Closing the Gap in Aboriginal Health Outcomes Initiative

Evaluation Progress Report

June 2012
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In this report, the word Aboriginal is used to include both Aboriginal and Torres Strait Islander peoples. The word Indigenous is retained where it is used in quoted material or in the formal name or document title.
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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisations</td>
</tr>
<tr>
<td>ACCO</td>
<td>Aboriginal Community Controlled Organisations</td>
</tr>
<tr>
<td>ACO</td>
<td>Australian College of Optometry</td>
</tr>
<tr>
<td>AEP</td>
<td>Aboriginal Employment Plan</td>
</tr>
<tr>
<td>AHLO</td>
<td>Aboriginal Hospital Liaison Officer</td>
</tr>
<tr>
<td>AHPACC</td>
<td>Aboriginal Health Promotion and Chronic Care</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AHLO</td>
<td>Aboriginal Hospital Liaison Officer</td>
</tr>
<tr>
<td>ALO</td>
<td>Aboriginal Liaison Officer</td>
</tr>
<tr>
<td>ASA</td>
<td>Aboriginal Service Area</td>
</tr>
<tr>
<td>BADAC</td>
<td>Ballarat and District Aboriginal Health Cooperative</td>
</tr>
<tr>
<td>BDAC</td>
<td>Bendigo and District Aboriginal Health Cooperative</td>
</tr>
<tr>
<td>BSW</td>
<td>Barwon South Western</td>
</tr>
<tr>
<td>CEITC</td>
<td>Centre for Excellence in Indigenous Tobacco Control</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CHG</td>
<td>Closing the Health Gap</td>
</tr>
<tr>
<td>CQI</td>
<td>Continuous Quality Improvement</td>
</tr>
<tr>
<td>DoHA</td>
<td>Commonwealth Department of Health and Ageing</td>
</tr>
<tr>
<td>ERH</td>
<td>Echuca Regional Hospital</td>
</tr>
<tr>
<td>EMR</td>
<td>Eastern Metropolitan Region</td>
</tr>
<tr>
<td>GEGAC</td>
<td>Gippsland and East Gippsland Aboriginal Co-operative</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPN</td>
<td>General Practice Networks</td>
</tr>
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<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<td>ICAP</td>
<td>Improving Care for Aboriginal and Torres Strait Islander Patients</td>
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<td>Individual Care Plans</td>
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<td>Koori Mental Health Liaison Officer</td>
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<tr>
<td>KRA</td>
<td>Key results areas</td>
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<td>LEAHA</td>
<td>Lakes Entrance Aboriginal Health Association</td>
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<td>LIN</td>
<td>Local Indigenous Network</td>
</tr>
<tr>
<td>LLEN</td>
<td>Local Learning and Employment Network</td>
</tr>
<tr>
<td>LMARG</td>
<td>Loddon Mallee Aboriginal Reference Group</td>
</tr>
<tr>
<td>LMR</td>
<td>Loddon Mallee Region</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MAC</td>
<td>Mildura Aboriginal Corporation</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>MVAC</td>
<td>Murray Valley Aboriginal Cooperative</td>
</tr>
<tr>
<td>NWMR</td>
<td>Northern and Western Metropolitan Region</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
</tr>
<tr>
<td>RAP</td>
<td>Reconciliation Action Plan</td>
</tr>
<tr>
<td>RDAC</td>
<td>Ramahyuck District Aboriginal Corporation</td>
</tr>
<tr>
<td>RTAC</td>
<td>Regional Tobacco Action Coordinator</td>
</tr>
<tr>
<td>SMR</td>
<td>Southern Metropolitan Region</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmissible Infection</td>
</tr>
<tr>
<td>TAW</td>
<td>Tobacco Action Worker</td>
</tr>
<tr>
<td>VACCA</td>
<td>Victorian Aboriginal Childcare Association</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>VACKH</td>
<td>Victorian Advisory Council on Koori Health</td>
</tr>
<tr>
<td>VACSAL</td>
<td>Victorian Aboriginal Community Services Association Ltd</td>
</tr>
<tr>
<td>VAED</td>
<td>Victorian Admitted Episodes Database</td>
</tr>
<tr>
<td>VEMD</td>
<td>Victorian Emergency Minimum Dataset</td>
</tr>
<tr>
<td>VIAF</td>
<td>Victorian Indigenous Affairs Framework</td>
</tr>
<tr>
<td>VPDC</td>
<td>Victorian Perinatal Data Collection</td>
</tr>
</tbody>
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Executive Summary

INTRODUCTION

Urbis has been commissioned by the Victorian Department of Health to undertake the evaluation of the Closing the Gap in Health Outcomes Initiative in Victoria (CtHG), over the three-year period, 2010-2013. The evaluation focuses on four key questions:

- how effectively the initiative has been implemented in Victoria
- the extent to which the targets have been achieved
- whether current projects represent the most appropriate, effective and efficient means for achieving these goals
- the extent to which a community driven approach has been adopted and effective in the regional implementation of the initiative.

The findings of the evaluation will be reported regularly throughout the three-year period, with a final report provided in January 2014.

THIS REPORT

This is the second Progress Report of the evaluation.

In the previous reporting period (to end of June 2011), we focused on the implementation of the CtHG initiative at regional and state-wide levels. We reported that, at that stage, there were early signs of change to health systems and processes which may over time be expected to lead to improved service access and delivery, and thereby have a positive impact on population-level health statistics over time. When we report again towards the end of 2012, there will be state-wide data to assess the extent to which population-level changes are beginning to emerge.

In the current reporting period (to end of December 2011), the focus has been on the continuing implementation of regional and state-wide activity.

FINDINGS

The state-wide activities have had an increasing focus on organisational change, or a whole-of-organisation approach, to addressing Aboriginal health. This shift away from individual actions (i.e. through specific staff positions) towards an organisational response aims to increase the sustainability of activities and outcomes achieved. Continuous quality improvement tools and resources to build and enhance the Aboriginal health workforce have also been developed to support sustainable changes in the provision of health care to Aboriginal people.

Significant progress was reported to have been made in increasing executive sponsorship in mainstream health services, the accessibility of smoking cessation support and eye health services to Aboriginal people, the supply of appropriately qualified Aboriginal health workers, and partnerships in service provision. By focusing on organisational change, state-wide activities also have an important role in facilitating the implementation of regional initiatives.

At the regional level, a particular focus of this evaluation phase has been on the extent to which the many projects being implemented across the regions are achieving enduring change to the health pathways and health systems relevant to the provision of Aboriginal health care.

In the last report, partnerships were identified as a key platform for achieving improved pathways and they continue to be in place or are strongly emerging in most regions. The most effective of these have the commitment of people in senior leadership roles from the community-controlled and mainstream health organisations. At this stage, partnerships continue to require this level of leadership, nurture and attention and in many cases, the support of a dedicated position focused on partnership development and
maintenance. It is not yet clear whether the partnerships will be firmly established enough within the life of the CtHG strategy to be self-sustaining, but those with the most senior level of sponsorship appear to be more likely to achieve this.

Governance arrangements have contributed to the opportunities for partnering, by bringing together key senior people in the health systems at a regional or sub-regional level. Where the governance structures have remained stable, a feature has been the continuing engagement (and attendance) by senior managers/CEOs of communality-controlled and mainstream services. Where a region-wide structure had proven not as effective, arrangements have changed to a local area or more place-based approach. In large regions this is a rational approach, as the services and stakeholders in a sub-region are best placed to initiate changes to local systems.

The risks associated with the devolved implementation of the CtHG initiative remain, but at a reduced level. Where governance structures are operating effectively, stronger accountability structures are also more likely to be in place, in regard to the progress of funded activity, management of delays, and general transparency of CtHG investment. The risks outlined in the previous evaluation report do remain in regard to accountability and reporting of progress against the regional plan, but attention to these risks is increasingly in place.

A burden on ACCHOs and ACCOs continued to be reported, particularly in regard to the provision of cultural competency or cultural safety training. Some regional plans have invested in this financially, whereas others have sought advice and prioritised it, without commensurate resourcing. Two issues arise for community-controlled services: the resources required to develop training, and the cost of delivering the training. Local ownership and leadership is critical to designing a course that conveys local knowledge and history. Nevertheless, some efficiencies may be achieved through a review of the range of approaches being taken, the resources required, the staging of the work, and the contingencies that CtHG regional groups can consider when nominating or investing in this priority.

In response to the limited outcome reporting available from regions leading into the previous Progress Report, a core set of outcome-focused indicators were selected from the evaluation framework, and promoted to regions as the central indicators for the current period. This has not, however, led to greater engagement in reporting against these measures. While conclusions can be drawn about the likelihood of a particular activity leading to improved outcomes, at this stage the evidence available to the evaluators is primarily qualitative. Overall, outcome evaluation is yet to be consistently prioritised and invested in across the state.

**NEXT STAGE OF REPORTING**

The Interim Evaluation Report (November 2012) will be prepared drawing on the state-wide and regional progress reports to the end of June 2012. Additional qualitative research will be undertaken to understand the value derived by community members engaging in activity and services funded through the CtHG initiative. A series of interviews will also be undertaken with people in professional roles, within the Department of Health, CtHG funded services, and other partners in the initiative.

At this stage, the evaluators suggest it will be the updated Regional Indicators Report that will be drawn on to determine population-level impacts, with the regional progress reports continuing to provide insight into the progress of implementation, rather than outcomes from the regional investment. A series of case studies, commencing in 2012 and followed up in 2013 will augment the available evidence of outcomes.

The approach to the next phase of the evaluation is detailed in section 5.
1 Introduction

Urbis was commissioned by the Victorian Department of Health to undertake the evaluation of the Closing the Gap in Health Outcomes initiative in Victoria, over the three-year period, 2010-2013. The evaluation focuses on four key questions:

- how effectively the initiative has been implemented in Victoria
- the extent to which the targets have been achieved
- whether current projects represent the most appropriate, effective and efficient means for achieving these goals
- the extent to which a community driven approach has been adopted and effective in the regional implementation of the initiative.

A baseline report was produced in May 2011, which presented baseline population health data provided by the Aboriginal Health Branch, Department of Health, and discussed the implementation of the initiative in each Victorian health region. The baseline report also included the evaluation framework that was produced to guide the evaluation. A first progress report was produced in October 2011, exploring ongoing progress against state-wide and regional targets.

This report is the second progress report of the evaluation, and reports on data provided by regions for the period July – December 2011.

The findings of the evaluation are reported regularly throughout the three-year period, with a final report provided in January 2014.

1.1 THE VICTORIAN APPROACH TO CLOSING THE HEALTH GAP

The Victorian initiative was developed in response to the national agreement signed by the Council of Australian Governments (COAG), which commits $1.57 billion to the Aboriginal Health National Partnership over four years to meet the goal of ‘halving the gap’ by 2030 by addressing five priority areas.

These five priority areas are:

1. **tackling smoking** to assist Aboriginal people to quit smoking and in turn reduce the burden of tobacco related disease in Aboriginal communities

2. **primary health care services** that can deliver to improve Aboriginal peoples’ experience and access to quality primary health care services

3. **fixing the gaps and improving the patient journey** to improve Aboriginal peoples’ satisfaction with care provided by hospitals and their transition between hospital and other health care providers

4. **healthy transition to adulthood** to improve the health of Aboriginal teenagers by promoting healthy lifestyle choices like nutrition and physical activity and reducing the take up of high risk behaviours such as smoking, alcohol abuse, substance misuse and unsafe sex

5. **making Indigenous health everyone’s business** to increase the responsiveness of all health services to improve the health of Aboriginal people currently engaged in child protection, youth justice, drug and alcohol and mental health services.

