits in on specialist appointments to support patients when required, assists PIP Indigenous Health Incentive registration and re-registration and has combined this support with broader health promotion work, such as '*a fruit and veg. program providing a weekly bag of fruit and veg for $15.00. We ... ended up with 25 or 30 people every week'* (Interviewee, AHS).

As shown in Figure 21.2, there have been several changes in the DGP-based OW and IHPO positions in Brisbane South. The positions have been reconfigured between part-time and full-time roles, and there have been several changes of personnel. The lack of staff continuity has caused some staff frustration in General Practices. The person currently in the OW role works with private practices and pharmacies and, since starting in April 2011, has trained and updated pharmacy staff, provided phone and on-the-ground support, helped clients to understanding what is available through the ICDP, advocated for families, connected people with services, trained GP staff in cultural awareness, PIP Indigenous Health Incentive registration and PBS Co-payments and worked with Tackling Smoking and Healthy Lifestyle teams at Healthy Community Days.

In summary, access to OW orientation and training has varied in the three urban sites. The flexible interpretation of OWs' 'patient support and access' roles has enabled the range of OW tasks performed in these urban sites to be practical, varied, and responsive to local needs. IHPOs and OWs in urban DGPs perform important roles in cultural awareness training and educating GPs and pharmacists about the ICDP, albeit their work targets a variety and large number of practices and businesses.

SUMMARY AND CONCLUSIONS

The three urban case study sites of Logan/Woodridge, Brisbane South and Campbelltown provide a useful study of the factors that enable and challenge the implementation of the ICDP in urban settings.

In the Logan/Woodridge site, the combination of General Practice engagement, early and full recruitment to ICDP positions to support GP and pharmacist education, community advocacy and the complementary work of the two Aboriginal and Torres Strait Islander community controlled Health Services (ATSICHS and IUIH) appears particularly successful. Brisbane South also has a long established AHS with comprehensive programs and a high level of community access; recruitment to most positions has enabled steady implementation of the ICDP. In the Campbelltown site there has been less staff stability in ICDP funded positions; however positions have been occupied through

most of the program. A high level of community engagement in health promotion activities generally has supported participation in ICDP funded Tackling Smoking and Healthy Lifestyle teams activities. ICDP funded care coordination is well established in the Campbelltown site.

Workplace stability is an important enabler for the timely implementation of ICDP measures. In each urban case study site, the AHS provides a stable work environment for relevant ICDP funded workers (compared with regional case study sites, where general high turnover of staff and changes in AHS governance have impacted on recruitment). The relevant urban DGPs also provide stable work environments. In terms of workforce, the urban sites are greatly advantaged compared with regional and especially some remote sites, where inability to recruit and retain suitably qualified and skilled workers has heavily impacted on the pace of ICDP implementation. A number of people engaged in ICDP positions in these urban sites are able to add value to their roles with specialised qualifications, skills and experience.

A feature of the two Queensland sites that sets them apart from most other Sentinel Sites is the roll-out and implementation of Tackling Smoking and Healthy Lifestyle teams by a regional support organisation, the IUIH. This reduces the burden of ICDP workforce management and service delivery by health services at the site, but reduces the capacity of the Tackling Smoking and Healthy Lifestyle teams to respond to local priorities and directly support local initiatives, especially as these two teams serve an extensive area of densely populated SE Queensland. This is an issue of concern for some site services and Aboriginal and Torres Strait Islander community members who, at the same time, recognise the good work being done by the IUIH, especially their successful engagement of young people in healthy lifestyle programs. The IUIH is taking a strategic approach – investing in young people to lead healthy lifestyle changes, strengthening the capacity of health services to support smoking cessation, and using social marketing campaigns to reinforce positive health messages across the population. The approach has the potential to reach a wide audience, thereby meeting the challenge of maximising reach and outcomes from limited resources. It is top-down health promotion, as perceived by community stakeholders. A bottom-up community development approach is not feasible using this delivery model and given the large, densely populated region the IUIH teams serve; however, best practice health promotion requires a combination of top-down and bottom-up health promotion approaches to build health skills and to support and sustain changes in health behaviours and lifestyles.

In all three sites, the ‘C Measure’ workforce offers practical and locally responsive support for ICDP implementation and improving client care, with roles that range across cultural awareness training and education in ICDP procedures for GPs, practice staff and pharmacies; ongoing GP advice and support; patient contact, ICDP education, advocacy, transport, home visits and consultation support; support for health promotion activities, and more. Success of positions can be largely attributed to incumbents being well known and respected and having (or developing) good knowledge of local communities and services available, as well as having the capacity to perform varied roles effectively.

Evidence from the SSE confirms that ICDP implementation is complex and has particular challenges in urban sites, as well as distinct advantages that assist service providers in their efforts to provide Aboriginal and Torres Strait islander people in urban areas with culturally appropriate chronic disease prevention and management services.

Box 1: Key for Figures 21.1 – 21.8

These figures show the trends in uptake of various measures (as reflected by administrative data) in relation to presence of ICDP workers that have a primary responsibility for enhancing the uptake of the ICDP measures at the local site level; these workers are the IHPO, OW, practice manager and CCs (where they have a direct role within the site).

In a number of sites there have been new service developments (such as the opening of a new facility) that may have impacted significantly on trends in the administrative data, and relevant service developments that have been identified by the SSE have been marked on the timeline.

The top section of the figure represents the ICDP funded positions and the major service developments that have occurred in the site from March 2010 – February 2012.

- Each horizontal line represents the length of time an ICDP funded position has been filled.
- Positions not working directly within the site and positions that have not been filled are not shown. Positions are 1.0 FTE unless otherwise specified.
- Where there is more than one position of the same type, positions are numbered (e.g. pos 1, pos 2).
- A discontinued line indicates a person left the position. A continued line at a lower level indicates a new person was recruited in the role.

Abbreviations: Outreach Worker (OW), Indigenous Health Project Officer (IHPO). Staff are located at Aboriginal Health Services (AHS) or at Divisions of General Practice (DGP) unless otherwise specified.

The lower part of the figure displays the administrative data from March 2009 – November 2011.

The graph in the lower part of the figure shows numbers of payments for various ICDP related items per 100 Aboriginal and Torres Strait Islander peoples per quarter (except where specified):

- PIP Indigenous Health Incentive registrations.
- Tier 1 PIP Indigenous Health Incentive items.
- Tier 2 PIP Indigenous Health Incentive items (annual payments).
- PBS Co-payment (number of people rather than number of prescriptions).
- Adult health assessments (MBS items 704, 706, 708, 710 to 1 May 2010 thereafter 715 for people aged ≥15 years).
- Follow-up by nurse or AHW (MBS item 10987).
- Follow-up allied health services (MBS Items 81300 – 81360).

Further information is available on the interpretation of the administrative data in the sections of the report that relate to various items (e.g. PBS Co-payment, PIP Indigenous Health Incentive).

The PIP Indigenous Health Incentive data are shown quarter by quarter in these timelines and not as cumulative data over the year (as they are shown in other sections of the report).

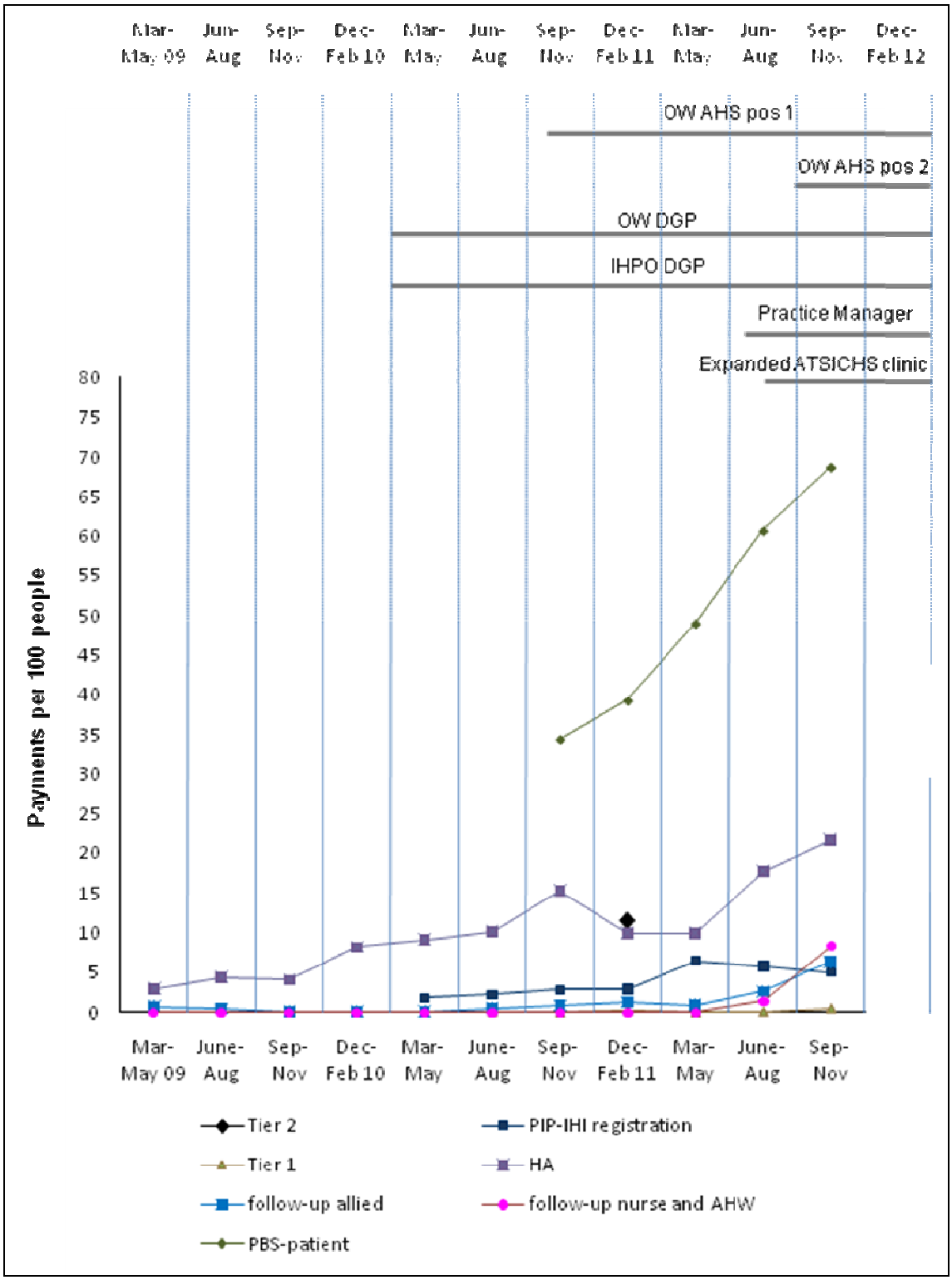


Figure 21.1: ICDP funded positions, service developments and trends in administrative data, Logan/Woodridge, March 2009 - February 2012.

Note: See Box 1 for further explanation.

The practice manager is believed to be ICDP funded, this is not confirmed.

