Australian Government
Department of Health and Ageing

CLOSING THE GAP
tackling Indigenous chronic disease

Closing the Gap

The Indigenous Chronic Disease Package in 2009-10

Annual Progress Report on the Australian Government's contribution to the **National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes**

November 2010

Closing the Gap.

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Disclaimer
To many Aboriginal and Torres Strait Islander communities, it is disrespectful and offensive to display photography of persons who have passed away. This report may contain such photos and we apologise to any communities who may be offended.

Foreword

Australia has an unprecedented opportunity to improve Aboriginal and Torres Strait Islander health.

As a group, Aboriginal and Torres Strait Islander peoples have one of the lowest life expectancy rates in the nation. A large part of this is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease. Many of these have common risk factors, including smoking, poor nutrition and lack of exercise.

Great work is being done by many dedicated people around Australia and there have been significant achievements, but more is needed. Much of the excess burden of disease can be prevented and managed with better access to health services, education and support for lifestyle changes.

The Indigenous Chronic Disease Package aims to achieve this by providing support to the health sector and better access to health care for Aboriginal and Torres Strait Islander peoples. It addresses the risk factors that cause chronic disease in the first place and seeks to improve how chronic disease is managed through better primary care and coordinated follow-up care.

The Package recognises and builds upon the many successful programs and initiatives already working in communities throughout Australia, and also provides training and support for an expanded Indigenous health workforce.

Fundamentally, the Package recognises that equity of access to health services and information is vital if Aboriginal and Torres Strait Islander peoples are to make informed choices about their own health care.

As the Minister for Indigenous Health, I am pleased to present the first progress report on the implementation of the Indigenous Chronic Disease Package under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

This progress report provides the Aboriginal and Torres Strait Islander community, state and territory governments and the wider Australian public with a valuable update on what has been achieved in these first 12 months.

I acknowledge and thank the many people who have dedicated themselves to closing the gap and supported the work undertaken through this Package.

The Honourable Warren Snowdon MP
Minister for Indigenous Health

Introduction

This report details progress in implementing the Indigenous Chronic Disease Package in 2009-10. It demonstrates how the Australian Government's commitment to tackling chronic disease and helping close the gap in health outcomes between Aboriginal and Torres Strait Islander and other Australians is being achieved.

This is the first report by the Australian Government on its progress in implementing the Indigenous Chronic Disease Package.

It covers the period from 1 July 2009 to 30 June 2010 and reports against the benchmarks and deliverables in the Australian Government's Implementation Plan, as required by the National Partnership Agreement.

The report also includes case studies from some of the organisations who are involved in the implementation of the Package.

For More Information

For more information on the Australian Government's Indigenous Chronic Disease Package or to obtain a copy of the Implementation Plan, please visit us at:

www.health.gov.au/tackling-chronic-disease

Acronyms

ACCHO	Aboriginal Community Controlled Health Organisation
ATSIOW	Aboriginal and Torres Strait Islander Outreach Worker
CDMP	Chronic Disease Management Program
COAG	Council of Australian Governments
FTE	Full-time Equivalent
GPET	General Practice Education and Training
ICDP	Indigenous Chronic Disease Package
MBS	Medicare Benefits Schedule
MSOAP	Medical Specialist Outreach Assistance Program
NACCHO	National Aboriginal and Community Controlled Health Organisation
NPA	National Partnership Agreement
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
RTO	Registered Training Organisation
USOAP	Urban Specialist Outreach Assistance Program

* For the purpose of this report, an Indigenous health service is a practice, Aboriginal community controlled health service, or a clinic providing primary care services to a predominantly Aboriginal and Torres Strait Islander population.