The Victorian CtHG initiative is also linked to, and builds on, other efforts to meet the targets set out in the Victorian Indigenous Affairs Framework (VIAF) relating to life expectancy and child mortality.

The vision of the CtHG initiative in Victoria is articulated in the following statement:
By 2020 the Department of Health will have had a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians.¹

The Department of Health proposes to achieve this vision through:

working with Victoria’s Aboriginal communities to improve Aboriginal health by providing leadership across government and engaging the health sector so Aboriginal health becomes everyone’s responsibility (emphasis original).²

1.2 EVALUATION METHODOLOGY AND ACTIVITIES

The evaluation methodology is described in detail in the baseline report, which includes the evaluation framework and a discussion of methodological challenges. The evaluation is conducted in line with the requirements of the Human Research Ethics Committee (HREC), which provided approval for the consultation and data analysis activities.

Since the submission of the baseline report, the evaluation has:

- continued ongoing consultation with the DH centrally and with DH officers regarding state-wide initiatives
- continued to review relevant policy and program documentation at state-wide and regional levels
- received ethics approval for the evaluation research
- undertaken consultations and interviews with regional DH officers as well as representatives of state-funded and Aboriginal community-controlled health services, as well as selected Commonwealth-funded agencies such as Primary Care Partnerships (PCPs) and General Practice Networks (GPNs)
- presented at a national meeting of all jurisdictions to share information regarding progress under the National Partnership Agreement
- participated in the Victorian Aboriginal health conference 2012
- prepared the October 2011 and the May 2012 progress reports.

1.3 THIS REPORT

This progress report addresses the status of state-wide and regional implementation, to the end of December, 2011. The evaluation team has analysed progress reports provided by each of the eight health regions, and additional data provided by the Aboriginal Health Branch on both regional and state-wide progress. In addition, we have consulted with advisory bodies/reference groups in each region, and with responsible officers within Department of Health centrally.

This report focuses on the implementation of the overall Victorian initiative, rather than the implementation of local projects, which will be the subject of separate local and regional evaluation activities, led at the local or regional level.

The focus of this round of analysis and consultation has been on the investment in systems changes, and the extent to which consumers of health services are likely to be experiencing improved access to health services, and an improved experience while on the patient journey.

Section 2 addresses progress in the regions against the five priority areas.

Section 3 describes the progress of the state-wide projects funded under the initiative.

² Ibid.
Section 4 addresses the risks associated with the implementation and the evaluation of the CtHG initiative.

The next steps in the evaluation project are outlined in Section 5.

For reference the program logic of the evaluation framework is included on the next page.
TABLE 1 – PROGRAM LOGIC MODEL

<table>
<thead>
<tr>
<th>IMPLEMENTATION ACTIVITIES</th>
<th>SHORT-TERM OUTCOMES (1-2 YEARS)</th>
<th>INTERMEDIATE OUTCOMES (BY 2013)</th>
<th>LONG-TERM OUTCOMES (POST-2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Develop Regional Implementation Plans in consultation with local communities</td>
<td>▪ Regional Implementation Plans reflect local needs and priorities</td>
<td>▪ Smoking rates among Aboriginal people are reduced by 20% by 2013</td>
<td>▪ The gap in life expectancy between Aboriginal and non-Aboriginal Australians is closed within a generation</td>
</tr>
<tr>
<td>▪ Conduct needs analysis at the regional/local level</td>
<td>▪ Local communities are engaged with the implementation of local initiatives</td>
<td>▪ Health services are culturally safe and responsive, and Aboriginal health is a core part of health service design and delivery</td>
<td>▪ The gap in mortality rates for Aboriginal children (under five years of age) has been halved within a decade</td>
</tr>
<tr>
<td>▪ Establish governance structures to support the implementation of regional/local initiatives</td>
<td>▪ Regional governance structures are effective and include community members</td>
<td>▪ Aboriginal health services have increased governance and workforce capacity</td>
<td></td>
</tr>
<tr>
<td>▪ Provide pooled, flexible and capped funding to support local initiatives</td>
<td>▪ Funding is appropriate and adequate to achieve local outcomes</td>
<td>▪ The impact of chronic diseases among Aboriginal people is reduced</td>
<td></td>
</tr>
<tr>
<td>▪ Enhance existing and/or develop new state-wide initiatives addressing the five priority areas</td>
<td>▪ State-wide initiatives linked to the five priority areas are enhanced or implemented</td>
<td>▪ The patient journey and continuity of care experienced by Aboriginal people are improved</td>
<td></td>
</tr>
<tr>
<td>▪ Enhance existing and/or develop new regional/local initiatives addressing the five priority areas</td>
<td>▪ Regional/local initiatives linked to the five priority areas are enhanced or implemented</td>
<td>▪ There is increased multi-agency and cross-sectoral collaboration to deliver services to Aboriginal people</td>
<td></td>
</tr>
<tr>
<td>▪ Develop linkages and collaborative activities (e.g., ACCHOs, mainstream health service providers, private health service providers, services in child protection, youth justice, drug and alcohol and mental health)</td>
<td>▪ Linkages and relationships between services are maintained and valued</td>
<td>▪ There is improved access to quality health care services across the health care continuum for Aboriginal people</td>
<td></td>
</tr>
<tr>
<td>▪ Promote evidence-based practice and successful local initiatives</td>
<td>▪ Collaborative initiatives are implemented</td>
<td>▪ There is increased engagement with health services by Aboriginal young people</td>
<td></td>
</tr>
</tbody>
</table>

3 This evaluation examines the achievements and impact of the overall state-wide investment, through state-wide projects and regional implementation. Regional and local projects are the subject of separate, local evaluations.
<table>
<thead>
<tr>
<th>IMPLEMENTATION ACTIVITIES</th>
<th>SHORT-TERM OUTCOMES (1-2 YEARS)</th>
<th>INTERMEDIATE OUTCOMES (BY 2013)</th>
<th>LONG-TERM OUTCOMES (POST-2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Information regarding Closing the Health Gap programs/projects and outcomes are communicated with Aboriginal people and service providers</td>
<td>▪ Evidence-based practice and successful local initiatives are promoted and used to inform the development of local initiatives</td>
<td>▪ Lessons learned through the process of improving health access and quality of care for Aboriginal Victorians are shared and disseminated across regions and services</td>
<td></td>
</tr>
<tr>
<td>▪ Report the progress of implementation of Regional Implementation Plans</td>
<td>▪ Evaluations of state-wide and regional/local initiatives are conducted and findings are used to refine existing initiatives and inform future initiatives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2 Progress report on regional implementation plans and demonstrated progress towards outcomes

2.1 INTRODUCTION

This section reports on progress to date in the implementation of regional projects and activities under each of the five priority areas. At a regional level, activity is based on regional plans developed at the outset of the CtHG initiative. Regions have provided progress reports against these plans at six-monthly intervals since the initiative commenced.

In addition to the progress reports, additional information was collected by the Aboriginal Health Branch in late 2011, in regard to three key factors:

- the visible change the CtHG activity or project was intended to achieve
- the extent to which the activity or project was progressing according to plan
- the extent to which the activity or project is sustainable beyond the CtHG funding.

The analysis presented in this section is based on progress reports for the activity from July – December 2011, and the status of activity and projects in regard to the three additional factors of visible change, progress, and sustainability. The analysis is structured around the five priority areas, and the extent to which activity is progressing satisfactorily. We draw on the ratings that were available, noting that not all activity was rated, and that ratings were based on region’s own self-assessment. The ‘satisfactory’ rating was determined based on whether projects were progressing in line with expected timeframes, using a rating of highly satisfactory through to not satisfactory.

2.2 PROGRESS OVERVIEW

The regional CtHG teams within DH report overall positive progress on activity underway in each region. Drawing on the progress reporting provided to the Aboriginal Health Branch, some 70% of projects and activities are tracking according to plan: 41% rated with ‘highly satisfactory’ progress and 28% rated with ‘satisfactory’ progress.

It is also positive to report that the majority of the projects rated as progressing so well are also considered to be sustainable, beyond the investment being made under CtHG. It is also worth noting that many of the projects which do require ongoing funding are starting to make a valid contribution to the closing of the gap, and strategies to secure alternative funds should be put in place or are already being pursued.

At this stage it appears that projects with the greatest sustainability are those that include partnerships between community-controlled and mainstream services, where the value has been identified by both parties, and the change (particularly changes to pathways) have the potential to be embedded as the new “norm”.

The ‘partnership positions’ have been identified as an important ongoing investment, which reflects the resources required to initiate and maintain collaboration at this stage of the CtHG initiative. The role provides the human resource to undertake the communication, liaison and joining up of activity required to deliver much of the regional plans. There is concern that these roles are critical to maintaining a commitment to significant system-wide change and that without them there is a risk of losing the community’s confidence.

Governance arrangements have continued to operate well in most regions, with the structures established early in the CtHG implementation continuing to deliver the planning, monitoring and partnership opportunities required. A feature of the effective arrangements is the presence and participation of senior members of mainstream and community controlled health services.
In the larger regions a feature of effective arrangements includes an element of ‘place-based approach’, where a governance group focuses on the systems and processes at a sub-regional level.

Capturing the evidence of the impact of the CthG activity continues to be a challenge across the regions. While there is evidence of new relationships between health providers and there is attention being given to better designed pathways, the tangible impact of these positive changes for Aboriginal people is yet to be captured at a regional level. The evidence of the impact of the new relationships, partnerships and pathways for the people using the services is an important set of information for the evaluation. In order to ensure this is captured for the Interim Evaluation Report (November 2013) the evaluators will engage with users of the services where CthG investment has been made, or change strategies have been implemented.

The table below provides a snapshot of the ratings provided by regional DH CthG teams. It is important to note that the figures below capture specific projects as well as activity within projects, hence the totals are higher than the number of ‘projects’ across the state.

Table 2 – Summary of satisfaction ratings for regional activity

<table>
<thead>
<tr>
<th>Priority</th>
<th>Highly Satisfactory (41%)</th>
<th>Satisfactory (28%)</th>
<th>Partly Satisfactory (29%)</th>
<th>Not Satisfactory (1%)</th>
<th>Total Activities/Projects Rated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sustainable</td>
<td>Not Sustainable</td>
<td>Sustainable</td>
<td>Not Sustainable</td>
<td>Sustainable</td>
</tr>
<tr>
<td>Priority 1</td>
<td>16</td>
<td>7</td>
<td>0</td>
<td>10</td>
<td>17</td>
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<tr>
<td>Priority 2</td>
<td>22</td>
<td>10</td>
<td>17</td>
<td>10</td>
<td>10</td>
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<tr>
<td>Priority 3</td>
<td>23</td>
<td>12</td>
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<td>Priority 4</td>
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<td>15</td>
<td>18</td>
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<tr>
<td>Priority 5</td>
<td>20</td>
<td>7</td>
<td>7</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Sub total</td>
<td>98</td>
<td>54</td>
<td>49</td>
<td>55</td>
<td>72</td>
</tr>
</tbody>
</table>

Source: Project and activity progress reporting from DH Regions to Aboriginal Health Branch, December 2011 - April 2012.

2.3 PRIORITY 1 - TACKLING SMOKING

Under Priority 1 the aim is to tackle smoking by assisting Aboriginal people to quit and in turn reduce the burden of tobacco related disease in Aboriginal communities. The last progress report noted that:

‘Smoking cessation training for Aboriginal health workers has been investigated, promoted and delivered across the state ... ACCHOs have formed working relationships with existing organisations that work towards the reduction of smoking; [and] a number of ACCHOs have commenced planning towards implementing a smoke-free workplace policy’.

Since the last evaluation report (October 2011), a wide range of projects have been delivered which are reported to be contributing to sustained outcomes under this priority. A major contributor to sustainable outcomes is the embedding of new ways of working, and new expectations, within the ACCHOs themselves, including smoke-free environs, supporting staff to quit, and introducing tobacco cessation into the range of health and wellbeing programs offered by community controlled health services. Specific examples are included in the detailed descriptions below.