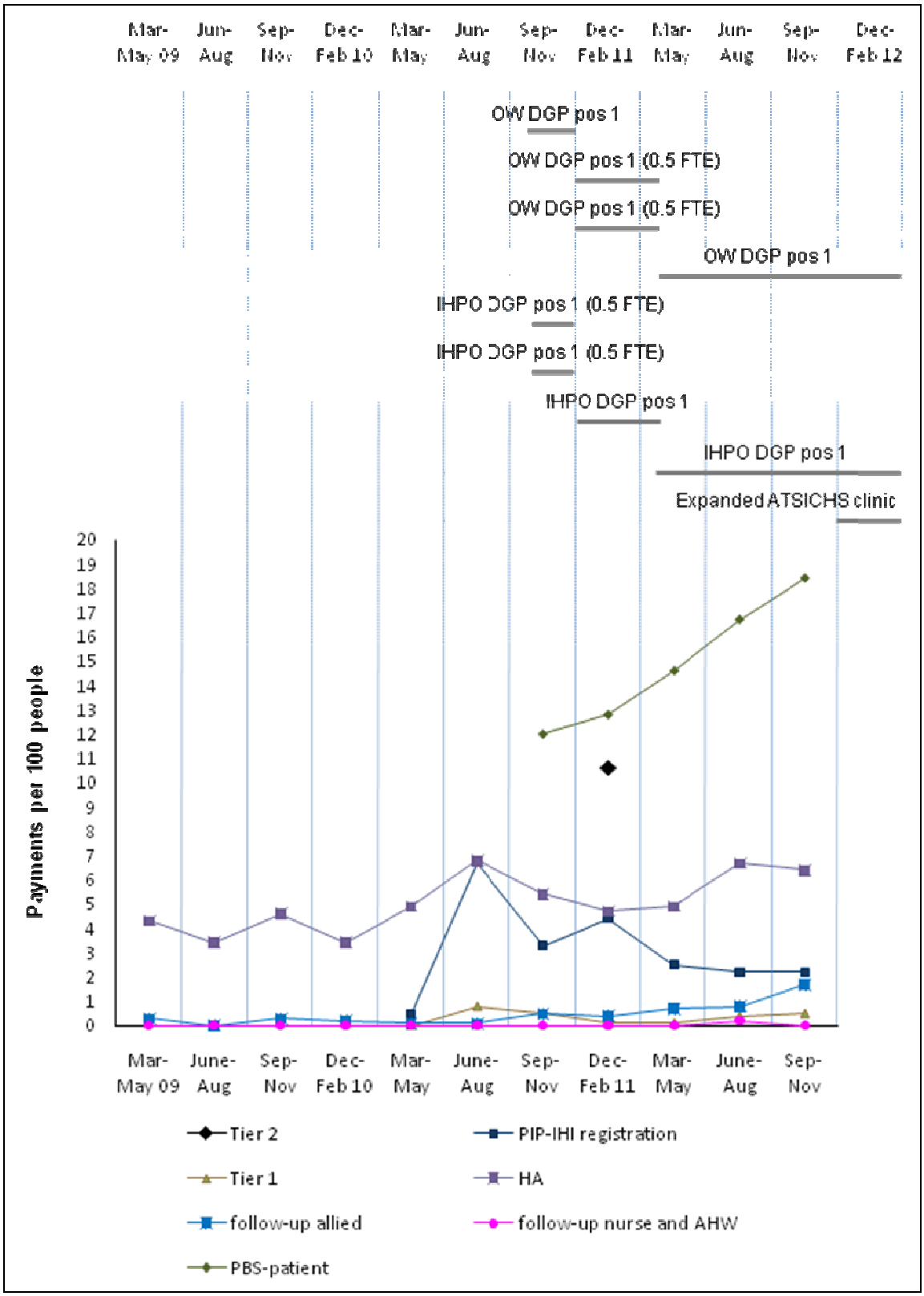


Figure 21.2: ICDP funded positions, service developments and trends in administrative data, Brisbane South, March 2009 - February 2012.

Note: See Box 1 for further explanation.

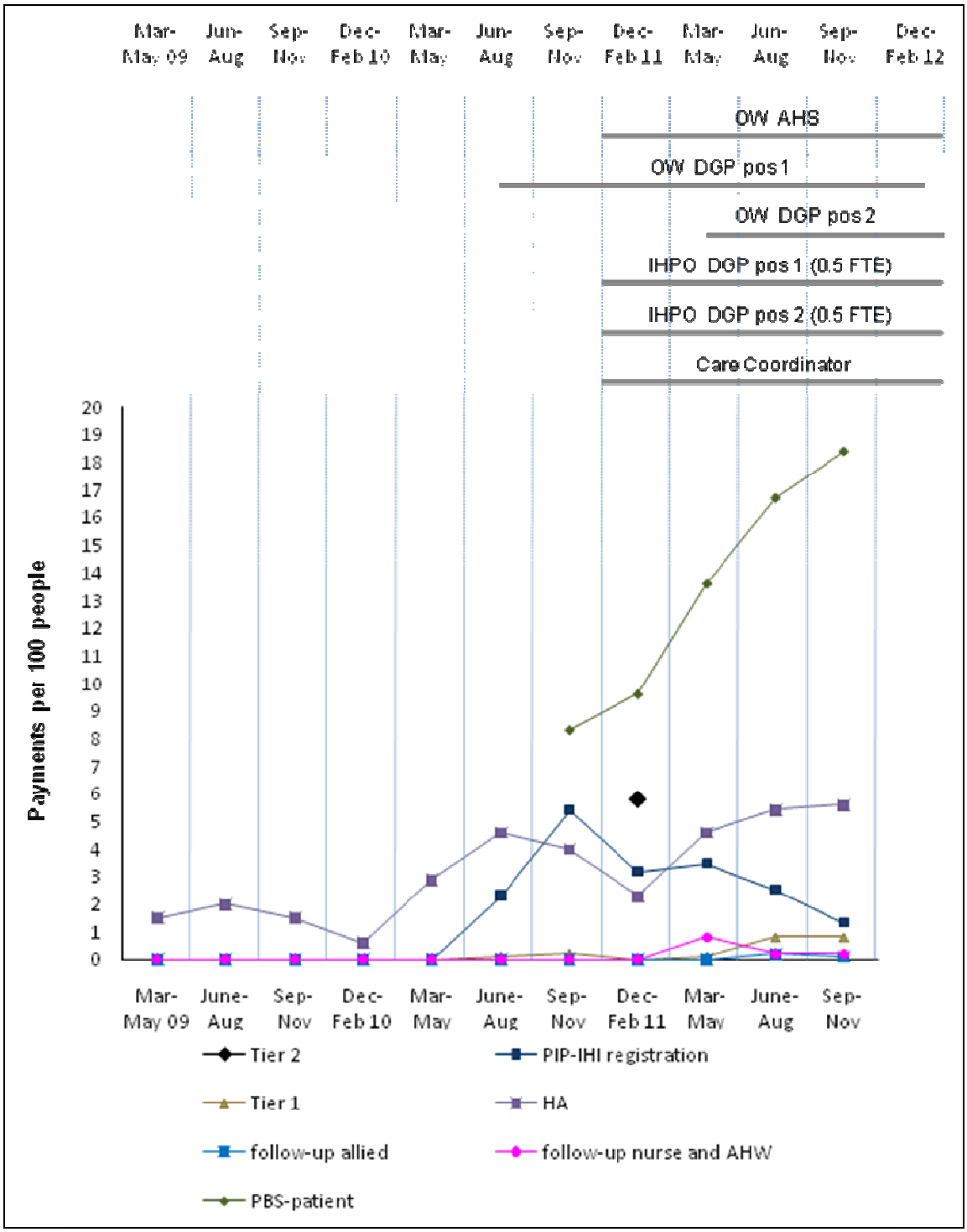


Figure 21.3: ICDP funded positions, service developments and trends in administrative data, Campbelltown, March 2009 - February 2012.

Note: See Box 1 for further explanation.

The IHPO DGP position 2 is based outside of the site at 'Marrumali'.

The OW DGP became vacant in Feb 2012.

21.2. Implementation of ICDP in regional case study sites: Tamworth, Bairnsdale and Port Augusta

The SSE covers twelve regional sites. Three are case study sites – Tamworth, Bairnsdale and Port Augusta. The site characteristics vary considerably in area, population size and proportion of Aboriginal and Torres Strait Islander residents. The regional city populations vary from 12 000 to over 50 000. As evident in the descriptions below, the sites also vary in terms of climate, local economy and the proportion of the population made up of Aboriginal and Torres Strait Islander people.

The Tamworth site in northern NSW is approximately 420 kms from Sydney and 280 kms inland from Port Macquarie. Situated in the fertile Peel Valley, and covering an area of 9892 sq km, the site includes the town of Tamworth, which has a population of approximately 53 600, and the surrounding areas, with about 4000 residents. The area is part of the extensive traditional lands of the Kamilaroi people. Aboriginal and Torres Strait Islander people make up about 7.0% of the total population of the site - about 3700 people. Famous for being the nation's 'country music capital', Tamworth is a prosperous farming region where horse and cattle breeding, grazing (including sheep) and grain cropping are the basis for the local economy. Tamworth has a range of public and private Health Services, a hospital and various community based organisations. The area's AHS, Tamworth Aboriginal Medical Service (TAMS), is located in Tamworth and services a region within a radius of approximate 70 kilometres. The North West Slopes Division of General Practice, (transitioning to the New England Medicare Local on 1 July 2012), is based in Tamworth. There are several private General Practices, however a significant factor for ICDP implementation is the shortage of GPs in the site. Tamworth is currently classed as a district of GP workforce shortage. Most Health Services have had their books closed to new clients for several years. Some have recently re-opened, however existing clients generally need to wait up to two weeks for appointments. There are about 1830 people per GP in the site – the only Sentinel Sites with poorer GP to population ratios are the WA remote sites of Derby and East Pilbara, and the regional site of Kalgoorlie.

The Bairnsdale site in the East Gippsland Lakes region of Victoria is located in an area that supports a range of rural industries including beef and lamb, dairy, wool, forestry, grain, fodder and vegetable production. It is also a popular holiday and retirement destination. The site includes the town of Bairnsdale, located on the Princes Highway 280 kms east of Melbourne, and several smaller towns. Bairnsdale has a population of approximately 12 000 people; about half of the 25 370 people who live within the site area of 628 sq km. In this respect the site's population distribution is markedly different from the other two regional case study sites, in which most people reside in the main city or town, albeit the site is comparatively small. Many people from areas outside the site travel to Bairnsdale to access services. Approximately 760 Aboriginal and Torres Strait Islander people make up about 3.0% of the total population of the site. Bairnsdale is in the traditional lands of the Gunai-Kurnai people. There is an AHS in the site - Gippsland and East Gippsland Aboriginal Co-operative Ltd (GEGAC) – a regional hospital and two private General Practices. GPs from the private General Practices also consult from the AHS. The East Gippsland Primary Health Alliance, formerly the East Gippsland Division of General Practice, has its office in Bairnsdale. The East Gippsland Primary Health Alliance transitions to the Gippsland Medicare local on 1 July 2012.

The Port Augusta site of 1153 sq km straddles the head of Spencer Gulf in South Australia, about 320 kms north of Adelaide, in Nukunu traditional country. It is a place of significance to Aboriginal people from the Anangu Pitjantjatjara Lands, the Flinders Ranges and the Eyre Peninsula. About 2300 Aboriginal and Torres Strait Islander people make up around 17% of the site population of

approximately 13 900 people. Port Augusta is a service hub for road and rail transport, wheat and sheep farming. Its huge power station has generated much of South Australia's electricity since the 1950s; fuelled by brown coal railed from Leigh Creek mine, 150 km to the north. Whyalla, SA's third largest city, with a population of over 20 000, is 75 kms to the south west. The site's AHS, Pika Wiya Health Service Aboriginal Corporation, recently transitioned from being a state managed service to a community controlled health service (see Figure 21.6) . It runs four clinics; two are located within the site in Port Augusta and Davenport (an Aboriginal community 3 kms from Port Augusta). The other two clinics are located outside the site at Copley, 267 km north of Port Augusta, and Nepabunna community, 63 km east of Copley. The site has a hospital with visiting specialist services, private General Practices and is the base of the Flinders and Far North Division of General Practice, which covers a large area extending to the state's northern boundary. The Flinders and Far North Division of General Practice transitions to the Country North South Australia Medicare Local on 1 July 2012. There is a history of service delivery partnerships between the AHS and the DGP. A high proportion of local GPs in Port Augusta are international medical graduates. The area is not currently classified as a district of GP workforce shortage.

The ABS Socio-Economic Index for Areas (SEIFA) score is drawn from income, education and employment statistics across the general population. The SEIFA average score for each of these three regional sites is similar, despite the different site characteristics. The SEIFA score for Tamworth is 972; for Bairnsdale it is 962 and Port Augusta 897. As points of reference, Canberra has the highest SEIFA average of the Sentinel Sites with a score of 1067, while the lowest site score of 543 applies to the remote site of Katherine West.

CHRONIC DISEASE RISK FACTORS: A MEASURES

Tackling Smoking (Measure A1) and Healthy Lifestyle Promotion (Measure A2)

Tamworth is the only regional case study site with Tackling Smoking and Healthy Lifestyle workers in place. The current Regional Tobacco Coordinator (RTC) has been in the position since August 2011. One of two allocated Tobacco Action Worker (TAW) positions was to commence soon after the evaluation visit; the second position remains vacant. A previously appointed TAW left the position within a month of commencing. One of the two allocated Healthy Lifestyle Worker (HLW) positions was recently filled. Difficulty in recruiting and retaining staff is not restricted to the ICDP workforce, but is a general problem experienced across the health sector within the site.