Some of the Tackling Smoking activity reported against in regional progress reports links directly to the Commonwealth funded tobacco strategy. The Australian Government funded the rollout of a national network of regional tobacco coordinators and tobacco action workers, to initiate or work in with community-based smoking prevention and cessation support activities. It should be noted that the Eastern Metropolitan Region (EMR) do not have an ACCHO or a Tobacco Action Worker.
In addition to the projects and activity that falls specifically under Priority 1 of CtHG, there are a further 50 or more projects that are reported to be likely to contribute to the tackling smoking outcomes across the regions. These include the work of Gathering Places, maternity pathways, pathways to hospital or acute care, men’s health strategies, employment strategies, elderly and community health services, cultural awareness training for medical students, and the youth projects being developed as part of the healthy transition to adulthood priority.

2.3.1 HIGHLY SATISFACTORY PROGRESS

Across the state, the tackling smoking projects most likely to be rated as progressing well were those that aimed to promote change within community-controlled health organisations, as well as those delivering community development and other health promotion and education activities.

The positive visible changes reported by regions included an increased knowledge of the impacts of smoking among community members as well as an actual reduction in the level of smoking. The additional investment is reported to have improved access to smoking-cessation services, as well as overall improvement in the coordination of services within regions. Specifically, changes were reported in how Aboriginal Community-Controlled Health Organisations (ACCHOs) deliver messages on smoking, as well as their ability to effect change through using health promotion and education activities.

A key focus of the tackling smoking priority has been the education of young people.

In the Loddon-Mallee Region, the Njernda Respiratory Working Group continues to implement several youth initiatives to tackle smoking, with progress rated as ‘highly satisfactory’. Murray Valley Aboriginal Cooperative (MVAC) recruited three young graduates from the high school for three months in 2011 to promote healthy life styles through the fortnightly youth program. Two of these young people are now employed by MVAC. Based on a review of programs in Swan Hill, Loddon-Mallee Region has decided that smoking education for youth will continue to be incorporated into the broader youth activities program rather than as a separate initiative. For example, the gym and fitness program for young people incorporates messages about quitting.

In the Southern Metropolitan Region (SMR), the Bunurong Healthy Lifestyle Team (consisting of a Commonwealth funded Healthy Lifestyle Team Coordinator, a Tobacco Action Worker, an Aboriginal Outreach Worker and two Healthy Lifestyle Workers) at the Dandenong and District Aboriginal Cooperative Ltd have made significant progress in implementing tobacco control initiatives in Dandenong, Frankston and Mornington Peninsula. A feature of this work has been the sharing of learnings with others in the northern part of the region, participating in many regional smoke-free events such as the Koori Night Market, the Bay Mob Health Day and Welcome to Bupup Country. While this team will only be sustainable if recurrent Commonwealth funding is allocated, there are some functions which may be able to be built into existing staff roles, including the mainstream health tackling smoking initiatives and the work of the Aboriginal Access and Equity team.

Training of Aboriginal Health Workers (AHW) in smoking cessation interventions has been carried out and promotion of tackling smoking messages has been built into health plans in two regions. In the Loddon-Mallee Region, qualified AHWS have undertaken training and it will also be part of the professional development for Bendigo and District Aboriginal Cooperative (BDAC) trainee AHWS in late 2012.

2.3.2 SATISFACTORY PROGRESS

In four regions there have been concerted efforts to contribute to smoking cessation and incorporate messages about the harmful effects of smoking into the ACCHO’s day-to-day operations. In the Grampians Region, Budja has become a smoke free ACCHO. This has been supported through posters and brochures on the dangers of smoking; nicotine patches for smokers; incorporation of anti-smoking messages into the new website; a health promotion seminar delivered in relation to smoking; and stronger links with GPs and referral into anti-smoking supports and activities.

In Loddon Mallee, all five ACCHOs are working with the Victorian Aboriginal Controlled Health Organisation (VACCHO) and staff to become smoke free workplaces including supporting staff attempts to quit. Mildura Aboriginal Cooperative (MAC) has already run one smoking cessation program for staff, with another planned for early 2012, and at MVAC ‘quitting smoking’ is on the agenda of weekly meetings of the health service. Njernda is already a smoke free workplace. In BSW region, positive progress is reported on making Wathaurong a smoke free environment by 2012. The EMR partnership with Eastern
Health clinical smoking cessation workers has included a focus on building capacity among AHWs to undertake smoking interventions.

There has been some progress towards implementing a Tobacco Action Workforce in Gippsland and Loddon-Mallee Regions. In Gippsland Region, the beginnings of a Tobacco Action Workforce are now in place with two male AHWs recruited to fulfil the roles of Tobacco Action Worker (TAW) in Lakes Entrance and Warragul/Drouin and a Regional Tobacco Action Co-ordinator (RTAC) appointed to support the development of a network for the workforce. The TAWs coordinate smoke free days once a month. The RTAC has made contact with all Gippsland-based TAW and has set up the first Tobacco Action Network meeting.

In Loddon-Mallee, there is also a target to establish an Aboriginal Tobacco Control workforce across the region, however, it is believed that this will be difficult to achieve within the four-year time frame as it will be dependent on how the Commonwealth distributes teams across the State. In particular, it was reported that there is a lack of shared understanding between the Commonwealth, State and the MAC on the reach of responsibility of the RTAC which requires clarification for the further implementation of region-wide actions.

In the North and Western Metropolitan Region, the ‘Western Region Gathering Place Reduce Smoking Pilot’ which aimed to reduce the tobacco use of the Western Region Gathering Place among clients and staff has been successful with the agency now smoke free.

Also in the NWMR is the Doutta Galla CHS initiative that aims to tackle passive smoking around young children with asthma, by combining asthma management and music therapy. Features of the implementation of this project include engagement with schools and Aboriginal Health Services in the NWMR around possible partnerships; engagement with children through music; the provision of health checks & ‘Quality of Life’ surveys to both participants and their carers; as well as asthma information and smoking cessation sessions provided to families, which encourage families to access GPs for Asthma Action Plans. The Region is in the process of contracting the University of Queensland to provide the formal evaluation of the project.

Another project in this urban region is the ‘Fitzroy Stars Health Screening and Mentoring’ program, which works closely with the Stars on improved planning and implementation of Nutrition and Smoke Free activities.

2.3.3 PARTLY SATISFACTORY PROGRESS

Activity which was rated as being ‘partly satisfactory’ includes some smoking cessation strategies; activity within men and women’s wellbeing services; and projects which provide a mix of health promotion and targeted work on smoking cessation within organisations.

A key characteristic of projects reported to have made ‘partly satisfactory’ progress and to also be ‘sustainable’ post the CtHG investment, have a strong focus on health promotion in the community, coupled with organisational change. These projects aim to develop a coordinated response to community need, commonly engaging in stakeholder consultation and seeking to develop partnerships across health and community services.

The accredited training offered by Centre for Excellence and Indigenous Tobacco Control (CEITC) - ‘Talkin Up Good Air’ - has been delivered once each within Gippsland Region and EMR.

Strategies to reduce tobacco consumption have also been included in the health promotion plans for Warragul/Drouin, Morwell, Sale, Bairnsdale, Lakes Entrance, Lake Tyers and Orbost. Activities to date have primarily focused on the development of smoke free health service policy. Appointment of the TAW in Lakes Entrance has enabled a review of the current service coordination arrangements and supported improvements. This has brought together staff from Lakes Entrance Aboriginal Health Association and Gippsland Lakes Community Health Service – TAW (LEAHA), Chronic disease nurse (GLCH), and GP (GLCH) to develop a co-ordinated, multidisciplinary pathway for smoking cessation which enables Aboriginal people to pursue culturally appropriate cessation options from either service.

To determine baseline smoking rates and readiness to quit of staff working in Gippsland based ACCHOs the Regional Tobacco Control Coordinator in partnership with CEITC developed a survey. The response
rate to the survey was reported to be low, hence baseline smoking rates and readiness to quit remain unknown.

Loddon Mallee Region is engaging with pregnant women and with mothers of infants through the local Best Start programs and Aboriginal Maternity Services to provide advice on the harmful effects of smoking during pregnancy, and to provide incentives for young pregnant women to give up smoking and to continue for three months after the birth. This project is considered both effective and sustainable. The holistic and health promotion role of the Koori Maternity Service has been central to the project. In SMR, the Smoking Susie doll has been used in all health promotion sessions, including monthly ‘Mums and Bubs’ groups.

2.4 PRIORITY 2 - PRIMARY HEALTH CARE SERVICES THAT CAN DELIVER

Priority 2 projects aim to improve access to, and the quality of, primary health care services for Aboriginal people in order to achieve long-term changes in health outcomes and increase participation in preventative programs.

The October 2011 evaluation progress report noted in regard to Priority 2:

‘... all regions were addressing this priority both through new programs and by enhancing existing services to achieve cultural competence in delivering healthcare to Aboriginal clients. Additionally, collaboration with key stakeholders to develop coordinated and integrated service delivery was being carried out across the regions’.

The governance structures supporting the CtHG initiative have provided an important forum for formal and informal engagement between mainstream and community-controlled organisations. Across all regions, it is the improved partnership arrangements that are reported to be leading to better integration; a higher level of openness between services; and services being less guarded about the sharing of information. There is some indication that it is the coordination between services and the establishment of partnerships, rather than the individual projects, that will help to improve health access over the longer term.

2.4.1 HIGHLY SATISFACTORY PROGRESS

In several regions, Priority 2 projects involving the delivery of cultural awareness training were found to be both ‘highly satisfactory’ and ‘sustainable’, in that the benefit was expected to be enduring beyond the CtHG investment.

Positive visible changes included increasing cultural awareness amongst mainstream health services; improved pathways to antenatal care; a partnership approach to chronic care resulting in improved access for clients; and improved systems after increasing cultural competency of health services.

Partnerships have been supported in EMR by the CtHG Executive and Project Management Groups, which were established at the commencement of CtHG. These structures are reported to have enabled strong, effective and broad partnerships. As at December 2011, the EMR had provided accredited cultural competence training to 77 GPs, practice nurses and managers, with an additional 25 people registered to participate.

In Barwon South-West (BSW) region, Barwon Health and BSW ACCO produced a film that was launched at the regions’ CtHG forum on 21 March 2012. Development of the DVD involved partnerships with the local Aboriginal community, as well as the ongoing consultation with the wider community. The DVD has been distributed for training to GPs in the region. Despite the inclusive approach to developing the training product, the region is considering how best to maintain the community’s engagement beyond the production of the DVD/training materials.

Other Priority 2 projects that were deemed ‘highly satisfactory’ and ‘sustainable’ have a strong focus on delivering culturally appropriate health promotion and chronic disease prevention and management. For example, in the North and West Metropolitan Region (NWMR) there are seven community health services which have undertaken cultural risk audits and developed plans of action to address the issues identified.
A key project in the Grampians region aims to support a more seamless approach to the enhanced delivery of culturally appropriate chronic disease management services at Ballarat and District Aboriginal Cooperative (BADAC) through the recruitment of an Aboriginal Chronic Disease Management Nurse (ACDMN), funded under CthG. This project has contributed to a 67% increase in health assessments compared to the 09-10 financial year, and the number of clients with a chronic disease care plan is up by 82% (BADAC 2011). A further outcome reported was a new ‘norm’ emerging among the chronic disease population group in regard to attending medical appointments. A flow-on effect reported is an increase in the number of referrals to other primary health and allied health services. The nurse runs the four Aboriginal LIFE programs, oversees the Smoking Cessation program and has established a Diabetes Support Group that meets monthly.

A primary aim of Priority 2 projects is to implement a higher level of coordination across services. In Hume Region, partnership managers have been employed in ACCOs across the region to build the capacity of agencies to support the implementation of CthG projects. The NWMR also has a Partnership Manager located at VAHS which has strongly supported VAHS and partner organisations on a range of projects to understand and embed knowledge of CthG activity across the region. Partnership Managers have also been leads for cultural competence and client journey projects.

Also in the NWMR, audiologists from several health services have been engaged in ensuring follow-up for Aboriginal children screened and found to be requiring further audiology assistance. This has resulted in a partnership with VAHS whereby community health service audiology staff attend the VAHS clinic and provide services for the Aboriginal community within the community-controlled setting.

In Gippsland Region two sub-regional consortiums have been established to implement projects in Central and West Gippsland and East Gippsland. Establishment of the Central and West Gippsland Consortium has provided a platform to strengthen relationships between Ramahyuck District Aboriginal Corporation (RDAC), health services, Primary Care Partnerships and local government. The commitment to working together at the sub-regional level is also demonstrated through participation in local site-based meetings to progress local health promotion planning and implementation. In the Grampians Region, the coordination of services has been facilitated through the role of the practice nurse.

In the Gippsland Region, the RDAC has completed delivery of the Cultural Awareness, Respect and Safety with Health program and has been accredited as a Registered Training Organisation to deliver cultural competency training. An evaluation report was submitted to the Department of Health and Gippsland Close the Health Gap Advisory Committee. While the project was delivered on time and on budget, further work is planned to ensure the product meets the health services’ training requirements.

2.4.2 SATISFACTORY PROGRESS

Building a flexible, culturally competent and cohesive health care workforce is a key goal of Priority 2 projects. In Loddon Mallee and Gippsland Regions, staff rotation and exchange initiatives are being progressed, but further work is required to establish policy directions and develop tools for future staff exchanges. In Gippsland Region, staff placement and exchange guidelines have been developed and endorsed by the Regional Advisory Committee. However, this project is reported to be struggling to gain traction and as a result no placements have taken place.

A large number of visible changes have also been recorded for projects considered ‘satisfactory’. These include increased access to services under the e-referral system, improved access to health and counselling services, and improved access to dental health services under the oral health plan. Strengthened partnerships are reported, with an increase in workforce skills and potential to influence organisational decision making and policy direction. Of particular note is the potential for improved pathways from hospital to primary health care services.

2.4.3 PARTLY SATISFACTORY AND NOT SATISFACTORY PROGRESS

While some projects were given a progress rating of partly satisfactory or not satisfactory, some also have the potential to deliver sustained change. This includes those related to health promotion and stakeholder engagement, as well as one project that aimed to develop cultural competency.

Most Priority 2 projects in BSW were considered ‘partly sustainable’ including the cultural education program; health promotion capacity building; and service coordination with Barwon Health in relation to mental health, maternity, dental and emergency services.
An example of a ‘partly satisfactory’ project in Gippsland Region is the development of an e-referral system which has been implemented at one ACCHO. Plans have been made by GEGAC to progressively introduce e-referral across all program areas, but there has been no progress reported at RDAC.

In SMR, there are two health care pathways projects which are rated as ‘partly satisfactory’ as they are only in the early stages of implementation. One of these is the ‘Improving health care pathways for Aboriginal children in out-of-home/kinship care’ which aims to link with existing primary care and community care services and projects being provided to Aboriginal and Torres Strait Islander families in relation to early intervention and out-of-home care. The project also aims to provide Aboriginal children in out-of-home care with comprehensive paediatric health assessments and then provide co-ordinated care pathways for these children following assessment. It is being coordinated with the ‘Reaching Out’ project which also targets Aboriginal and Torres Strait Islander children in out-of-home care and other vulnerable children in the acute setting of Monash Medical Centre. The model aims to result in easy access to and from the acute and community sectors. The ambition is that this will be sustainable over the longer term as the model will be built into the usual practice for roles within the primary and community based systems.

There is a concern reported about the viability of the longer-term feasibility of projects that require ongoing coordination and funding beyond the CIHG initiative. In Gippsland Region, for example, two projects relating to the provision of service information sessions for AHWs are noted as requiring ongoing coordination resourcing.

2.5 PRIORITY 3 - FIXING THE GAPS AND IMPROVING THE PATIENT JOURNEY

The aim of Priority 3 is to ensure that the care provided to Aboriginal people by hospitals, and the transition to other health care providers, is seamless.

In the last progress report, Urbis noted that this priority:

‘...[was] being worked towards across the state by improving the patient journey and access to services. Ensuring that the hospitals and primary health care services within each region have the capacity to cater for the cultural needs of Aboriginal and Torres Strait Islander clients is a key component.’

The majority of activity under Priority 3 is focused on system changes across acute, emergency and primary health services, in order to increase and improve access across the health service continuum. Cultural change is also a key characteristic of these projects and is being directed toward changes in cultural understanding within mainstream services and GP clinics. Some Priority 3 projects also seek to develop the skills in mainstream and community-controlled services by offering staff exchanges, and joint development training opportunities. Underpinning these projects is a strong commitment to developing partnerships across a range of antenatal, mental health, general health and community services, as well as to stakeholder and community engagement.

2.5.1 HIGHLY SATISFACTORY PROGRESS

Of the Priority 3 projects rated as ‘highly satisfactory’, almost two-thirds were also rated as ‘sustainable’. These include projects that seek to address issues in acute, emergency and general medical services, staff exchanges between an Aboriginal and mainstream service, as well as cultural awareness training of medical staff. The outcomes of these projects include making changes in systems and organisational culture, as well as shifting community attitudes about the use of health services.

Although detail on the progress of some projects since the last reporting period is scant, visible changes associated with the current level of implementation are reported to include improved systems and strengthened partnerships.

A number of projects under this priority which were rated as both ‘highly satisfactory’ and assessed as ‘sustainable’ are located in the Loddon Mallee Region. These include the Maternity Services Pathways project, which focuses on young women at risk, and aims to improve service pathways and discharge planning. Overseen by an interagency steering committee and drawing on the outcomes of a community consultation process, this initiative is implementing changes to the care pathway, and increasing the
cultural awareness levels of hospital maternity staff. Cultural care training for Echuca Regional Hospital (ERH) maternity staff has been scheduled, and multi-disciplinary team meetings are being held between ERH and Njernda. A culturally safe space for Aboriginal women has also been established at the hospital.

This project is reported to have contributed to systemic changes that have improved the care pathway for Aboriginal women.

Also in the Loddon Mallee are four projects relating to emergency and acute services that aim to increase the provision of culturally safe services, and as a consequence, decrease the number of clients leaving emergency services prior to receiving treatment.

Promoting partnership agreements between health services and ACCHOs is a common approach across the regions, as a means of improving the patient journey and increasing access to services. For example, in Loddon-Mallee Region, the Bendigo Partnership Project aims to improve the care journey and the outcomes for the community who are accessing mainstream health services, through collaboration between BADAC and the BCHS. This includes implementing a professional development calendar for joint staff activities, reciprocal staff exchange and mentoring programs; and monthly governance meetings between the two organisations.

Other ‘highly satisfactory’ and ‘sustainable’ projects are located in the BSW, NWM, EMR, and SMR. The Journey to Common Ground project in BSW Region seeks to achieve better health outcomes by increasing the cultural awareness of medical students and GPs. A cultural awareness DVD has been produced (launched on 21 March 2012) and will be distributed to GPs across the region.

Similar to other priority areas, the development of cultural understanding is a core goal of this priority area, as well as increasing the community’s understanding about how to access these services.

There are two projects in the NWMR designed to address this goal. The first aims to develop a model to improve support and access to pathways through antenatal services, and the second, to provide health professionals and the community with culturally appropriate health material over the internet. With regard to the antenatal pathways project, the progress report notes that although this is being developed at a late stage of the CthG strategy’s implementation, it is expected to produce rapid improvement to the accessibility of antenatal pathways. Consultation has been carried out with Aboriginal women and Northern Health to develop a culturally appropriate pathway model, which is due to be implemented in the first quarter of 2012. To progress the second project an Aboriginal worker has been appointed to develop a website. At the time of reporting the website was averaging 170 hits per month. Despite being small, this project is considered to be effective, and will require ongoing funding to be sustained.

A project considered ‘highly satisfactory’ is the EMR’s Commonwealth Liaison Officer position. This position, located within the Eastern Ranges GP Association, is designed to contribute a local Aboriginal cultural perspective ensuring that GP cultural competency training reflects local community protocols; to improve health pathways, particularly around chronic conditions, in an inclusive and sustainable way; and to promote the region’s CthG priorities in local service development.

To this end the Liaison Officer runs cultural awareness training sessions; represents the ERGPA on two Local Indigenous Networks (LIN) and the Mullum Mullum Indigenous gathering Place cultural wellbeing program; actively participates in cultural and health promotion activities; and has developed improved referral pathways and relationships with Eastern Health’s Aboriginal Liaison Officer (ALO). The position is dependent on ongoing funding, so while reported to be effective, is not sustainable without alternative resourcing.

The only initiative rated as ‘highly satisfactory’ but with no assessment regarding its sustainability was the Hume Project Management project, through which Partnership Managers are employed. As noted in the discussion on Priority 2, it is believed that these positions have been essential in the development and implementation of the region’s CthG projects, and have provided visible leadership which has assisted in the building of relationships across services, which will be sustainable in the long term. The positions are considered essential for embedding cultural and systemic change within local health services, but will require funding beyond the CthG investment.
2.5.2 SATISFACTORY PROGRESS

One of the projects considered both ‘satisfactory’ and ‘sustainable’ aims to improve outcomes for clients exiting emergency services in Gippsland. This project is being undertaken by health services with emergency departments in the region. The project aims to understand why people leave prior to completing treatment and to ensure appropriate care is received. A daily report is used to inform the Koori Health Officers of the required follow ups. An annual review of the system should provide more detail on its effectiveness, the level of case management involved, the impact this project has on the client journey and how this may impact on the patterns of usage associated with emergency departments across the region.

Another project making satisfactory progress and which is considered ‘sustainable’ is the co-location of family counselling and health services in the NWMR. This project involved funding for the purchase of equipment and establishment costs. Additional funding to cover future operating costs has been sourced beyond CtHG.

Also in NWMR, a project called Improving the Pathways to Hospital Care has been successfully piloted in St Vincent’s Hospital and will move to two other hospitals in the region. The implementation of this trial project, which utilises a range of resources, tools and guidelines from the ‘Improving the Culture of Hospitals Project’, aims to improve the client journey between hospital and primary care services. The outcomes of the pilot have shown to successfully increase the focus on Aboriginal health. The trial will move to the Austin and Royal Melbourne Hospitals in the next phase.

The EMR has the Outer East Aboriginal Innovation and Service Coordination project that aims to link and extend activity both internally and across outer LGAs of the Eastern Region. This program is being progressed by the Aboriginal Cultural Services Manager and ALO positions, and commenced with a cultural audit of all Each programs, in order to establish a baseline of quantitative and qualitative data on service delivery, access points and presenting issues. This project aims to improve care pathways through enduring systemic changes.

The Client Journey Project in Hume Region is trialling a pathway model with four components:

- identifying client pathways from ED and Inpatient services to primary health care
- utilising a model of care that incorporates evaluation and planning for improvements of the existing services
- focusing on developing an evidence base that uses existing patient utilisation data
- promoting reform at a health service level through the CtHG Steering Committee structure.

Three pilot sites will utilise partnership groups, with funding for a system coordinator to work with the service partners to identify opportunities to improve identification, assessment and referral pathways. An identified position based in the emergency department is also being appointed, to work with Aboriginal clients to support follow up care. Consultations were held with each pilot partnership to ensure clarity of expectations and confirming the budget. Further activity to support the pilots includes a ‘Transition Officer’ role and a regional resource kit for use by hospitals and primary care agencies.