Focus groups in Tamworth site indicate a high level of community readiness for Tackling Smoking and Healthy Lifestyle activities And AHS staff are generally keen to have them implemented as soon as possible. *'So many people want to give up smoking and do healthy lifestyle programs … When motivation arises if you don't use it you lose it*.' (Interviewee, AHS). Evidence supports this statement; thirty community members recently expressed interest in a ten week 'balance & strength, walk and talk' program promoted at the AHS.

The Port Augusta site has funding allocated for one RTC, one full-time TAW, and two full-time HLWs. None of the positions have been filled since funding became available; this delay is at least partly attributed to instability within the employing AHS, which has had five CEOs in the past two years and has been transitioning from government to community control. Vacancies continue to be advertised.

There are no Tackling Smoking and Healthy Lifestyle positions allocated to the Bairnsdale site. GPs at the AHS are pro-active with smoking cessation interventions and the MSOAP-ICD funded dietitian provides patients with healthy lifestyle education.

In the regional case study sites, a small pool of suitably skilled workers is a barrier to recruitment and might, in some cases, impact on implementing other measures. For example, in one site an AHW moved into a HLW role, prompting the following comment: *'Now … we do not have the health worker to do what we need to do … [such as] more health checks'* (Interviewee, AHS). There is also a lack of clarity about the scope and way of working in health promotion roles. *'The RTC can't offer any counselling, so there's no point'. [We need] 'a culturally appropriate tobacco counsellor who can be in regular contact with Aboriginal patients to [support] quit smoking or other services … or medications for smoking cessation.'* (Interviewee, AHS). In the same regional site a community focus group participant did, in fact, recount how her son had worked one-on-one with the RTC to successfully quit smoking; suggesting that Health Service staff would benefit from further information about the support available for patients. The focus group also identified the need for a supported, ongoing group program to help people stop smoking and maintain change, reinforcing the need for a range of approaches to be available.

In summary, both regional case study sites with workforce allocation for the Measures A1 and A2 have experienced difficulties recruiting staff, resulting in delays in implementing Tackling Smoking and Healthy Lifestyle activities and limited understanding of roles among some Health Service staff. Staff retention does not appear to be related specifically to ICDP funded positions, as other positions, including the GP workforce, have experienced high turnover. The AHSs in both sites have recently had changes in governance arrangements and leadership. This instability is likely to influence staff recruitment and retention. While this situation may not be typical of regional site implementation, the combined factors currently pose a significant challenge to the implementation of A measures in these regional settings.

CHRONIC DISEASE MANAGEMENT AND FOLLOW-UP CARE: B MEASURES

PIP Indigenous Health Incentive (Measure B3 Part A) and PBS Co-payments (Measure B1)

The three sites provide a picture of the implementation of B measures in regional settings and the opportunity to consider the factors that enable and challenge implementation. In relation to numbers of Aboriginal and Torres Strait Islander people in the population, there are fewer Health Services available to provide PIP Indigenous Health Incentive related services in regional locations compared to urban locations, but more compared to remote locations.

PIP Indigenous Health Incentive registration in the Tamworth site has been slower than in the other regional case study sites. In the September 2010 - November 2010 quarter there were approximately 3.5 registrations per 100 adults; the only quarter with a higher number of new registrations is the March 2011 - May 2011 quarter, with about 6 PIP Indigenous Health Incentive registrations per 100 adults (Figure 21.4). As would be expected, the number of adult health assessments follows similar trends, with the highest number of assessments per quarter indicated in the most recently provided data for September 2011 - November 2011– approximately 7 per 100 people. As shown in Figure 21.4, PBS Co-payments have risen steadily over the period of implementation, from approximately 12 claims per 100 people to 31 per 100 people.

One General Practice in Tamworth had used funds generated from the PIP Indigenous Health Incentive to support a dedicated role to do adult health assessments. The practice has dedicated days and times when health checks are done. It is evident that more flexibility in relation to times is needed; some community focus group participants pointed out that health check days were not accessible to those with weekday jobs (a concern being addressed).

Longer serving staff in Tamworth's private General Practices appear to be well informed about PIP Indigenous Health Incentive registration and the PBS Co-payment measure. Challenges to implementation within GP practices mainly appear to relate to the temporary employment of GPs in this district of GP shortage. *'We are not sure what all doctors know, when … [they are] … coming and going'* (Interviewee, private General Practice). Evidence suggests that practice nurses are important sources of information about the PBS Co-payment measure for patients, particularly when doing health assessments. ICDP workers have observed that the measure has encouraged access to private GP practices. *'This [PBS Co-payment] measure has got them in the door [and] and they go from there'* (Interviewee, ICDP worker).

In the Bairnsdale site, PIP Indigenous Health Incentive registrations peaked in the September 2010 - November 2010 quarter with about 25 registrations per 100 adults. This peak corresponds with the first record of PBS Co-payment claims, which indicate approximately 52 claims per 100 people, a level maintained over subsequent quarters (Figure 21.5). Since that September 2010 - November 2010 quarter, PIP Indigenous Health Incentive registrations in the Bairnsdale site have dropped, with no new registrations recorded in the corresponding quarter a year later. It would appear that a push to register eligible patients in the first year of the ICDP was not sustained. The average number of adult health assessments completed in the site have been reasonably steady throughout the period of data collection, ranging between 1 and 5 assessments per 100 adults in each quarter (Figure 21.5).

Private GP practices are used by a number of Aboriginal and Torres Strait Islander residents in Bairnsdale - one practice has over 100 Aboriginal patients identified on their patient information system. Participants in one community focus group '*preferred mainstream'* because they had a perception that privacy was more assured in private General Practices. The GPs from two General Practices do shifts at the AHS, and focus group discussion indicated that some people '*follow their doctors*', basing their decision to use the AHS or private General Practice on their preferred GP's practice schedule. In light of this service delivery arrangement, there is anecdotal evidence that some GPs in the Bairnsdale site are unhappy that patients signed up at the AHS for the PIP Indigenous Health Incentive while using private General Practices for the majority of their medical care.

In the Port Augusta site, the average number of adult health assessments per 100 people has remained steady, ranging from 1 to 3 per 100 adults in each quarter. In the first recorded period of PIP Indigenous Health Incentive registration in March 2010 - May 2010, there were 17 registrations per 100 people. The number has decreased since then to about 2 new registrations in the September 2010 - November 2011 quarter. PBS Co-payments have continued to rise, from about 33 per 100 people in September 2010 - November 2010 to 50 PBS Co-payments per 100 people in the latest available figures (Figure 21.6). From the perspective of at least one Health Service in Port Augusta, the PBS Co-payment measure is 'the most successful of CtG [measures]. Patients remind you if you forget' (Interviewee, private General Practice). This message is consistent with other regional sites. Observation of improved medication adherence is common to all sites.

A proactive approach to encouraging patient access in General Practice has been described at the Port Augusta site: *'As soon as our clients walk in the door, our practices are asking them 'Are you Aboriginal and Torres Strait Islander? If you are you are eligible for this'. We have developed two signs, one sign goes on the front door, [and] says, 'We welcome Aboriginal and Torres Strait Islander people to our practice'. Soon as they walk in they can see a sign ... that says 'Are you aware of the PIP incentive program?'* (Interviewee, DGP). A key achievement of this approach is that over two years every practice in the site has been signed up for the PIP Indigenous Health Incentive.

Port Augusta is a service centre for remote communities in northern SA. People travel to the town to access health services from communities in which medications are free under the S100 arrangement. These patients are usually not registered for CtG prescriptions. This can result in confusion and further financial burden for these people. It is a particular issue for patients who come to the regional hospital for treatment and are required to stay in town for more than a week following discharge, as the public hospital pharmacy only supplies seven days of medication upon discharge. It can also be an issue for family members or others escorting patients and requiring medications.

It appears that in regional sites local ICDP workers are well placed to support practices to ensure relevant administrative procedures are as straightforward as possible.'... *I have given every practice ... the link to the software with the PIP information ... so they can do it all electronically ... if [there is a problem] they ring us and ... our staff will follow up' (Interviewee, ICDP worker).* This may in part be due to the workers in regional settings having fewer practices to engage with. ICDP staff also described establishing communication systems with site services. *'More information about [referral of registered patients to specialists] will be going out … with another fact sheet ... I will put that out in the mid-week memo to GPs so it is well covered'* (Interviewee, ICDP worker). Existing relationships and a smaller, less dispersed number of General Practices (when compared with urban sites), is an enabling factor in fostering engagement, communication and providing support between ICDP workers and General Practices.

Long patient wait times for GP appointments

Long patient wait times for GP appointments is reported by patients across these regional sites. *'Sometimes you don't get to see a doctor for a week, sometimes for 3-4 weeks with your own doctor'* and *'[We] have to put a day aside to wait to see a doctor'*. Access to GPs in private General Practices appears to be a particular issue. *'It's not easy to get in to see doctors in mainstream, unless you have seen them before'* (Community focus group). A number of community focus group participants in these sites continued to be unaware of the benefits available through the ICDP, and were not registered for the PIP Indigenous Health Incentive despite suffering from chronic diseases - *'My heart medication costs $209 per month'.* Turnover of doctors in regional sites, higher proportions of overseas trained medical graduates, together with clinicians being generally 'time poor' may be reducing their capacity to engage in the ICDP. Despite these factors in one site, community focus group participants reported that the ICDP was perceived to be reducing wait times, by enabling greater choice when accessing health care. *'We can choose our doctors now … that is how we get in quick - we shop for doctors, to see which one we can see [first]'.*

Engagement of pharmacists in regional sites

In contrast to urban settings, most pharmacies in these three regional sites are well engaged with the ICDP, well informed and have systems in place to dispense medications under the PBS Co-payment measure. The resident pharmacist at the AHS in one site reported that the PBS Co-payment measure had actually decreased workload; the subsidised medication system the AHS had in place prior to the introduction of the ICDP (to pay the gap in price for concession card holders) was more complex to administer. The pharmacist has visited private pharmacies in the town to raise awareness of the PIP Indigenous Health Incentive and the PBS Co-payment measure. Some private pharmacy businesses are also highly engaged. A pharmacist with several pharmacies in this site has also supported the work of the IHPO and DGP-based OW by visiting medical practices and pharmacies to explain PIP Indigenous Health Incentive and the PBS Co-payment measure. At another site, a pharmacist was reported as taking the initiative to '*sometimes suggest a home medicine review to a doctor*'. These approaches have had a positive impact. An interviewed pharmacist at one

site revealed sound knowledge of the PBS Co-payment measure and described supportive practices with patients. The pharmacist reported that about 90% of Aboriginal and Torres Strait Islander clients presented annotated scripts, while six months previously the figure was just over 50%.

This level of engagement was not consistent across all regional sites. Pharmacies in one of the regional sites appeared to be less engaged. These providers appeared 'stretched' meeting general service demand. Several pharmacies in this site reported having very limited or no knowledge of the PBS Co-payment measure when approached by the evaluation team. This raises concern about adequate access to the measure for PIP Indigenous Health Incentive registered patients.

The capacity of the IHPOs and DGP-based OWs to visit most pharmacies in regional towns has no doubt supported pharmacy engagement. *'… with one of the Medicare [staff], we went around to most of the pharmacies ... all pharmacies have CtG in place'* (Interviewee, DGP). This contrasts with the experiences of urban counterparts, who struggle to visit the large number of widely dispersed pharmacies within their sites. The capacity to work with pharmacy staff to raise cultural awareness and to improve staff-client communication was also evident in interviews. *'We asked if they needed any assistance with cultural support and when I observe the interaction, if I see that something is not right, I will follow-up'* (Interviewee, ICDP worker).

Cultural awareness training delivery

Factors that particularly influence cultural awareness needs of health sector staff in these regional sites include high turnover of temporary GPs and, in one site, a relatively high proportion of overseas trained doctors. Interviewee responses indicate cultural safety continues to be an issue in these regional settings. *'A lot of the doctors don't have the [cultural] knowledge of the way to approach Aboriginal people [from our communities], particularly people from the APY lands and more traditional people. There are cultural rules to abide by, but a lot of doctors don't know that ... they need that bit more [locally relevant] training'* (Interviewee, AHS). Within the site, however, *'all practices know the ICDP team'*, who provide additional cultural awareness training to supplement online modules.