2.5.3 PARTLY SATISFACTORY PROGRESS

Projects categorised as ‘partly satisfactory’ include two joint projects in BSW – the ‘Keep the Mob Alive’ and the Dhauwurd Wurrung Elderly and Community Health Service (‘Delivering Deadly Services’) project.

Wautharong’s ‘Keeping the Mob Alive’ involves partnership building, stakeholder engagement, health promotion and service coordination strategies. It is designed to build the capacity of Wautharong to respond to community identified need, and increase access to mental health, maternity, dental and emergency services. Information provided identifies a need to re-engage all partners in order to progress

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4 Each was previously Eastern Access Community Health, now known as Each.
the project, including Departmental stakeholders, ACCO and mainstream antenatal, and Maternal Child Health Services (MCHS).

Dhauwurd Wurrung’s ‘Delivering Deadly Services’ aims to address access to universal services by engaging Portland District Hospital and the Heywood Rural Health Team. Together Dhauwurd Wurrung and the Hospital will develop a new Aboriginal Hospital Liaison Officer (AHLO) model in order to improve cultural safety practices. An initial focus is on self-identification tools as well as identifying Aboriginal health issues in Western District region of BSW Region. The project is described as having already achieved strengthened partnerships and systemic changes.

Three Wellbeing Partnerships have been established across the NWMR. Taking into account variations, these groups essentially seek to develop high-level partnerships across health and community services in order to support Aboriginal people of all ages to achieve optimal health. Underpinning these partnerships is a strategy to consult with key stakeholders and the community to identify and address service gaps. All projects have been delayed due to recruitment to the Partnership Manager positions, but in general, it is reported that these projects should be viable over the longer term.

Across the SMR, the Inner South Community Health Service is leading a group of services in the local area, including the Alfred Hospital and Caulfield General Medical Services in a three stage project to develop better patient pathways. Stage One will involve research and planning around what are the barriers and enablers of clients/patients progress from home into, through and out of community-based primary care services. Stage Two will be the implementation of best practice strategies and building the capacity of the regional health providers. Finally, Stage Three will be an evaluation of the project to report on findings and provide recommendations on future directions. It is not possible to provide a rating higher than ‘partly satisfactory’ at this early stage of implementation, however, it is anticipated that ongoing sustainability of the project will be integral to the design of the project. The project will endeavour to build systems change into usual practices and thereby contribute to continuous improvement.

2.6 PRIORITY 4 - HEALTHY TRANSITION TO ADULTHOOD

The focus of projects under Priority 4 is on the healthy transition of young people to adulthood. These projects aim to cover key periods of development in the lead up to adulthood, including antenatal care and schooling – which have recognised impacts on long term health outcomes – as well as programs which focus on youth-teenage activities, both in terms of health and risk taking behaviours, and programs that look to workforce skill development in community services.

The last progress report noted:

‘There has been a strong focus on health promotion and screening for youth across the state… [and that] a particular focus on young women’s health is notable in some of the regions.’

Recent feedback shows healthy living messages are being delivered through a range of methods, and workforce capacity is being developed to improve leadership and pathways. Importantly, partnership development, community engagement and systemic changes have helped to facilitate the impact of Priority 4 projects.

2.6.1 HIGHLY SATISFACTORY PROGRESS

Projects classified as having ‘highly satisfactory’ progress and as ‘sustainable’ are underway in every region.

In EMR, the School Retention/Parenting Capacity initiative is reported to be achieving improved care pathways and more effective relationships between the school and health sectors. These outcomes are being achieved through three programs which target pre-school and school years, as well as providing health screenings. Under this project homework support groups at both primary and secondary schools in Healesville have been established; health screenings at the EMR Health Expo were conducted; and 14 families enrolled in the ‘school-readiness’ Boorai Program, which works with parents on child development issues.
There are two initiatives in the Loddon Mallee region that are hoped will be sustainable over the longer term based on the focus on systemic change and increased access to services. The first involves young people in the planning of programs and activities. The Njernda-based youth group meets monthly with themed meetings, including guest speakers, which cover topics such as mental health, family violence, sexual health, and justice issues relating to family violence. Similarly, Swan Hill youth have been integral to the planning and delivery of one-off projects such as Busta Groove and On the ‘G’ school holiday programs. At the MAC, healthy lifestyle behaviours are promoted through local sporting clubs and a youth leadership group which meets regularly.

The implementation of the Senior Clinical Advisor Role in the EMR is reported to have had a number of positive results. These include partnership development; improving the cultural awareness of clinicians in partnership with local Aboriginal people; co-facilitating cultural awareness training for a large number of services; supporting organisations to implement an art project with students; and helping facilitate an Elders’ screening program. The person in this role has received a Health Super Award, in recognition of the contribution made by the project’s work. Notwithstanding the ‘very successful’ progress rating, ongoing funding will be required to continue the work.

The EMR also invested in an extension of the nursing hours available to the young women at Worawa College. Training was also funded to bring ‘Mental First Aid’ into the delivery of nursing services. The aim of extending Worawa’s nursing services was to identify and respond to issues arising among young women boarding at the school, which would otherwise remain untreated. This project is described as a very successful initiative, but again requires ongoing funding to continue beyond the CIHG investment.

Loddon Mallee Region’s other ‘highly satisfactory-sustainable’ youth initiative supports a range of targeted health promotion activities and has focused on developing a coordinated and collaborative health promotion plan in each local service area. Through this ‘umbrella’ project, the Loddon Mallee Region aims to ensure a wide range of health activities are conducted across the region; that health promotion messages are integrated into current and developing youth programs; and that health plans and promotional materials are developed by youth.

Healthy lifestyle messages are also being implemented effectively through the East End project in Loddon Mallee Region, and the Willum Wurrain Iron Bar project and Youth Health Plan in the SMR. These initiatives are focused on improving the health of Aboriginal children and teenagers through activities that promote healthy choices around nutrition and physical activity, and reduce the take up of high-risk behaviours such as smoking, alcohol abuse, substance misuse and unsafe sex.

Connecting Aboriginal people to culture is being encouraged through SMR’s Gathering Places project which is working towards establishing four Gathering Places for cultural, health and wellbeing activities. The region funds a Gathering Place Officer to facilitate the development of the four sites in Hastings, St Kilda, Frankston and Cranbourne. Progress at two of the sites is reported to be ‘highly satisfactory’; however, all sites require ongoing funding to be sustained. Other funding sources are reported to have been investigated, but to date alternative funding has not been secured.

2.6.2 SATISFACTORY PROGRESS

Projects which were rated as satisfactory in progress, and are also considered to be sustainable include the South West project in the BSW Region; the Grampians’ Goolum Health Gaps project; and the Health and Cultural Strengthening and Workforce Innovations projects in the EMR.

The South West project in the BSW Region is a collaborative initiative between South West Health Care, Gunditjmara Aboriginal Cooperative and Kirrae Health Services. The aim of it is to address the gaps and barriers Aboriginal people experience in accessing health services. Clinical workers have been employed to facilitate access to an integrated service delivery model that aims to address family violence, mental health, and drug and alcohol issues. The project has experienced a series of staffing retention issues; however, despite this, referral pathway barriers that exist between South West Healthcare and Gunditjmara Aboriginal Cooperative are reportedly being addressed via an MOU between both parties.

Housing has been identified as a major issue for Aboriginal people in the area. This will be further explored through the development of case studies top capture the impacts on health of insecure housing.
In response to concerns about young people’s health, Goolum Goolum Co-operative in Grampians Region has identified chronic health gaps in adolescents. To address these issues the Indigenous Adolescent Health Coordinator (IAHC) developed the Deadly Ute project in May 2011, with 18 students enrolled and attending classes last year. The Deadly Ute project utilised partnerships across local sectors including community development, health, training and education sectors, to create pathways for Aboriginal youth towards further education and employment.

Participants were secondary school-aged students, mostly Indigenous, and are being introduced to a range of experiences in automotive, multimedia, communication and business. At the end of 2011 the Coordinator position was again being recruited.

The Hume Region has a Young Women’s Health Project aiming to improve the service and support available to address the reproductive health and wellbeing and pregnancy journey of young women living in region. The planning phase of this project has been completed and the second phase involves employing a Project Officer to support implementation of the project. This phase was reported to have been delayed, due to recruitment issues which were ultimately resolved. The role is designed to facilitate the development of sexually transmitted infections (STI) services, ante and postnatal care, parenting programs and playgroups; to develop health information and service access resource kits; and through community engagement, support increased cultural competency of service providers and develop partnerships across the sector.

The two projects in the EMR rated as progressing satisfactorily and to be sustainable are the Health and Cultural Strengthening of Young People and the Workforce Innovations projects. Health and Cultural Strengthening of Young People has research and clinical service programs being implemented under two different initiatives – one involves mental health research and the other seeks to engage youth to utilise clinical services. Under the first Health and Cultural Strengthening project, the aim is to undertake research on mental health issues, the pathways and service entry points in Outer EMR, and then to build linkages and protocols to support early engagement and more timely referrals. The project has been scoped and key partners have been identified; and it is considered viable over the longer term because of the systemic changes it is likely to produce. The second Health and Culturally Strengthening Young People project is now at a stage where a registered nurse has been engaged to provide on-site clinical services, and young people are involved in developing an arts project for the Centre.

Three of the projects that are considered ‘satisfactory’ but ‘not sustainable’ (due to the lack of ongoing funding) are located in the NWMR, and include the VACSAL and VACCA children and youth health promotion and screening activities; the culturally sensitive ear health checks project; and the regional dental pilot. In EMR, the Health and Culturally Strengthening Young People clinical service project mentioned above; the Communication Strategy, which has developed service-based and community-focused promotional materials; and the Specific Family Support program have each been assessed as satisfactory in progress, but requiring investment beyond CtHG.

The Specific Family Support project involved a pilot that extended antenatal services to support mothers of children up to five years of age. It also included increased health promotion around the risks of smoking in pregnancy, improved identification of disabilities and developmental delays and increased culturally appropriate birth support in regional hospitals. Recruitment for a family support worker has been initiated, the pilot evaluated and a 12 month plan based on the outcomes of the pilot, has been developed.

EMR’s Workforce Innovations and Cultural Awareness Training project is a community health and hospital project to increase the number of ALOs working within the EMR. Staff implementing this project have been recruited and have begun planning for regional CtHG activities which includes an audit of community health services to ascertain levels of past, current and future activity related to Aboriginal health and workforce recruitment and development. This project also requires ongoing funding to be sustained.

There is cross-over in many regions between projects which meet more than one of the priority areas; for instance, some of the Hume region projects discussed previously also address priority 4 such as the Client Journey Project.
2.6.3 PARTLY SATISFACTORY PROGRESS

Included in the ‘partly sustainable’ category are the NWM’s ‘Wellbeing Partnerships’ (discussed under Priority 3), Gippsland’s Health Promotion Plans and the Healesville Belong Place in the EMR.

Gippsland Region is aiming to implement seven Regional Health Promotion Plans covering Lake Tyers, Lakes Entrance, Orbost, Bairnsdale, Sale/Morwell, and Warragul/Drouin. Current status of planning and implementation at local town level is mixed, with plans now approved for Lake Tyers, Lakes Entrance, Sale, Morwell and Warragul/Drouin. Difficulties encountered to date primarily relate to the capacity of the workforce to undertake the agreed planning. To address this issue at a local town level RDAC has now appointed project workers to assist the Central and West Gippsland Coordinator. A similar structure does not exist in East Gippsland.

In the EMR, the Healesville Belonging Place project, while delayed, is reported as getting underway. A manager has been employed, a strategic plan developed, and youth programs are underway, including the Deadly Drivers and drum beat programs. Community BBQ lunches are held monthly and the Belonging Place has partnered with the Yarra Ranges Shire to develop a children’s reconciliation project. The CthG funding has enabled this series of events and engagements, in order to progress community ideas regarding the establishment of an Indigenous centre.

Under Priority 4, the only project that is considered as ‘partly satisfactory-not sustainable’ is the NWM’s ‘Coordinating Tackling Smoking’ project that aims to reduce smoking across the community. The project had experienced recruitment problems, which were eventually resolved. Ongoing resources would be required beyond the CthG investment.

2.7 PRIORITY 5 – MAKING INDIGENOUS HEALTH EVERYONE’S BUSINESS

Priority 5 under the CthG strategy aims to make Indigenous health everyone’s business. The types of projects being developed and implemented under Priority 5 are, in many instances, the same projects as those described elsewhere, particularly under Priority 3, fixing the gaps and improving the patient journey, and to a lesser extent Priority 4, which focuses on a healthy transition to adulthood.

The last progress report noted that under Priority 5:

‘… the growing understanding of Indigenous health was underpinned by the strengthening of relationships across state and community-controlled health services’.

In this regard, some of the projects seek to initiate change through modifying pathways in the areas of antenatal care, emergency and acute services; or aim to build partnerships and joint initiatives with mainstream services in order to develop an integrated service model; or work with GPs to develop their cultural understanding of health issues.

2.7.1 HIGHLY SATISFACTORY PROGRESS

The majority of the projects with progress rated as ‘highly satisfactory’ are also considered to be ‘sustainable’. A key characteristic of these is pathway development, which reflects the similarities between Priorities 3 and 5. These projects also seek to reform mainstream systems – GP services, allied health services, acute and emergency services, as well as schools - in order to make ‘Indigenous Health Everyone’s Business’.

In the EMR the Ongoing Practical Supports to GPs project will place three Aboriginal Health Workers across the two proposed Medicare local catchment areas.

Another project in the EMR is Improving Patient Experiences in Emergency Departments which was delivered at Box Hill Hospital. This initiative includes undertaking an analysis of strategies to improve the emergency department patient experience of Aboriginal people; doing cultural audits at each emergency department; and identifying and implementing site specific pilot projects for each of the three emergency departments in the region. In 2011, a literature review and data collection process was undertaken and a project manager recruited. Prior to introduction of the project, EMR report that the majority of community
members relayed a negative experience but the majority now say this has shifted to a positive one. The project is due for completion by the end of June 2012.

There are two projects in the NWMR which are reported to be both highly satisfactory in progress and also sustainable. One is the Improving Access, Support and Pathways to Antenatal Care Project which has directly led to the sustainable development of services that will continue to be delivered as part of Koori Maternity Services program at Northern Hospital and Western Health. The other is the health resources website. Both these projects have also been described under other Priorities.

Key Priority 5 projects in the Loddon Mallee Region are the Festival for Healthy Living and Integrated Service Delivery initiatives. The Festival project aims to promote mental health issues; build skills for resilience and emotional wellbeing; utilise the arts to promote mental health and wellbeing, and support schools to integrate the Festival's program into their broader structure of activities. After consultation and planning, the implementation phase of this project was reported as ready to commence. The Festival is expected to increase mainstream knowledge of Aboriginal communities and be sustainable through funding from the Mental Health, Drugs and Regions (MHDR) Division.

Under the Integrated Service Delivery program, action plans have been developed across the sub-regions that set out the partnership arrangements and outline the course for coordination, monitoring, review and evaluation of the program. Njernda's action plan will have a focus on chronic illness. This overarching project is expected to strengthen partnerships and lead to systemic changes.

In the SMR, 'highly satisfactory' Priority 5 projects have also been described as fulfilling the aims of Priority 2 and 3. These projects are: a study that aims to gauge the experiences of patients who have accessed acute and sub-acute care, in order to begin system reform; engaging GPs in the PIP scheme; and the Frankston-Mornington Peninsula project which focuses on linkages, referral pathways and cultural awareness training across chronic, acute and allied health services. For this last project positions have been advertised and cultural awareness training has been planned. Moreover, a survey of 600 patients who do not access other Aboriginal specific services will be undertaken to review care pathway gaps and successes.

2.7.2 SATISFACTORY PROGRESS

Among the projects rated by regions as being both satisfactory and sustainable is the Men’s Health Strategy in Loddon Mallee. This is being developed as part of each Aboriginal Service Area’s (ASA) action plan through existing men’s groups, and generally focuses on health checks and access to primary health services. In this regard, BADAC is engaging with key stakeholders in other health agencies to discuss joint initiatives; the MVAC men’s group and Time Out service is the focus of the work in Robinvale; and at Njernda, the men’s group is taking part in the Bull Roarer program, which has a focus on lateral violence.

The EMR’s Communication Strategy for promoting the CthG during the four years is also rated as progressing satisfactorily.

Satisfactory progress has been reported for a number of North and West Metropolitan projects, including the VACSAL and VACCA health promotion and screening activities for children and young people; the culturally sensitive ear pilot; the asthma clinic and music therapy program; and the Partnerships Manager position. Sustainability is viewed as being limited, however, as continuation of the work will require ongoing project coordination through the Partnership Manager positions.

Hume has two significant projects which are progressing well. The Central and Lower Hume projects are focusing on identifying health needs within PCP catchment area, and models developed to meet these needs. The young women’s reproductive and pregnancy wellbeing and health initiative is also progressing satisfactorily. The same rating has been given to the Client Journey Project, which was reported to be in the process of implementing an evidence-based model for improved pathways between hospital and primary health care services through five pilots. Engagement of mainstream health services in the client journey project is described as a significant positive change.

The Cultural Competency Project, which is the regions ‘umbrella’ project, aims to increase the cultural competency of the health service system across the region. The assumption is that if mainstream health
services act to improve the cultural competence of their services, and thereby increase accessibility for Aboriginal people, then each of the regions other priority projects will also be enhanced.

Visible changes described for the projects in the Hume Region include strengthened partnerships and improved care pathways, with two of the projects achieving ‘significant improvement in care pathways and access to care’. Additionally, the projects are described as being underpinned by a strong governance model supported by significant leadership from Partnership Managers. The steering committee has strong cross sectoral management, and operates with a high level of authority. Structurally, each project working party includes representation from the Department of Health and the Steering Committee. This provides a strong connection between the strategy plan and the implementation of the projects, and contributes to and generates a high degree of commitment and enthusiasm from the team managing the project implementation.

Despite positive progress in Hume, the risk of losing community confidence is identified, should projects not be fully implemented. As noted above, and under Priority 3, maintaining the Partnership Management positions continues to be vital for sustaining the projects.

2.7.3 PARTLY SATISFACTORY PROGRESS

Two small groupings of projects have been categorised as ‘partly satisfactory-sustainable’, including Gippsland Region’s five sub-regional health plans, and the Wellbeing Partnership projects in the NWMR.

One of the Grampians projects rated as ‘partly satisfactory’ is the initiative in Goolum Goolum that aims to provide children (0-12 years) with Individual Care Plans (ICPs). These plans are intended to result in a reduction in crisis and child safety interventions. After discussions with the Department of Health in June 2011 about the future of the project, a Family Facilitator position has been recruited.

In the Loddon Mallee Region a project has been flagged as ‘not satisfactory’. The MAC/LMARG initiative involves building the capacity of ACCOs to address social and emotional wellbeing in their communities by implementing a social and wellbeing plan. The Department is following up on the progress of this project.

2.8 SUMMARY

The overall implementation picture is positive, with regions reporting that most activity is progressing according to plan. Where there have been delays these have been due primarily to workforce issues, common to most parts of the state. At the time of the regional reports drawn on for this report, most delays were being addressed and regions indicated optimism that activity would commence, albeit later than planned.

While the amount of activity underway across the regions is extensive, the evidence to support some of the reported improvements is limited. Progress outcomes are being documented, for example, new working arrangements and in some cases, well designed new patient pathways, but there is less evidence at this stage as to the benefit to patients of these changes. As the implementation of the changes continues, evidence of the impact of these efforts would assist the evaluators draw conclusions as to the efficacy of regional projects.
3 Progress to date – state-wide implementation

This section outlines the progress on the implementation of state-wide initiatives.

3.1 ABORIGINAL TOBACCO CONTROL INITIATIVES

Dedicated male and female Aboriginal Quitline Counsellors have been employed at Quit Victoria. These positions have led to an increased number of Aboriginal client referrals and accepted call-backs. Based on the six-monthly progress reports provided by Quit Victoria to the Victorian Department of Health and the Commonwealth Department of Health and Ageing (DoHA), it can be seen that there has been an increase in the number of health services referring Aboriginal people to Quitline as well as the number of Aboriginal people referred to the Victorian Quitline (see Table 3). Furthermore, there has been a marked increase in the number of Aboriginal clients accepting call-backs. These data provide evidence for the acceptance of the Quitline Model as a means of providing smoking cessation support to Aboriginal people. An evaluation plan has been developed to evaluate this model of providing smoking cessation support to Aboriginal people in Victoria.

An Aboriginal Quitline Liaison Officer position has also been created and recently recruited. It is expected that this position will enhance the relationship between Quitline and Aboriginal communities, and promote services and referral pathways.

| TABLE 3 – VICTORIAN QUITLINE ABORIGINAL CLIENT REFERRAL AND SERVICE ACCESS DATA |
|-------------------------------------------------|-----------------|-----------------|
| Number of Health Services referring Aboriginal people to Quitline | 40 | 54 |
| Number of Aboriginal people referred to Quitline | 147 called the Victorian Quitline (with additional 45 referred by their health professional) | 143 called the Victorian Quitline (with additional 71 referred by their health professional) |
| Number of Aboriginal clients accepting call-backs | 78 | 123 |
| Total number of information calls, counselling calls and further referrals for Aboriginal clients | 156 | 237 |

The state-wide coordinator at VACCHO has continued to provide support for state-wide activities in Aboriginal tobacco control, including supporting and advising ACCOs on smoke-free policies and coordinating the tackling smoking workforce within Victoria. In the next six months, the state-wide coordinator will be involved in developing and promoting evidence-based programs and resources for Victorian Aboriginal communities – there will be a focus on educating and resourcing the Victorian Aboriginal Health workforce on smoking cessation program options and working towards smoke-free Victorian Aboriginal organisations and communities. This work reflects the final report of the recently completed centrally funded three year Action Research project ‘Goreen Narrkwaren Ngurn-toura - Healthy Family Air: Reducing smoking amongst pregnant Aboriginal women in Victoria: an holistic approach’ which recommended focussing on organisational development, training and community development to address pregnancy and smoking cessation in Aboriginal communities.

Quit Victoria has been funded to support Aboriginal football/netball clubs or clubs with a significant number of Aboriginal players and links to the local community to promote smoke-free sporting events, days and games. Quit Victoria has sponsored Robinvale Football/Netball Club for a second term in 2011 and delivered education sessions at Sunraysia Community Health and at the Club’s annual Ladies’ Day fundraiser. This program promotes smoke-free events, days and games. It is anticipated that this program will be extended over the coming years, coordinated in partnership with VACCHO. An evaluation of this project is being undertaken to measure outcomes and help refine the project to achieve agreed objectives (e.g. for sporting clubs to become smoke-free). Quit Victoria will continue to deliver smoke-free messages via football/netball activities to Aboriginal communities. Quit Victoria is in discussion with two Aboriginal Sports clubs regarding sponsorship.
The progress of these three initiatives was assessed to be satisfactory.