In another site, cultural safety is perceived to be a problem in specialist services. '*When I go there I am the only Aboriginal and two of our sisters have said [the same] … you go there and all they do is look at you … '* (Community focus group). Work is being done through the DGP to raise cultural awareness through facilitated regional training sessions which help to *'break-down the barriers, even though … they could do the RACGP on-line*' (Interviewee, ICDP worker). General Practice staff are attending full day sessions and responding in positive ways. *'I didn't want to go [but] it was wonderful. It made us look at things differently. I learnt so much'* (Interviewee, private General Practice).

The capacity to deliver this mode of training in regional case study sites (which have less staff to reach) provides an opportunity for participants across a region to share experiences and local information, learn from each other and develop rapport with ICDP workers.

Care Coordination and Supplementary Services (measure B3 Part B), Self-management training (measure B4)

Care Coordinator positions have been filled since September 2011 in Tamworth (Figure 21.4), and since June 2011 in Port Augusta (Figure 21.6). There is no Care Coordinator allocation in Bairnsdale; however AHS staff reported that Healthy for Life funding has had a positive impact on staffing levels

and clinical care, including doing care coordination well, and do not require ICDP funding for care coordination.

When the DGP in Tamworth designed the care coordination program and applied for funds, links between services and roles were planned. The Care Coordinator works closely with the Aboriginal health team at the DGP in order to enhance links with patients, and the team works with community members to support the Care Coordinator's role. The DGP based OW and the AHW assist with transport and the IHPO assists in reporting for the care coordination program. It is evident the arrangement works well, as does the arrangement in the Port Augusta site, where the Care Coordinator has been working with the IHPO and OW to build rapport in six local practices, and is currently working in three practices. The regional town environment appears conducive to team work and communication. Some state-based initiatives may also be contributing.

Care Coordinators are focusing considerable effort on negotiating improved patient access to specialist services. Through these negotiations, some private specialists have agreed to bulk bill Aboriginal and Torres Strait Islander patients. Working in partnership with OWs enables the significant barrier of lack of patient transport to be removed when necessary. *'We take out the facts that prevented [patients from] going, which is cost or transport. Now they are going'* (ICDP worker).

Local community knowledge also adds value to the roles. *'[This] is a small community. We know everyone, especially Aboriginal people'*. One Care Coordinator meets regularly with allied health teams, travels with them on their outreach work and has found it beneficial to participate in their client case management as *'they are seeing clients I have seen [and] I am trying to get my foot in the door with other network allied health mob … '*.

Chronic disease self-management training experiences differ between the three sites. In one site, nursing staff and an Aboriginal Health Worker had recently attended chronic disease self management offered by a NACCHO affiliate. In another, practice nurses in private practices had also undertaken this type of training, but not through the ICDP. One site reported that up-skilling of Aboriginal workers in chronic disease self management is occurring through the Certificate IV in Aboriginal and Torres Strait Islander Health.

Rural Outreach Teams MSOAP-ICD (Measure B5 Part B)

Access and referral arrangements for specialist outreach services in the three regional case study sites have improved as a result of the measure (in combination with the use of supplementary services funding).

It is evident that the MSOAP-ICD measure has improved access to specialists for Aboriginal and Torres Strait Islander people in these regional sites. *'These doctors here will send you to everyone they know, they are sending us to all the specialists'* (Community focus group). Another focus group participant (in Tamworth) was grateful the measure was reducing the cost and inconvenience of travelling to access care*. 'Before this [ICDP] came in … we had to go to Sydney, Newcastle, back and forward to specialists all the time. It was costing us a lot of money but now it is really good'.*

In the Tamworth site, there appears to be good coordination of patient care between service providers and the MSOAP-ICD outreach team and well organised procedures. An AHS clinician noted more attendance for the dietitian than for other allied health specialities, possibly because *'it is easy to follow-up using Communicare'*. This suggests a need for additional links to specialist providers within patient information systems. There has been a recent policy change to include referrals from private General Practices as well as the AHS within the site. In the Bairnsdale site, MSOAP-ICD has

given the AHS the ability to set up a diabetes clinic as part of their chronic disease management program activity, and to offer complementary services. A dietitian is employed full-time and others specialists are engaged through Gippsland Regional Health. Patients are positive about the improved services. *'[Diabetes educator] was ringing me twice a day to see how my blood sugar was', and 'there's good support'* (Community focus group). According to ICDP workers, General Practices at the site are not accessing MSOAP-ICD. In Port Augusta, the measure has increased access and enabled coordination of visiting specialists '*It is all new, from Royal Adelaide Hospital. ... When all specialist providers are [here] together, we hold diabetes day - the patients [with diabetes] can get to see everyone'* (Interviewee, AHS). A visiting occupational therapist works at the AHS for three days every fortnight*, 'which [the AHS] has never had [before]'.* This clinician also visits elderly and special needs Aboriginal clients in residential care. In only one regional site did providers raise concern about patient non-attendance at specialist appointments, which contrasts with findings in urban case study sites. The aligning of services within existing Health Service programs may be an enabling factor in these settings.

B Measure implementation – enablers and challenges in the three regional sites

In summary, identified enablers for implementation of B Measures in the regional case study sites include:

- established, long term networks between a number of service providers in regional towns where 'everyone in the community knows everyone'
- recruitment of local people who have strong community links and know the local health service issues and environment well
- ability to disseminate information about the benefits of the ICDP through local facilities and media (community radio, newspapers and TV are used in regional areas)
- flexible modes of training delivery, including on site cultural awareness training.
- Aboriginal and Torres Strait Islander patients accessing private General Practices
- accessibility of the ICDP workforce for Health Services staff
- having a smaller number of Health Services and pharmacies to engage, compared with urban sites, while an adequate number for patients to exercise choice.

Key challenges for implementation of B Measures in the regional case study sites include:

- workforce recruitment and retention issues across the health sector
- changes in organisation governance arrangements and leadership, which constrain the capacity to recruit staff and provide management
- high turnover of GPs, and higher proportions of overseas trained medical staff compared with other ruralities, which increases need for cultural awareness and ICDP systems training
- cultural safety issues, including those stemming from a high proportion of overseas trained doctors, and from entrenched attitudes

- limited capacity to integrate measures with health promotion measures to address chronic disease risk factors among patients, due to limited or no A measure workforce. This hinders opportunities for progressing patients' interest and readiness, knowledge and skills in addressing chronic disease risk factors, and limits referral of patients to health promotion and smoking cessation programs

- lack of access to role orientation

- distances and travel involved in accessing some training opportunities

- slow uptake of the ICDP funded self-management of chronic disease training, indicating that the training offered by Flinders University is either not sufficiently promoted in regional areas, or is not readily accessible.

WORKFORCE EXPANSION AND SUPPORT: C MEASURES

Two of the three regional case study sites have full recruitment to funded Indigenous Health Project Officer (IHPO) and the Outreach Worker (OW) positions in both AHS and DGP sectors. The AHS in Port Augusta has not been successful in recruiting to the OW position to date.

Workforce support and training (Measure C1)

Engagement with the OW orientation and training activity has been variable across these sites. At one site the OW has been in the position for more than 12 months and is yet to receive orientation training. The OW based at the DGP has received orientation through the NACCHO affiliate. OW training has been accessed by the OWs at another site, which was also offered through the local NACCHO affiliate. Nevertheless, it was perceived that a delay in training delivery has impacted on its effectiveness. *'We did a needs analysis and the orientation package is complete now and we've had two and a half workshop days, but it was hard bringing together OWs who had been in job for a while with new OWs and facilitate a good meaningful workshop to suit both'* (Interviewee, NACCHO affiliate).

In regional sites, as elsewhere, interviewees have commented about how the varied education backgrounds of OWs impacts on training needs. Basic training in blood pressure and blood glucose monitoring was suggested in the Tamworth site. The SBO recently worked with the NACCHO affiliate in NSW to deliver a workshop for ICDP teams (including IHPOs, OWs and Care Coordinators). One aim was *'to support a team approach on the ground'*, an approach obviously found to be effective in these sites.

The professional development experience of the IHPO in one site has been very positive. She received relevant training soon after being appointed and has been funded to attend CtG conferences organised by the local SBO. An individualised training plan has been negotiated and uptake of local training opportunities is encouraged. Limited capacity to travel due to family commitments was reported as affecting capacity to attend training delivered outside the region for some ICDP workers.

Two of the three regional sites have hosted GP registrars. Two GP registrars who did placements at the AHS in Tamworth stayed on to work in the organisation. One GP registrar in the Bairnsdale site has since taken up a position in the Northern Territory. In both sites the GP registrar program has been running for several years and has not been expanded through ICDP funding. No student nurses have taken up available clinical placements.

OW in AHS (Measure C2), OW and IHPO in DGP (Measure C3)

In the three regional sites, as in other sites, the roles of IHPOs and OWs tend to build on existing community relationships. Where the roles are enhanced by supportive management practices, they are reported as effective and able to respond to local needs.

In the Tamworth site, the IHPO and DGP-based OW have been employed since March 2011 (Figure 21.4) As previously described, they have played a significant role in raising awareness and supporting service providers to implement measures. *'The roles make themselves available and very approachable, the links and partnerships are well established'* and *'I can call them for assistance - they would come'* (Interviewees, private General Practices). Their community links are valued. *'They know how to communicate with the Aboriginal community and with Aboriginal people'* (Interviewee, private General Practice).

Focus group participants at this site were well informed about the support available through the DGP and the procedures required, (such as the 24 hours notice for transport from out of town). '*The Division helps to make appointments to the GPs, [OW name] and [AHW name] ring us before appointments and organise transport'*. Some community focus group participants (community Elders) were also keen to advocate for and promote awareness of the OW role. *'We don't think many people know what she can do, so we really need to advertise more what [she] is doing'.* There is no OW allocation in the AHS in Tamworth.

In the Port Augusta site, the IHPO has been employed since June 2010, and the DGP based OW since June 2011 (Figure 21.6). They have been keen to identify implementation problems and test solutions to establish patient referral pathways at private General Practices. A process has been established for providing patient transport and having the OW involved in GP consultations. Community education and support is a major part of the IHPO and OW roles and the team has used innovative approaches to engage people in the ICDP. The team has expressed concern about the limited capacity of local services to meet identified need for treatment and follow-up services, should an increase in health assessments and chronic disease diagnoses be achieved. It is evident that strong community links and adequate support structures are in place to enable the ICDP C Measure workforce to work effectively. An important resource is strong links with other health staff and supportive leadership, training and mentoring provided through the DGP.

In the Bairnsdale site, the IHPO and OW based with the DGP and the OW based in the AHS have been employed since December 2011 (Figure 21.5), however the IHPO resigned in April 2012. The IHPO has been raising community awareness about the ICDP and working with General Practices to improve Aboriginal identification and cultural safety. The current focus of the role of the OW based at the DGP is providing and collating information about ICDP implementation and liaising with stakeholders. The OW is trained in supporting chronic disease self management, undertook a clinical placement at the AHS, and is doing a Certificate III course in Aboriginal and Torres Strait Islander Health. There is possibly scope for the OW's work at the DGP to be more oriented towards patient and practice support, such as transport assistance. The OW in the AHS is mainly providing patient transport and is also undertaking Aboriginal and Torres Strait Islander Health Worker training

In summary, workforce support and training, including access to orientation training of the ICDP workforce, varies across the three regional sites. Interpretation of OW roles also varies, however in general OWs and IHPOs are well supported in their roles and appear to work closely with community members, pharmacies (as discussed under the B measures heading) and Health Services in regional sites. Community size is an enabling factor in fostering these connections, as is positive support and leadership from divisional staff.

SUMMARY AND CONCLUSIONS

The three regional case study sites of Tamworth, Bairnsdale and Port Augusta provide a useful study of the factors that enable and challenge the implementation of the ICDP.