3.2 ABORIGINAL EYE HEALTH

The Aboriginal Patient Pathway Co-ordinator position at the Royal Victorian Eye and Ear Hospital was redefined to become two separate positions to better fulfil the intended functions of the original position. The two positions are a Pathway Co-ordinator position (full-time) and a Patient-Centred Co-ordinator position (part-time). While the Pathway Co-ordinator position has been filled, the Patient-Centred Co-ordinator position remains vacant. Reported reasons for the difficulty in filling the Patient-Centred Co-ordinator position included the part-time nature of the position. While the delay in filling this position slowed the expected progress in facilitating referral pathways, it has led to a re-thinking of the strategies needed to improve referral pathways to eye health – in particular, to shift from position-focused strategies to strategies that support systemic changes at the organisational level (e.g. executive sponsorship, policies and protocols). Given the workforce challenges that exist, the shift towards organisational change is intended to embed changes such that outcomes become less position-dependant and more sustainable.

The Aboriginal Eye Health State-wide Coordinator at VACCHO has continued to implement the 12-month Work Plan. A service mapping of eye health services and programs has been undertaken, and progress has been made in relation to the development of an eye health training module for Aboriginal Health Workers. The State-wide Coordinator has also been working with the Australian College of Optometry (ACO) to identify additional areas of need for visiting services.

The Spectacle Subsidy Scheme has continued to be implemented, with ACO working with VACCHO, community partners, private practice network, DH and DoHA to improve service accessibility. Data collected included 71 case vignettes and change stories.

As at the end of March 2012 (21 months into the three-year program), 1,437 visual aids had been dispensed by the ACO throughout Metropolitan Melbourne and the Visiting Optometry Scheme (143% of running target, 80% of total three-year target). In addition, 686 visual aids had been dispensed by VES rural practices (142% of the rural running target, 64% of total 2.5 year rural target).

| TABLE 4 – DISTRIBUTION OF SPECTACLES THROUGH THE SPECTACLE SUBSIDY SCHEME |
|-------------------------------------------------|-------------------|-------------------|-----------------|------------------|
| Metropolian                                      | TOTAL OCTOBER 2011 | TOTAL TO 31 MARCH 2012 | INCREASE | % INCREASE |
|                                                 | 993               | 1437               | 444      | 45%           |
| Regional/Rural                                  | 358               | 686                | 328      | 92%           |

There is also support for the effectiveness of the Scheme in increasing access to eye health services based on anecdotal evidence. There were reports from private optometrists, for example, that the Scheme had led to increased demand for spectacles from Aboriginal people and increased appointment attendance to collect glasses, which provides an opportunity for eye examination and early detection of related health issues (e.g. diabetes).

An internal evaluation of the Scheme was conducted and a draft evaluation report has been prepared.

Factors contributing to the success of the Scheme include:

- the capacity to distribute glasses through multiple channels (e.g. public and private settings)
- community involvement in the design of glasses – hence, glasses are perceived to be attractive and of good quality by Aboriginal people and there are more frames from which people could choose

5 Based on information provided in the VACKH Aboriginal Eye Health Subcommittee Spectacle Subsidy Scheme report, October 2011 (Australian College of Optometry)
6 Based on information provided in the VACKH Aboriginal Eye Health Subcommittee Spectacle Subsidy Scheme report, April 2012 (Australian College of Optometry)
reduced price of glasses ($10 each).

With the higher than expected uptake of the Scheme (with number dispensed significantly exceeding target), funding for the Scheme was predicted to run out within two years (i.e. one year earlier). Additional funding ($100,000) has since been obtained through the Closing the Gap in Health Outcomes Initiative to ensure that the Scheme could continue for another year (i.e. to its full term).

Sustainability is considered a key issue for the Scheme. It is expected that it would be possible to assess the extent to which saturation has been reached in the next six months.

3.3 IMPROVING CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PATIENTS (ICAP)

ICAP has provided funding to 40 health services to implement initiatives in line with its strategic directions. These initiatives cover a wide range of activities, including improving cultural security for patients (e.g. by establishing a culturally welcoming environment), the development of a Reconciliation Action Plan or cultural Framework, employment of a project worker, providing cultural awareness training for staff, improving care coordination and referral pathways (e.g. through linkages with ACCHOs, AHLOs), and ensuring consistency in data recording and reporting.

A forum was held with the executive sponsors of these ICAP-funded initiatives in 2011. Over 30 hospitals were represented at the forum and representatives from St Vincent’s Hospital and Orbost Hospital (one metropolitan and one regional/rural hospital) talked about how the ICAP Key Results Areas (KRAs) were being addressed in their organisations and how they were implementing the ICAP strategic directions. This forum provided an opportunity for information sharing and networking among the health services, bringing together executive sponsors, who might not have been in the same room before. The increased organisational engagement with the objectives of ICAP can also be seen in the high number of abstracts submitted on ICAP-funded initiatives for presentation at the Victorian Aboriginal Health Conference (24-25 May 2012).

The implementation progress and outcomes of these initiatives will be reported in the Quality of Care reports produced by the health services at the end of the 2011-2012 period. The progress of these funded initiatives was assessed to be satisfactory.

The implementation of ICAP in the last six months has involved the trial of the Continuous Quality Improvement (CQI) tool. This tool was trialled in eight hospitals and enabled greater discussion with senior management staff at hospitals, which facilitated buy-in for the tool. However, further work is needed to refine the tool and to ensure that the tool is applied consistently across services. It was also noted that there are a number of CQI tools in existence, and there is a need to learn from other CQI tools currently in use as well as reduce duplication.

In the next six months, the focus of ICAP will be on moving beyond a position-based approach (whereby quality care for Aboriginal and Torres Strait Islander patients is associated with a position, such as the Aboriginal Health Liaison Officer) towards a whole-of-organisation approach. There will be a focus on the refinement and subsequent roll-out of the CQI tool, and the ongoing implementation of recommendations from the ICAP review and the application of review findings to progress initiatives.

Risks to the ongoing implementation of ICAP include reduced health funding and the flow-on effects for staffing levels at the Central Office and capacity to progress new initiatives.

ICAP was reported by DH Officers consulted to have contributed to an overall increase in investment in Aboriginal Health among health services.

3.4 ABORIGINAL HEALTH PROMOTION AND CHRONIC CARE (AHPACC) PARTNERSHIP

Following the AHPACC review, 20 Strategic Project Grants were provided to agencies to support the implementation of initiatives in line with AHPACC’s new strategic directions. These agencies include 13 community health services and six ACCOs (some agencies received more than one project grant). These projects are to be completed on 30 June 2012. These time-limited projects serve as a mechanism to
engage organisations with the findings of the AHPACC review and guidelines, and encourage agencies to think more broadly about their partnerships and approach to Aboriginal health.

Interim progress reports for the Strategic Project Grants have been submitted, with the Final Reports due on 30 September 2012. Based on the interim progress reports, the majority of projects were progressing well, with some projects experiencing delays owing to the need to amend the scope of the project. Staff turnover was a key issue affecting the progress of some projects, particularly for projects that were reliant on staff with certain skills. Overall, the progress of these grant projects was assessed to be satisfactory.

Based on the success factors identified through the AHPACC review, the AHPACC CQI tool was developed to support the planning and prioritising of activity by AHPACC partnerships. The completion of this tool twice in the first year and annually thereafter is part of the funding requirement. It is also expected that this tool may assist other organisations and partnerships to implement Aboriginal health programs. This tool was refined in March 2012.

An Industry Advisor was contracted to facilitate the implementation of the CQI tool and help organisations develop partnerships and agreements. An informal review of the investment made in the Industry Advisor indicated that organisations that had accessed the Industry Advisor felt that the implementation was more meaningful. Although the Industry Advisor is no longer available, the facilitation undertaken has helped to equip organisations with the knowledge and skills (i.e. mechanisms) required to support the ongoing implementation of the CQI tool. Support to organisations implementing the tool is also provided through quarterly meetings with Central Office staff.

The findings of the AHPACC review and the AHPACC guidelines were reported to have good buy-in from the various agencies involved in AHPACC.

In the next six months, the focus will be on implementing and embedding the CQI process at the organisational level and supporting organisational response to Aboriginal health promotion and chronic care, rather than individual actions. This shift towards organisational change reduces the reliance on specific staff positions and increases the sustainability of activities and progress made. There is a need to ensure consistency in the implementation of CQI process, while allowing for variations at the local level to meet local needs. There is also a need to ensure consistency in data collection so that progress can be monitored and organisations are accountable.

Similar to ICAP, there will be a focus on changing organisational culture so that changes made are more robust and less likely to be influenced by changes in staffing.

One of the challenges to maintaining the achievements and momentum of AHPACC is potential internal and external workforce issues (e.g. reduction in staff numbers, unfilled positions).

3.5 ABORIGINAL HEALTH WORKFORCE PLAN

The implementation of the Aboriginal Health Workforce Plan has continued, in line with its KRAs, to:

- provide
  - AHW training grants
  - Nursing, Allied Health and Dental Health Assistant training grants
  - management training grants
  - clinical supervision training grants
  - small infrastructure grants
  - professional development program for ACCHO CEOs
implement

- the Victorian Cadetship in Nursing and Midwifery Pilot Program
- role and workforce redesign projects (Scope of Practice tool, Clinical Supervision framework and Practice Health Atlas pilots)

provide funding at the regional level to

- undertake training needs analysis
- develop and implement cultural awareness, respect and safety in health programs
- develop and implement regional workforce projects to increase participation by Aboriginal people in the health workforce
- develop and implement leadership succession planning initiatives.

In the 2011-12 period, a total eight Nursing Grants, 16 Allied Health training grants, 18 Dental Health Assistant training grants, and nine Alcohol, Other Drugs and Mental Health grants have been offered (as at 2 May 2012). The scope of the training grants has been expanded to include alcohol, other drugs and mental health, and there is the potential to expand the training grants to the area of fitness. In addition, 43 Management training grants and six clinical supervision training grants have been provided (as at 2 May 2012).

Four Aboriginal cadets have been recruited for the Cadetship in Nursing and Midwifery Pilot Program, and draft resources have been developed. A project coordinator has been funded to mentor and coordinate the cadets. It is expected that this Pilot Program will inform the subsequent roll-out of cadetship programs.

Small infrastructure grants have been made available to increase the capacity of ACCHOs to undertake clinical placement activities. One grant has been provided to a Clinical Placement Network to support three ACCHOs with small infrastructure improvements (as at 2 May 2012). Clinical supervision frameworks for AHWs have been piloted at two sites, and the pilot will be extended for another six months.

The Practice Health Atlas has been successfully piloted, with the next step being to expand its use beyond the pilot sites. An assessment undertaken by VACCHO has highlighted the impact of the Practice Health Atlas in facilitating role definitions for AHWs.

The development and implementation of a professional development program for ACCHO CEOs has involved a survey of ACCHO CEOs. Training of ACCHO CEOs is expected to commence in the next six months (a slight delay was experienced owing to the need to recruit a new Project Officer at VACCHO).

There are variations in the implementation of Aboriginal health workforce initiatives across regions. Key observations for the different regions are outlined below.

In Barwon South West, for example, an Aboriginal Health Pathway Project Pilot has been undertaken by Smart Geelong Local Learning and Employment Network (LLEN) to employ an Aboriginal project officer to develop sustainable health pathways for Aboriginal people in partnership with local stakeholders in the Education and Health sector. An Aboriginal Employment Plan has been developed in major health services in the region, and there is a focus on careers in health for Aboriginal people currently not in the workforce or in schools.

A good uptake of training grants was reported for Gippsland, where the Project Officer acts as a champion and facilitates mainstream organisations to recruit Aboriginal workers. There is a focus on achieving the requirement of 1% Aboriginal workers in organisations in Gippsland, and hospitals have put in place a pre-employment training program, management training and training for existing workers.
In Southern Metropolitan Region, consultants and relevant organisations have been engaged to undertake the region’s three proposed projects (training needs analysis, cultural awareness training and leadership succession planning).