Throughout the period of ICDP implementation, each of the regional case study sites has experienced difficulties in recruitment and retention of Health Services staff. Recruiting to the Tackling Smoking and Healthy Lifestyle teams (where allocated) has been a particular challenge and reflects a skills shortage in health promotion. A limited number of suitably skilled workers is not only a barrier to recruitment but, in some cases, impacts on the implementation of other ICDP measures. Changes in leadership or governance arrangements of AHSs have also delayed recruitment to positions.

Capacity to deliver health promotion measures have thus not been as robust in the regional case study sites as intended. Lack of staff has also limited the integration of measures and the synergy to be achieved when complementary strategies are in place. Nevertheless, it is evident that staff employed to deliver the B and C measures are working together effectively. More timely delivery of role orientation and cross-sector training opportunities for clinical staff could improve training reach, and have the potential to enhance service links.

A factor that appears to enhance the pace of ICDP implementation and the success of strategies in regional sites is the community knowledge and established relationships local people tend to bring to the ICDP funded positions. Having Aboriginal and Torres Strait Islander family connections and/or being well respected in the Aboriginal and Torres Strait Islander community clearly adds value to roles.

In regional centres, there is a contained network of key health service providers compared with metropolitan areas, and generally less transience of health professionals and managers compared with remote areas. People usually live and work locally (whereas in urban sites both health workers and clients tend to be more dispersed). As one ICDP worker noted, '*everyone in the community knows everyone*'. While the observation referred to the town's Aboriginal and Torres Strait Islander community, it is evident that strong networks across regional communities enhance the communication and facilitate the links on which well coordinated implementation of a program such as the ICDP depends. The workforce is accessible to community members and service providers. Staff in Health Services and pharmacies are more accessible for the ICDP workforce to provision of information, training and support. The links between the DGP and the AHS are able to be established in more seamless ways, particularly when workers move between these employing organisations and know the working environments, program and staff in each workplace.

Close community connections may contribute to a significant proportion of Aboriginal and Torres Strait Islander people choosing to access private General Practices in regional settings, where they feel privacy and confidentiality are protected. The long wait times for GP appointments that characterise the Tamworth and Bairnsdale sites have potential to impact on timely access to health care and health outcomes. Affordability is a further important factor in improving access to services for Aboriginal and Torres Strait Islander patients in these regional sites - not only to improve access to medication, but to specialist services and to patient transport that supports attendance at services. This includes access to PBS Co-payments for those usually covered by S100, who travel to these ruralities to access additional health care. The financial burden of travelling to other centres and capitals for specialised care is a significant factor in regional sites.

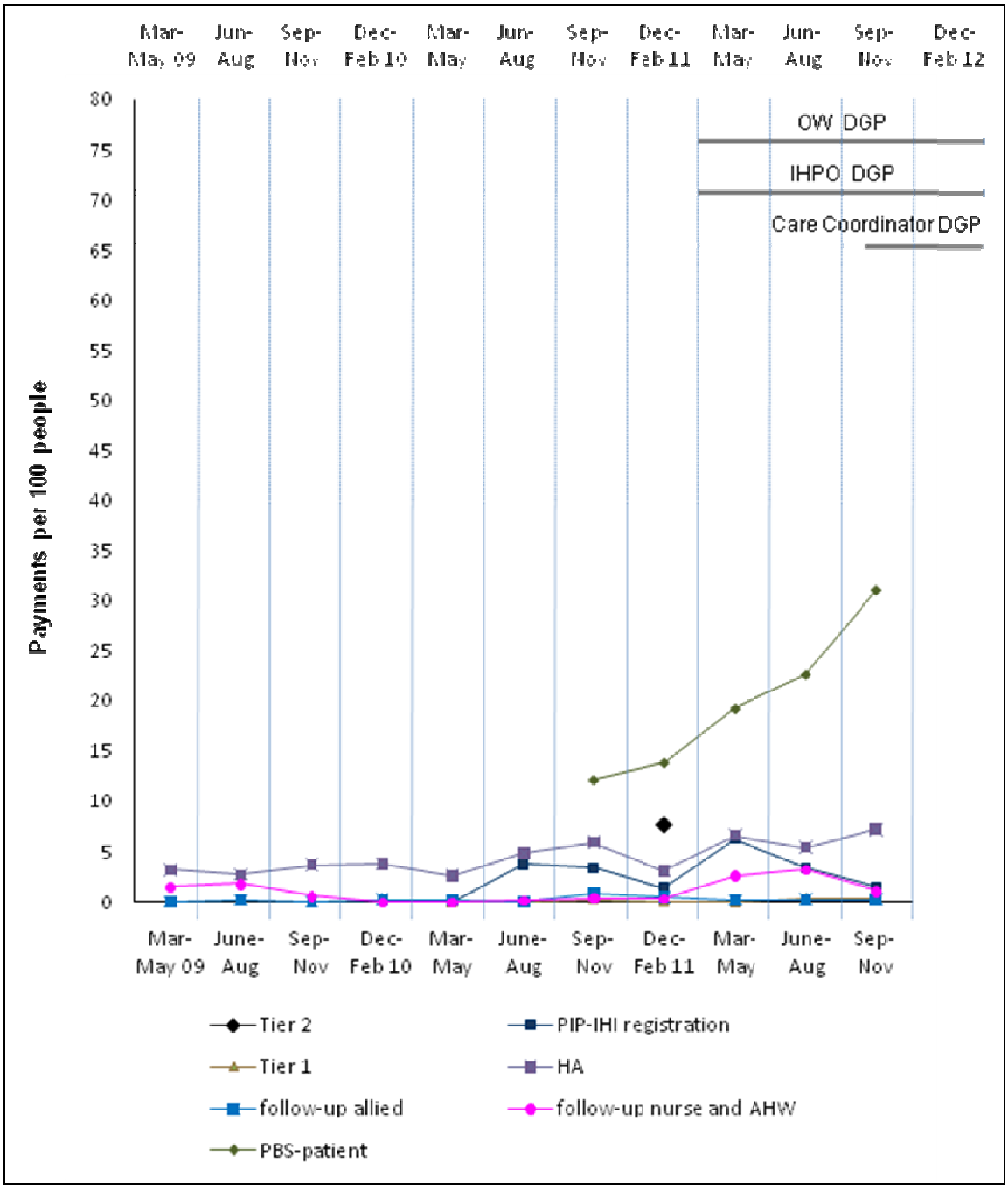


Figure 21.4: ICDP funded positions, service developments and trends in administrative data, Tamworth, March 2009 - February 2012.

Note: See Box 1 for further explanation.

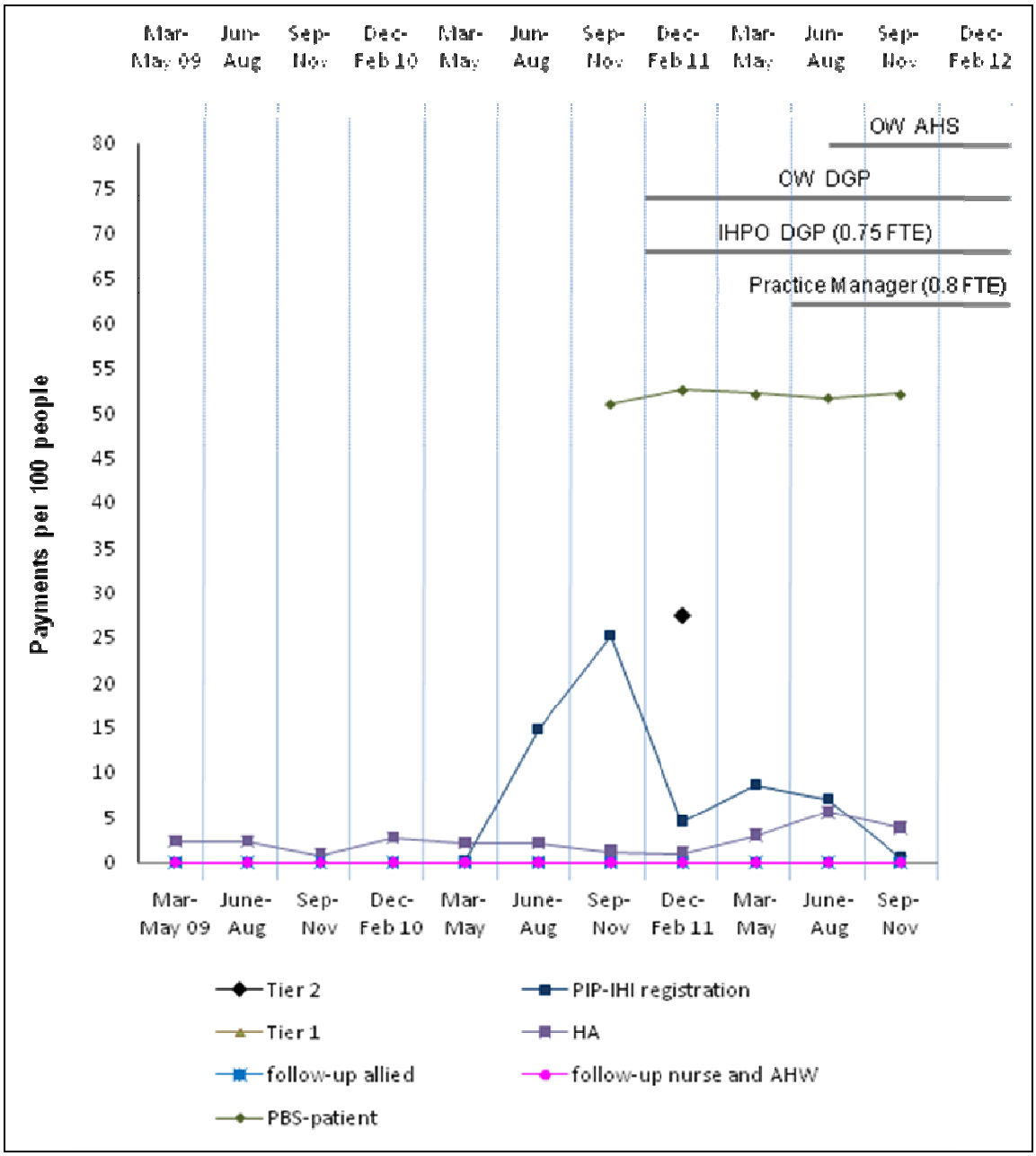


Figure 21.5: ICDP funded positions, service developments and trends in administrative data, Bairnsdale, March 2009 - February 2012.

Note: See Box 1 for further explanation.

The practice manager is funded as ICDP additional health staff.

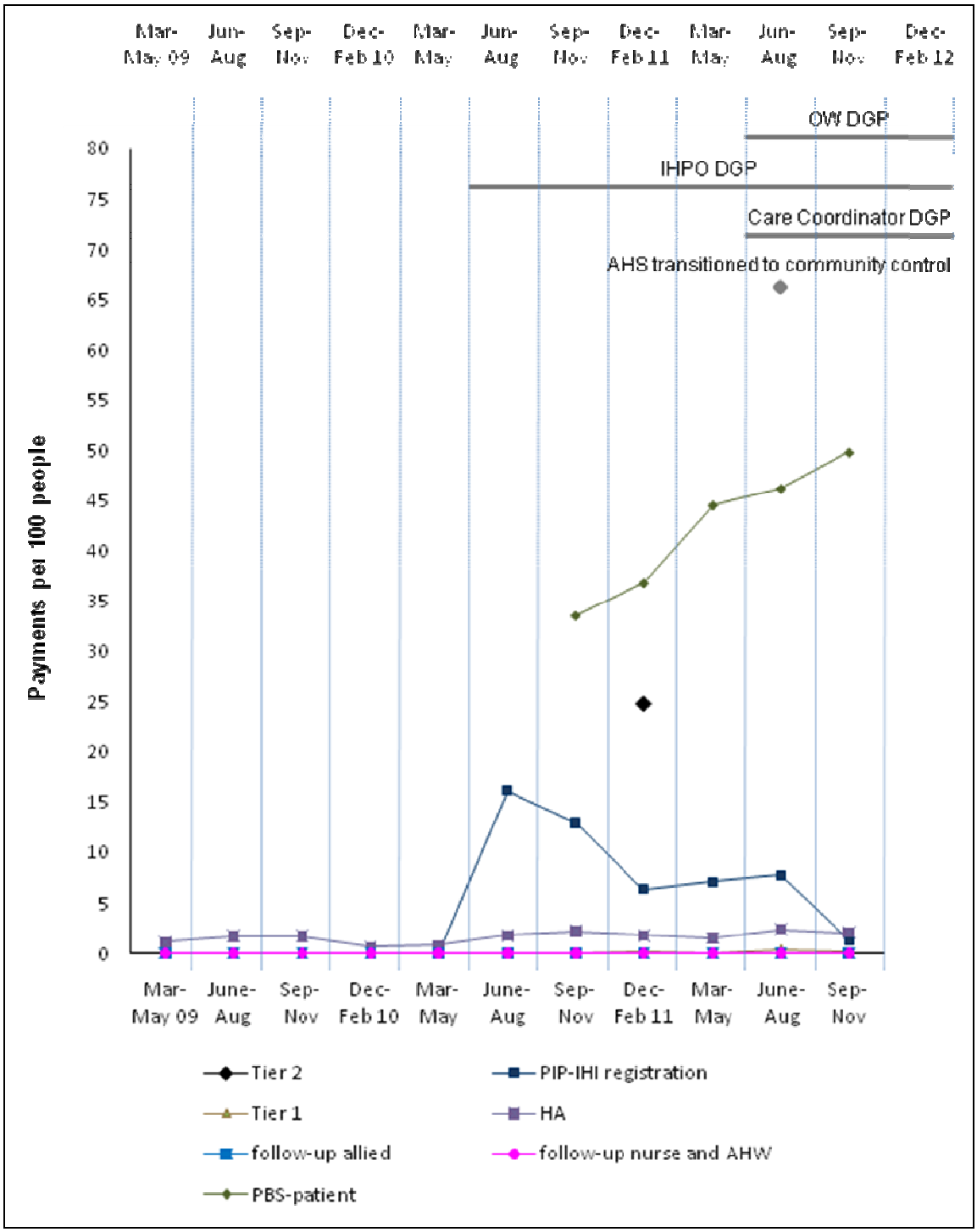


Figure 21.6: ICDP funded positions, service developments and trends in administrative data, Port Augusta, March 2009 - February 2012.

Note: See Box 1 for further explanation.

21.3. Implementation of ICDP in remote case study sites: East Pilbara and Katherine West

The SSE covers four remote sites. Two are case study sites - East Pilbara and Katherine West. Both sites are characterised by vast distances and widely dispersed populations of Aboriginal and Torres Strait Islander people living mostly in small communities.

The East Pilbara site covers an area of approximately 371 600 km^2 in northern Western Australia. Aboriginal and Torres Strait Islander people make up almost 22% of the total site population of about 6500. Approximately 5000 people live in the mining town of Newman, with several communities accounting for most of the remaining site population, including the majority of the Aboriginal population. The largest of the Aboriginal communities, with approximately 300 residents, is Jigalong, 165 kms from Newman.

In the 162 000 km^2 site of Katherine West in the Northern Territory, 76% of the 2800 residents are Aboriginal and Torres Strait Islander. The largest community in Katherine West is Lajamanu, 560 km south west of the regional hub town of Katherine. With up to 1000 residents, Lajamanu is significantly larger than other communities within the site.

Aboriginal community populations can fluctuate across the two sites due to factors such as ceremonial activity and seasonal changes (roads closures can last for months in the wet season). Traditional culture is strong in both sites. At least fourteen Aboriginal languages are currently used in the Katherine West region and a similar number in the East Pilbara region. English is a third or fourth language for many Aboriginal residents of both sites. English literacy levels tend to reflect this, together with factors such as limited access to education services compared with urban and regional sites.

Comparison of the SEIFA for the two sites reveals a significantly higher SEIFA average in East Pilbara (936), than in Katherine West (543). An important difference between the two sites is that the East Pilbara site includes the mining service town of Newman, whereas the regional service town of Katherine lies outside the Katherine West site boundaries. There is thus no significant economic centre within the Katherine West site, and this is likely to be an important factor in the differences between the average SEIFA for the two sites.

In relation to health service delivery models, there are important similarities in these two remote sites. Both sites host one AHS that is responsible for providing services over a vast area. In East Pilbara, the Puntukurnu Aboriginal Medical Service, administered from Newman, delivers health services to the community of Jigalong and to three outlying clinics in Parnngurr (375 kms north east by unsealed road and track from Newman), Punmu (680 kms north from Newman) and, further to the north east along the Canning Stock Route, Kunawarritji. In Katherine West, the Katherine West Health Board Aboriginal Corporation, administered from the town of Katherine, operates seven health centres in the communities of Bulla, Kalkarindji & Daguragu, Lajamanu, Mialuni, Pigeon Hole, Timber Creek and Yarralin, and a mobile health team that travels to outstations and cattle properties. Pharmaceuticals are supplied under S100 arrangements in both sites. Both sites have one public hospital within or relatively near the site, with the relevant DGP based elsewhere (in Darwin, in the case of Katherine, and in Karratha, in the case of East Pilbara). While the East Pilbara site includes one General Practice in the town of Newman, Katherine West has no private General Practice within the site boundary.

CHRONIC DISEASE RISK FACTORS: A MEASURES

Tackling Smoking (Measure A1) and Healthy Lifestyle Promotion (Measure A2)

Katherine West site has funding allocated for one Regional Tobacco Coordinator (RTC), one full-time Tobacco Action Worker (TAW), and two full-time Healthy Lifestyle Workers (HLWs).

The RTC, based in Katherine, has been in the role since late August 2011. Limited opportunities to attend training have been partly compensated by strong RTC networking within the NT, and support within the AHS to build the necessary relationships and trust. *'It's unrealistic to think a new non-Aboriginal person [the RTC] will be able to make much of a difference unless she works closely with our Health Promotion Officers who have established credibility … the key to it all is people working collaboratively'* (Interviewee, AHS). In addition, a consultant is helping the RTC to develop an action plan, drawing on relevant guidelines. This includes *'a number of resources such as [AHS] strategic plan, the NT Department of Health Tobacco Strategy and the National Smoking plan. [They are] going to be incorporated into the regional action plan as well as the individual training plan.'* (Interviewee, AHS).

The TAW position, to service Lajamanu, has not been filled to date and the two HLW positions remain vacant. The ICDP funded 'Red Dust Role models' healthy communities program recently visited Lajamanu. An AHS nutritionist, mascots and a music team worked with school students to produce posters, write and record a song and develop a video to promote healthy eating. School and community sporting sessions were also held during the visit. A focus group participant indicated that the team had '*engaged the kids really well and the kids really liked them'.* A return tour to Lajamanu is planned for the 'Get Active, Eat Good Tucker and Live Longer' Program.

Evaluation visits to East Pilbara in late 2011 indicated that nearly all Tackling Smoking and Healthy Lifestyle allocated positions - one full-time RTC, two full-time TAWs, and two full-time HLWs - had been vacated. More recent evaluation visits reported that funding allocations for all positions have since been utilised.

Recruitment and support issues – site approaches

The geographical remoteness of the largest community in the Katherine West site, and its infrastructure in terms of availability of accommodation, together with the more traditional cultural backgrounds of local residents have made recruitment of community based suitably qualified, skilled and experienced Tackling Smoking and Healthy Lifestyle workers difficult from the outset of ICDP implementation.

Lack of local accommodation and the importance of having locally based workers has restricted selection to local residents and resulted in modified selection criteria in order to fill positions. *'The only criteria [for these positions] was finding someone who didn't smoke. [We] must simplify the job description … '* Experience has highlighted that modification of selection criteria will contribute to additional training and support needs, and present further challenges in practice, and that community based colleagues have limited capacity to provide this input *'Capacity is always an issue in a remote setting, as well as local supervision of staff in newly created positions'* (Interviewee AHS). The RTC will need to provide support and professional development (including mentoring) from Katherine, 560 kms away - a complex scenario, especially if numeracy and literacy support are needed. A particular strength within the site is that the AHS has an active Aboriginal Reference Group that guides the cultural safety of the organisation and suggests suitable approaches with target groups. In terms of this measure, *'the suggestion from them [to address ongoing workforce*

issues] is … to get into schools and do a lot of education before [children] take up smoking … addressing it through health literacy at that grass roots community level' (Interviewee, AHS). The National Tobacco Action Coordinator, Tom Calma, is currently involved in the AHS's planning to help develop a sustainable solution to these ongoing workforce issues in Katherine West.

East Pilbara also experiences the recruitment challenges that are associated with remoteness, shortages of local accommodation and sourcing a local workforce with the capacity to develop the necessary skills. The AHS responded to its workforce retention problem by reconfiguring positions to implement community-based tobacco and healthy lifestyle generalist worker functions. Funding for one TAW and two HLWs has been combined and the respective roles allocated part time to create three health promotion workers residing in Jigalong, Punmu and Newman (respectively) and serving Parnngurr and Kunawarritji. The Newman based position has been split and another funding source used to enable a full-time male and female worker to be employed to deliver gender specific services. The RTC, based in Newman, supports the delivery of A Measures through collaborative work and information sharing. The other TAW funded through the AHS is based in Port Hedland and does not service the site. The site has structured ICDP funded positions in this way in order to maximise appropriateness, reach and benefit to the dispersed communities it serves across an area of approximately 90 000 square kilometres. In this respect, the local service delivery model reflects the community centred approaches upon which the service is based. The availability of accommodation in communities enabled the appointment of applicants from outside the communities - a significant factor enabling recruitment of suitably qualified candidates.

The high incidence of smoking that has impacted on recruitment in both of these remote sites is locally acknowledged as a particular challenge. It has hindered recruitment of TAWS and HLWs in remote areas. Smoking, and chewing tobacco, is part of a complex system of social interaction, with tobacco use often determined by who buys, distributes and barters cigarettes. In this context, locally informed strategies and community endorsement of approaches will be crucial to successful implementation of Tackling Smoking and Healthy Lifestyle measures.

Combining the roles of the Tackling Smoking, Healthy Lifestyle, and Outreach Workers into common health promotion/support roles across a site has the potential to enhance team-work and create a stronger team presence. In practice, it appears to have been difficult to provide the East Pilbara team with clarity regarding roles and prioritisation of duties. *'… feels like we just sink or swim … I've basically come into the position and learning everything myself'* (Interviewee, ICDP worker). Effective communication across long distances and sharing of information about ICDP resources also appears to have been challenging. *'I have not [yet] seen the toolkits'* (Interviewee, ICDP worker). ICDP orientation and training has yet to be delivered to East Pilbara workers.

While it is too early to determine the impact of the East Pilbara TAW/HLW positions on practitioner awareness of the resources available, there are, nevertheless, reports of positive indicators of increasing community resources and participation. *'We are still in start-up phase, however, plenty of ground work is under way. Walking groups and cooking groups have started, healthy lunches are now being provided, and movie nights with healthy food which are all well attended.'* (Interviewee, AHS). However, community focus group participants in Parnpajinya and Jigalong were not aware of the activities. Some people had seen healthy lifestyle and smoking cessation materials, but commented that they were not designed for Aboriginal people.

In the NT, a similar combined-role approach to service delivery is favoured by the state-based organisation. *'OWs, HLWs, TAWs they are all similar roles. I would like to see the workforce a little more generic with specialisation in certain areas.'*

In both sites, there are community controlled structures that have a strategic role and provide another level of decision making in determining health service priorities and delivery in remote sites. There appear to be differences in the way the two remote site AHSs approach governance, and these differences impact on recruitment to community based positions. KWHB's management structure and decision-making processes reflect grass roots community engagement and control. The governing board represents all seven communities in the site, has an elected all-Aboriginal membership and drives decision making about how programs, including the ICDP, are locally implemented – including staff selection. While it appears the AHS in Katherine West may be slower to fill community-based ICDP positions than the AHS in the East Pilbara site, a commitment to employing and strengthening the capacity of local people in local positions is likely to be influencing selection decisions. It is aimed towards increasing community capacity and sustaining program benefits in the longer term. Longer implementation timeframes in Katherine are accepted as necessary to achieve genuine community engagement. *'In remote areas, you need to allow at least double the time for program implementation'* (Interviewee, AHS).