A delay in the submission of funding proposals was reported for Loddon Mallee. A lower than expected uptake of training grants and delays in project progress (including the development of a cultural training package) were reported for EMR.

A comprehensive training needs analysis has been undertaken in Grampians – the analysis included not only workforce characteristics, but also organisational structures. Training needs analysis has been completed in Hume, and has commenced in Gippsland.

In relation to regional cultural awareness, respect and safety programs, three projects have been completed, with two continuing.

Overall, the implementation of the Aboriginal Health Workforce Plan was assessed to be satisfactory.

In addition to the above activities, health and allied health INTRAIN scholarships have been established and administered using an existing system used by the Victorian Department of Human Services.

A total of five projects have been supported to develop and implement a sustainable business model to employ Aboriginal health workers in community health medical clinics utilising the Medical Benefits Schedule.

VACCHO has undertaken an Aboriginal Health Worker work observation pilot in hospitals. Hospitals provide a good entry point for people to access primary health care and allied health services. Work observation and traineeships in hospitals can help to build referral pathways and increase workers’ knowledge of the health system, which in turn, facilitates access to emergency as well as broader health services at hospitals.

In order to further develop the Aboriginal health workforce, there is a reported need:

- to ensure that TAFE subsidies are available for cross-disciplinary studies (currently, they are only available to people upskilling)
- for subsidies other than scholarships to be made available for studies at the tertiary level
- for subsidies to be made available for short courses or specific units rather than only for entire degrees/qualifications
- for dedicated human resources (HR) role in many ACCHOs – having a HR role is critical for supporting supervision, training and succession planning. There is potential for sharing HR positions across ACCHOs
- to address employee burnout and improve staff retention (e.g. through Employee Assistance Programs)
- to embed culturally appropriate clinical supervision practices and framework across disciplines in ACCHOs and mainstream health services
- to increase and coordinate work experience and traineeships as part of the health pathway
- for clinical governance training to ensure that changes are systemic and sustainable
- establish an Aboriginal Nurse Graduate program for Victoria to increase opportunities for employment.

The Victorian Government’s Aboriginal Employment Strategy (Karreeta Yirramboi), which aims to increase Aboriginal participation in the Victorian public sector workforce (with a target of one per cent Aboriginal employment for the Victorian public sector by 2015), was reported by DH officers consulted to have contributed significantly to the momentum in Aboriginal health workforce development.
Four pilot sites are developing their Aboriginal employment plans (AEPs). This is part of the AEP project which aims to develop 32 AEPs with health services with 500 staff or more over the next 14 months.

Successful implementation of workforce initiatives was also reported to be facilitated by dedicated workforce officers at the regional level.

In the next six months, the implementation of the Aboriginal Health Workforce Plan will include:

- marketing of training grants to increase uptake among AHWs
- finalisation and roll-out of the Scope of Practice tool
- expansion of Practice Health Atlas project sites
- continued provision of training grants (potentially further expanding the scope of the training grants)
- continued implementation of regional projects
- increased engagement with ACCHOs by Clinical Placement Networks to increase clinical placement activities in ACCHOs as well as mainstream organisations
- delivery of targeted professional development training to ACCHO CEOs
- development of an Aboriginal graduate nurse guideline for piloting in 2012. The guidelines will then be distributed to other health services in Victoria.
- development of 28 Aboriginal Employment Plans in health services with over 500 or more staff as a priority.

3.6 SUMMARY

In summary, the CtHG state-wide initiatives have made progress towards achieving the expected outcomes of the five priority areas – in particular, tackling smoking (Priority Area 1), enhancing the capacity of primary health care services to deliver services to Aboriginal patients (Priority Area 2), fixing the gaps and improving the patient journey (Priority Area 3), and making Indigenous health everyone’s business (Priority Area 5).

For state-wide initiatives, there is an increasing emphasis on developing systems and mechanisms (e.g. resources) that support organisational and sustainable change. With workforce issues, such as staff turnover and difficulties in filling Aboriginal staff positions, continuing to impact on project implementation progress and the achievement of outcomes, the focus on organisational (and executive) engagement and whole-of-organisational change reduces the dependency on specific positions to bring about change.
4 Risk management

There has been progress on many fronts in the past six months, with positive developments emerging across the state and highlighted in this report. At the same time, participants have identified a number of risks and challenges which need to be managed in order to ensure that the CtHG investment leads to sustainable and substantial change in health service delivery for Aboriginal people.

We have updated the table below to include what we consider to be the most significant risks facing the initiative, as well as an assessment of risk level, and some suggested mitigation strategies. The risks remain the same as in the previous report, although the levels of risk have changed slightly.

We have downgraded #1 below (partnerships) from high to medium, on the strength of evidence that partnerships are being developed, although we consider that it will continue to take time for relationships to become fully established.

We have also downgraded #4 below (accountability) from high to medium, on the basis that by and large reporting and accountability systems are in place, although these are stronger in some places than others.

We have upgraded #2 below (evidence) from medium to high on the basis that there is a need for greater evidence through data collection and evaluation at the local level; while it is still early in the process for many projects, ultimately the success of the CtHG will depend on being able to demonstrate system change in service delivery, access and uptake.

<table>
<thead>
<tr>
<th>TABLE 5 – RISK ANALYSIS</th>
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<tbody>
<tr>
<td><strong>RISK</strong></td>
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<tr>
<td>1. Depth and strength of partnerships differ widely across the state, and time required to build partnerships in some localities will delay implementation of effective service improvements. Progress is definitely evident, but needs attention and nurturing for partnerships to become well established.</td>
</tr>
<tr>
<td>2. CtHG is based on well-grounded assumptions of what will work, but there is not a substantial body of rigorous health research providing evidence for changing intergenerational poor health patterns within the Aboriginal Australian population. It is possible, therefore, that some projects under CtHG will prove not to have been effective in practice.</td>
</tr>
<tr>
<td>3. CtHG is funded for four years, however the changes which are sought will not be evident until well after 2013. The investments which are made under CtHG need, therefore, to be sustainable systemic changes which will facilitate long-term health gains. Some regions have focussed more than others on sustainable systemic change.</td>
</tr>
</tbody>
</table>
4. Regional control over implementation means that implementation will differ across the state, and some regions and local projects may achieve more than others; local accountability is critical for ensuring that funds are expended effectively.  

| Medium – but challenges remain in some regions | Six-monthly reporting should provide a mechanism for identifying obstacles, and responding at an early stage. Regional information sharing could be a mechanism for encouragement and innovation, sharing lessons learned, and assisting each other to address common challenges. |
5  Next stage of the evaluation

The next progress report, which will be in the form of the Interim Evaluation Report, will be prepared over the period August – November 2012. The report will draw on three sets of data:

1. Regional and State-wide project progress reports
2. Data provided by the Aboriginal Health branch updating the 2010 baseline report
3. Case studies, drawn from qualitative inquiry with health service consumers and community leaders, and service providers in community controlled and mainstream services.

In planning the next phase of evaluation activity, the place of each data source in drawing overall conclusions against the key evaluation questions has been considered.

Regional and State-wide Progress Reports

It is likely that the regional progress reports are likely to continue to focus on implementation outcomes and progress on projects against timelines, rather than be a source of evidence for outcomes resulting from the investment under CtHG. A number of the state-wide projects will be subject to outcome evaluations and the results will be available to this, the state-wide evaluation.

Aboriginal Health Outcomes Framework

The data to be provided by the Aboriginal Health Branch will include updated Regional Indicators Report available on key morbidity and mortality indicators. This will allow us to assess any changes in population-level data on key. As discussed in the Baseline Report of the evaluation, it will not be possible to attribute any changes in data, at this early stage, to the various CtHG initiatives discussed in this report. However, monitoring changes in population-level data over time should provide some indication of whether the cumulative efforts towards closing the health gap are leading to measurable, discernible change at the population level.

The state-wide data can be augmented by data held by health providers within regions, for example, increases in patients identifying; reductions in patients leaving without treatment, etc. The evaluators will utilise the most recent and valid data provided by both the Branch and the regions in developing the Interim Evaluation Report.

The table below shows the agreed ‘snapshot’ indicators which it was considered might indicate a closer influence on particular CtHG initiatives. The Interim Evaluation will analyse, to the extent possible given data availability, what progress has been achieved against these indicators.

<table>
<thead>
<tr>
<th>TABLE 6 –SNAPSHOT INDICATORS</th>
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<tbody>
<tr>
<td><strong>INDICATOR</strong></td>
</tr>
<tr>
<td>Tobacco</td>
</tr>
<tr>
<td>1 Smoking rate among Aboriginal adults</td>
</tr>
<tr>
<td>2 Smoking rate among Aboriginal pregnant women</td>
</tr>
<tr>
<td>3 Number of Aboriginal people accessing smoking cessation support and services</td>
</tr>
<tr>
<td>Workforce</td>
</tr>
<tr>
<td>4 Increase in number of Employment of Aboriginal</td>
</tr>
<tr>
<td>INDICATOR</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aboriginal staff employed in mainstream health services</td>
</tr>
<tr>
<td>Workforce recruitment and retention rates in ACCHOs</td>
</tr>
<tr>
<td>Access and quality of care</td>
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<tr>
<td>6 Evidence of increased hospital recording of Aboriginal identification</td>
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<tr>
<td>7 Reduction in afterhours primary care-type ED presentations by Aboriginal people</td>
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<tr>
<td>8 Rates of discharge of Aboriginal people from hospital against medical advice</td>
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<tr>
<td>Eye health</td>
</tr>
<tr>
<td>9 Uptake of subsidised spectacles among Aboriginal people</td>
</tr>
<tr>
<td>10 Number of eye health examinations conducted</td>
</tr>
<tr>
<td>Infants</td>
</tr>
<tr>
<td>11 Infant mortality rates</td>
</tr>
<tr>
<td>12 Rates of low birth weight</td>
</tr>
<tr>
<td>Governance</td>
</tr>
<tr>
<td>13 Number of MoUs or</td>
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</tbody>
</table>
other formal agreements between universal health services and ACCHOs are developing stronger relationships across universal and community-controlled health services, evidence of formal partnership provides a foundation for improving services and systems to provide seamless care.

| Number and type of mechanisms for engagement of universal health services with Aboriginal community members | Increased engagement of Aboriginal people in universal services is a mechanism for making Aboriginal health everyone’s responsibility | Consultation with state-wide and regional government stakeholders, VACCHO, health service providers | Six-monthly |

Case studies
Case studies will be used to capture the evidence for improved access, pathways and outcomes for the people using health services, as a result of the Closing the Gap investment. The challenge is to collect qualitative data that contributes to the key evaluation questions, rather than an assessment of individual projects within each region. To this end the evaluators will focus on the development of 10 case studies, aligned to the five priority areas.

The focus of the case studies will be proposed by the evaluators, and agreed by the Aboriginal Health Branch. Case studies will focus on the success factors leading to, or highly likely to contribute to, improved outcomes. Qualitative interviews will be undertaken for the agreed case studies in October 2012, and again in 2013 to re-visit the sites of positive change and understand the extent to which change has been embedded over the 12 month period. The case studies will be included in the Interim Evaluation and the Final Evaluation reports.

The case studies will address each of the following aspects:

- consumer experience of the new/improved service, and reflections on previous arrangements to the extent possible (different consumers in 2012 and 2013)
- the governance arrangements that have or are supporting a change or improved system of care
- the clinical or other partnerships in place and how they were established/utilised
- the extent of community engagement/ownership of the new or enhanced service and how this has been achieved
- the factors that will ensure the new or enhanced service can be sustained.