A Measure implementation – enablers and challenges in the two remote sites

In summary, identified enablers for implementation of A Measures in remote sites are:

- scope to reconfigure positions as needed to support delivery across site locations
- flexibility to adapt selection criteria to enable targeting of local workers (thereby increasing recruitment and retention prospects)
- flexible modes of training delivery (refer to C Measures)
- employment of workers with adequate English literacy levels
- capacity to provide effective mentoring and support for entry level workers, including literacy and numeracy support
- existing health promotion programs and resources in the site, and collaborative and complementary approaches
- strong foundation of health promotion strategies and policies at the regional and/or state level

Key challenges for implementation of A Measures identified in both remote sites include:

- workforce recruitment and retention issues, including availability of accommodation. Recruitment of local people may not necessarily solve accommodation issues, because of long distances between site communities and eligibility to public/community housing.
- lack of access to role orientation
- constraints on capacity of managers to supervise and support staff in outlying communities, particularly when workers have combined health promotion and clinic support roles
- developing clear job descriptions that reflect combined functions and developing communication and work plans that support implementation

- limited capacity to provide/undertake ongoing training and support, including literacy support. *'They have struggled with information as English is second language'* (Interviewee, SBO). Not attending training courses inhibits opportunities for information and resource sharing, collaboration and networking between ICDP workers (refer to C Measures).

- team members dispersed over a wide area

- distances and travel involved in accessing training and implementing measures across sites. Travel particularly affects those with family responsibilities, cultural obligations and/or personal health issues

- acute care priorities and workforce pressures that take precedence over health promotion.

CHRONIC DISEASE MANAGEMENT AND FOLLOW-UP CARE: B MEASURES

PBS Co-payments (Measures B1) and PIP Indigenous Health Incentive (Measure B3 Part A)

Patients in Katherine West and East Pilbara sites are eligible to receive free medication under S100 arrangements. As a result, improved access to medicines through the PBS Co-payments measure is most relevant when site residents travel into towns and areas where they cannot access free (S100) medications. There is a perception in the East Pilbara site that neither PBS Co-payment scripts nor S100 arrangements adequately address the population transience associated with cultural practices, family responsibilities and the need to leave remote locations to access particular facilities and services, including health care.

A number of Aboriginal residents access the Newman hospital's accident and emergency department for GP consultations. GPs from the private General Practice in Newman also work in the hospital department.

The private General Practice in Newman (the only private General Practice within the site) has put effort into improving access for Aboriginal clients and accessing ICDP funded benefits for Aboriginal patients, with positive outcomes. 'Since September/October last year there has been over 100 patients registered' (Interviewee, private General Practice). Cultural awareness training has been accessed by all staff and the practice has introduced bulk billing. This represents a shift in direction for the practice. Focus group participants in the Parnpajinya community on the outskirts of Newman spoke about the practice not previously having a welcoming and culturally safe environment for Aboriginal people. These efforts also represent an important development in the site, as the AHS does not provide clinical services in Newman. Some focus group participants indicated that they regularly travel 165 kms from Newman to Jigalong to seek treatment at the Jigalong Clinic, pointing out that there are no public transport services linking Parnpajinya community to Newman or to Jigalong. A staff member at the GP considers all Aboriginal patients and their children to be eligible for PBS Co-payment scripts because '*all are at risk of a chronic disease … and [access to medicine] impacts upon the whole family*'. Ongoing confusion among patients about PBS Co-payments has been observed. '*Some Aboriginal patients think that the CtG means the whole GP service is free, they do not fully understand the chronic disease focus. More information/marketing is required to explain what exactly the CtG is aiming to provide'*.

In the East Pilbara site, the number of adult health assessments peaked at thirteen per 100 people during the March 2011 - May 2011 quarter, dropping to three patients per 100 people in the September 2011 – November 2011 quarter, a number more consistent with records for earlier

quarters (Figure 21.7). Interviewees indicated that the spike was due to a visiting nurse at the AHS being dedicated to doing adult health assessments during this quarter. This finding is consistent with the average number of health assessments per GP at the site, which peaked at 32 during the same quarter- the highest number of any Sentinel Site over the period of the evaluation, regardless of rurality. Registrations for the PIP Indigenous Health Incentive in East Pilbara peaked in the following quarter, at 10 per 100 people (Figure 21.7). The percentage of re-registrations by November 2011 was high in East Pilbara compared to the rest of remote Australia – about 44% compared with about 28% in the rest of remote Australia.

In the Katherine West site, there were no PIP Indigenous Health Incentive registrations during this, or previous reporting periods. The highest number of adult health assessments was recorded in the September 2010 - November 2010 quarter with 4.5 assessments per 100 people. There is no clear trend in the number of health assessments over the duration of the evaluation (Figure 21.8). Interviewees suggested fluctuating figures reflect seasonal influences and staff constraints, including high staff turnover and use of locum staff (who are not always trained in using PIRS and Medicare systems).

Administrative burden and limited staff capacity

During the previous evaluation cycle it was reported that, while routine adult health checks were completed, the AHS had not registered patients for the PIP Indigenous Health Incentive because the administrative burden, relative to high workloads experienced as routine in these remote clinics, was perceived to be too onerous. While more than 300 PIP Indigenous Health Incentive registration forms had been generated on behalf of eligible patients and sent to clinics, none had been returned for a variety of reasons. These include staff turnover and the loss of an entire set of signed forms from one community. Identifying those who are eligible has not caused difficulty; however, some patients are confused when asked to sign consent to receive a service that they believe they have been receiving for some time. The AHS reports that almost 70% of adult Lajamanu patients with a chronic disease have care plans in place without PIP Indigenous Health Incentive registration, and follow up services are reported to work effectively. This suggests that the service could readily meet eligibility criteria to receive tiered payments providing administrative processes can be completed. Managers were, until recently, unaware of the ICDP Tier 1 and Tier 2 payment arrangements. In March 2012 patients were still not registered for the PIP Indigenous Health Incentive. However, it is anticipated that a recent re-issuing of forms (undertaken by medical students on rural placements), will result in a better registration rates, but this does not appear to be a sustainable solution. Staff are reminded about the forms in weekly telephone conferences between the AHS and clinics and a priority of the recently recruited Care Coordinator will be to review care and general practice management plans, and sign up patients. Having a dedicated Medicare officer at the AHS is also expected to assist ICDP-related administration and processes.

Care Coordination and Supplementary Services (Measures B3 Part B) and Self-management of Chronic Disease (Measure B4)

The recent recruitment of the Care Coordinator is a significant development within the Katherine West site. (This worker commenced after February 2012, therefore not shown on Figure 21.8). It is anticipated that linkages with NT government services in Katherine will improve through the role. The Care Coordinator is promoting the role with health centres across the site and targeting care planning around service availability. Travelling with a doctor's bag of equipment enables on-site follow up of patients identified through the PIRS, thereby doing as much of the work as possible to streamline GP consultations.

An ICDP funded Care Coordinator is based at the Pilbara Health Network in Karratha and does not service the East Pilbara site. Interviewees have referred to care coordination and there is good support for the notion of one person coordinating referrals and overseeing the 'patient journey'.

Contracts for Coordinated Care and Supplementary Services (CCSS) were signed in January 2012 and in Katherine West, as in East Pilbara, staff are aware of the considerable funds and limited time frame available. *'We've got five months to spend twelve months worth of funds'* (Interviewee, AHS). In East Pilbara it also appears that supplementary services funds have been under-utilised, with under-spending attributed to visits by service providers (instead of patient travel to service centres) and the availability of the Patient Assisted Transport Scheme (PATS), 'Royalties for Regions' (a state government initiative), and dedicated Aboriginal organisation funding for health activities. Use of SS funding for patient escorts would be supported in Katherine West as PATS funding does not cover this cost; travel from Lajamanu to Katherine for specialist treatment involves a long journey and several days away with associated expenses for accompanying family members.

Constraints linked to clinical staff recruitment and workloads in Katherine West

Inability to appoint a Chronic Disease Nurse (due to accommodation shortage) continues to impact on the work of other staff in the Katherine West site. *'When we had the CD Nurse there was less [acute] work.*' As expected, recruitment and retention of clinical staff continues to be a major issue in Katherine West, with the follow on challenge of continually providing new and locum staff with orientation to the demands of remote area work, the use of the PIRS (Communicare) and the Medicare billing system. Confusion about the relationship between ICDP measures and other previously existing and ongoing services is understandable.

Remote area nurses are not necessarily trained or orientated towards chronic disease management '*We recruit nurses based on if they can bag, mask and cannulate and this is therefore where they feel more comfortable'*. Providing acute care takes priority. '*If [patients] are not screaming, bleeding or have pus they don't get [care]'* (Interviewee, AHS). Understanding of chronic diseases across the population can challenge staff assumptions about eligibility criteria for accessing ICDP funded services. '*That chronic care is not just old [people is] something to get through, [that] a 22 year old with diabetes and a 12 year old with rheumatic heart disease have chronic conditions'* (Interviewee, AHS). Staff stability is considered fundamental to reorienting the service towards chronic disease management. *'If all you have is a dedicated CD Nurse you've at least got that. [We] need to look longer than a three month model of employment'* (Interviewee, AHS). Focus group participants in Lajamanu talked about high staff turnover, including regular periods with no GP *'… there are times when there is no doctor and it is very hard, at the moment there is no doctor'*. They also described how older people with chronic disease are 'fast tracked' by the liaison officer when they arrive at the health centre for appointments, and how the OW and liaison officer *'work hard to reach elderly or young people that won't get themselves to clinic - especially men and boys'*. Patients described how nurses offer health checks 'on the spot' if they go to the clinic to collect medication and computer records indicate that health checks are due.

MSOAP-ICD (Measure B5 Part B)

Although bringing specialist services into communities is a priority, capacity to support visiting specialists in health centres continues to present a challenge, as does handover and use of local clinical information systems by visiting specialists. *'If they don't enter information into Communicare it's at least a week before they send a letter back to us and more if you factor in administration time, so there are delays in finding out what the patients need'* (Interviewee, AHS). In remote sites, despite good planning processes, it was perceived that the types of services received were more determined

by specialist availability than by need. Some staff are keen to discuss alternative delivery models. *'I would like to see DoHA work to create hubs at the health service delivery level to support allied health workers. I'm not sure if the current service delivery model meets the needs of local areas … a very consultative process was undertaken by SONT [workforce agency in NT] but it then came down to [which specialists and allied health providers] were available*'. The challenge of providing specialist services is further complicated by the requirements for meeting the service provider criteria.

In relation to self-management of Chronic Disease (Measure B4), there are notably different responses within the two sites. The AHS was involved in an original trial of self-management training and determined that the approach was not appropriate as it was text heavy, required a high level of client health literacy and assumed the availability of a range of problem solving options for patients. East Pilbara, however, are proactively implementing the model. A staff member at the AHS is an accredited trainer using the Flinders University model; she has trained 300 staff in the wider region including the AHS program manager and Chronic Disease Nurse. Nevertheless, it is anticipated that implementation will be slow because *'…there are huge numbers of people out there that require self-management plans and one person to do them is not enough, as usual'* (Interviewee, AHS).

WORKFORCE EXPANSION AND SUPPORT: C MEASURES

Support and training (Measure C1), Outreach worker in AHS (Measure C2)

The AHS OW in East Pilbara (Figure 21.7) found orientation training in Perth [provided by WAGP Network and the Aboriginal Health Council of WA (AHCWA)], to be informative and confidence building. An ongoing individual training plan has yet to be developed with this recently appointed worker.

As indicated in (Figure 21.8), the AHS based OW position allocation in Katherine West has been divided into two part-time positions to enable the employment of a male and female worker to provide the gender specific services required in this setting. One part-time position was vacant at the time of the evaluation visit. The OW employed in the other part-time position (at Lajamanu) has not attended orientation training. It is felt that training should be delivered in the workplace where it can be more relevant and tailored, and where lack of literacy and capacity to travel can be taken into account. On-site OW support has been intermittent in Katherine West as the Chronic Disease Nurse supervisor travelled in the role, was not qualified to provide literacy training and was often called upon to provide acute care. She recently took up a different position in the community, and the vacated Chronic Disease Nurse position cannot be filled due to lack of accommodation. OW cultural obligations result in frequent non-attendance at work. Cultural security and patient transport are important aspects of the OW role in the Lajamanu clinic. In East Pilbara, an interviewee estimated that 80% of patients now follow through with GP appointments, and 60% follow through with medication compliance. It is believed the OW is *'gaining ground with the people who really need to be listening and attending appointments'*.

Outreach Worker & Indigenous Health Project Officer in DGP (Measure C3)

The Pilbara Health Network (DGP), where one OW is located, is located off-site in Karratha, therefore the OW does not resource services and clients within the East Pilbara site. In this neighbouring region the DGP-based OW has considerably increased patient access to GPs, and the C3 measure is highly valued by colleagues at the Division. *'We could do with six Outreach Workers ... it definitely is a good program'*. The Perth-based orientation training available to OWs based in northern Western Australia was valued for its networking and colleague support benefits. *'[They] really learnt a great deal ... ongoing support is [also] important … sitting in an isolated position and*

the only person in that role ... it is really important to network with other OWs ... so that you can share experiences' (Interviewee, DGP).

Staff in both remote sites consider the primary IHPO role is to support the OWs and other ICDP workers. A focus of work for the IHPO based at the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) in Darwin (with responsibility for Katherine West), has been contributing to training other ICDP workers, including *'a role in developing an orientation package and individualised training pathways for the NT'*. Limited travel funds have restricted the capacity of the IHPO to support KWHB with ICDP implementation.

SUMMARY AND CONCLUSIONS

The two sites are very similar in terms of small total site populations (relative to urban and most regional sites), vast distances, remoteness and health service delivery models. An overview of ICDP implementation in the two remote case study sites reveals common interdependent challenges related to high workload and acute care demands, and workforce recruitment and retention across ICDP measures. Lack of local qualified, skilled workers and lack of accommodation hinders recruitment and service delivery; poor capacity to deliver local orientation, training and support impact negatively on workforce capability and retention. The AHS's recent success in recruiting to ICDP positions can be attributed to a key factor - availability of accommodation, which has enabled recruitment of workers from elsewhere into East Pilbara communities.

The two sites demonstrate common enablers – health services that are resourceful, know their policy and management environments well and are able to adapt employment and service delivery strategies to suit complex health and culturally based needs within the local context.

KWHB has been slow to fill community based ICDP positions. Commitment to community engagement and governance, and to the employment and development of local people, is foremost. A shortage of accommodation in communities hinders recruitment to ICDP funded (and other health) positions. Existing procedures and health promotion programs provide a sound basis for the implementation and continuity of culturally appropriate activities and services.

PAMS in East Pilbara is delivered through a more conventional health service management structure than the KWHB service; it provides another example of ICDP implementation in a remote setting. East Pilbara communities do not appear to have the accommodation problems experienced in the communities served by KWHB. PAMS is rising to the challenge of implementing the ICDP in this remote site, finding workable, creative local solutions to the problems presented in this complex service delivery environment (such as recruitment issues and the need to deliver strategies across isolated communities). Examples are the reconfiguring of community based ICDP generalist workers to provide a continuous presence in small, dispersed communities, and the bringing in of a short term workforce to progress the implementation of A and C Measures.

The private General Practice in the East Pilbara site is putting some effort into implementing the ICDP, and is improving access and benefits for Aboriginal and Torres Strait Islander patients living in Newman and Parnpajinya (on the outskirts of Newman).

ICDP implementation has been slower, overall, in remote areas than in urban and regional sites. The evaluation shows that remote area services are resilient and solution-oriented in their efforts to provide Aboriginal and Torres Strait islander clients with culturally appropriate chronic disease prevention and management services. They are able to adjust service delivery models to meet the challenges and needs of local environments and populations. There appear to be a number of

systems gaps that constrain the ability of services to strengthen the prevention and management of chronic diseases in these remote sites. Improved systems are needed to minimise the administration burden on clinical staff, because clinical services are often under-staffed (e.g. to streamline PIP Indigenous Health Incentive registration and re-registration, to complete Medicare paperwork). Other areas where improved systems are needed are coordination of the use of electronic patient information systems by all involved in a patient's health care, including visiting specialists, and timely and effective orientation training of new and locum staff (including PIRS training as relevant). A systematic approach is also needed to identify the individual training and development needs of the remote workforce (especially entry level Aboriginal and Torres Strait Islander workers) and to find practical ways to resource and meet those needs. This is specialised work beyond the capacity and role of most health service staff/supervisors, and is key to expanding and supporting the chronic disease prevention and management services workforce in remote sites. Improvement of the systems that support services and staff is likely to contribute to improved workforce retention in remote areas.

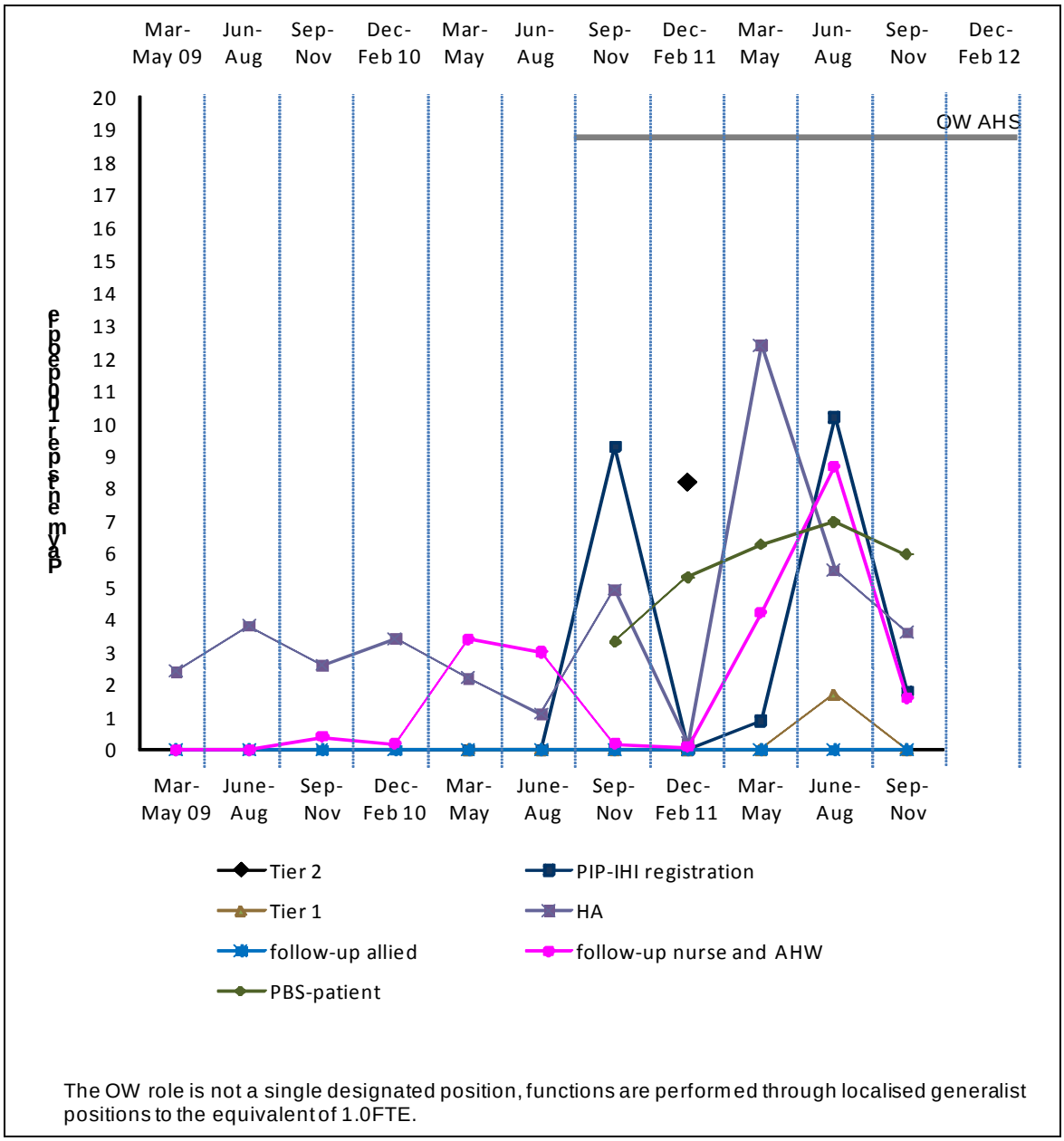


Figure 21.7: ICDP funded positions, service developments and trends in administrative data, East Pilbara, March 2009 – February 2012.

Note: See Box 1 for further explanation.

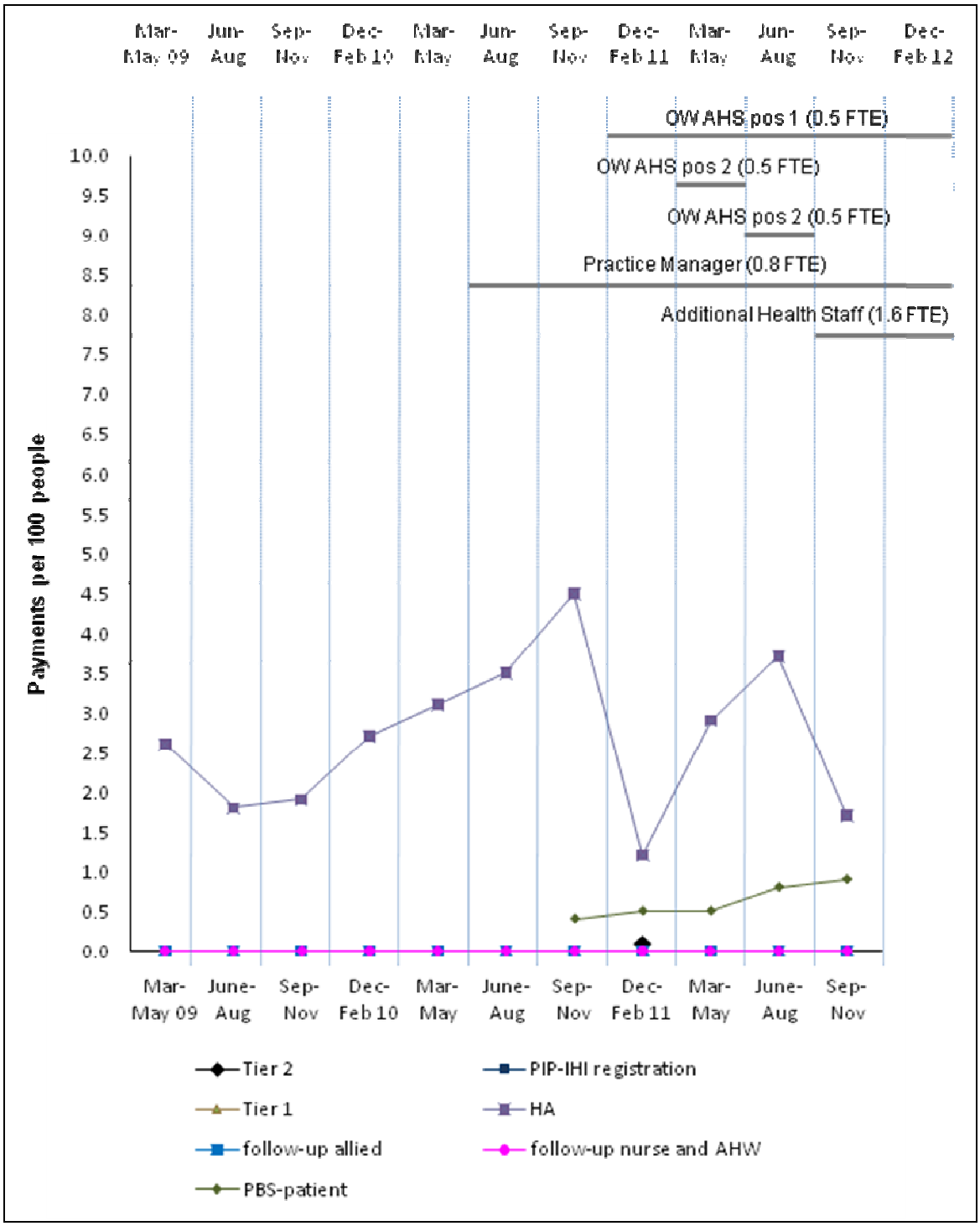


Figure 21.8 ICDP funded positions, service developments and trends in administrative data, Katherine West, March 2009 – February 2012.

Note: See Box 1 for further explanation.