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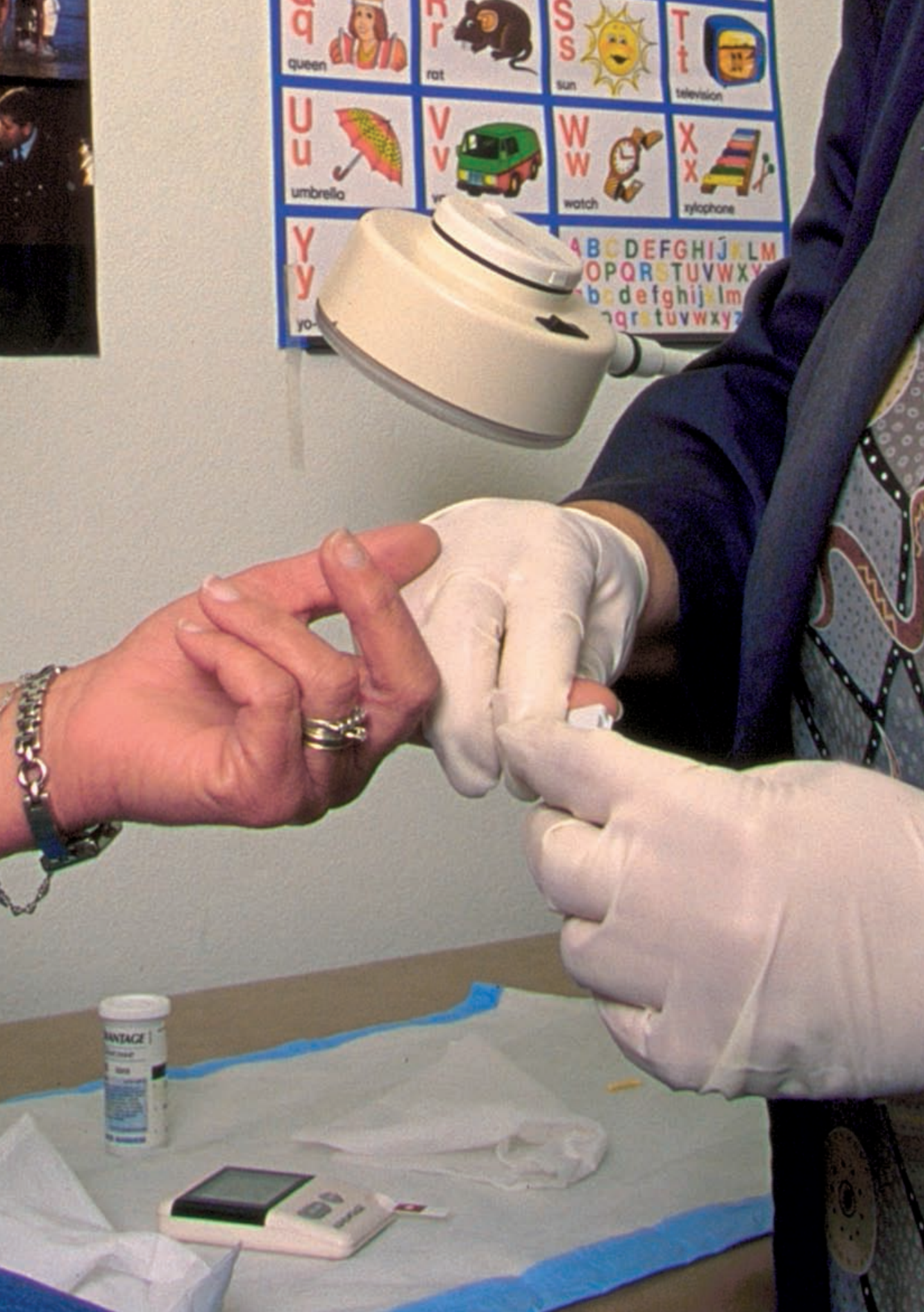
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Overview

Overview

The Indigenous Chronic Disease Package plays an important role in the Australian Government's wider response to closing the gap in Indigenous disadvantage. It is the Australian Government's contribution to the $1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, agreed to by the Council of Australian Governments in November 2008. This partnership aims to contribute to closing the gap in life expectancy between Aboriginal and Torres Strait Islander and other Australians within a generation.

Aboriginal and Torres Strait Islander peoples experience a burden of disease two and a half times that of other Australians.[1] A large part of the burden is due to chronic diseases such as cardiovascular disease, diabetes, cancer, chronic respiratory disease and chronic kidney disease.[2]

The Indigenous Chronic Disease Package is helping to build a primary health care system that meets the needs of Aboriginal and Torres Strait Islander peoples. It takes a holistic approach to addressing the risk factors which lead to chronic disease, increasing people's understanding of the lifestyle choices which lead to chronic disease, and building their awareness of ways the health system can help prevent chronic disease. The Package also focuses on improving the detection and management of chronic disease in primary health care settings, including providing better access to follow-up and specialist services.

It is essential that comprehensive and effective primary health care can be delivered for Aboriginal and Torres Strait Islander peoples wherever they live in Australia. To achieve this, the Package is providing support to both Indigenous-specific health services and general practices.

One of the key barriers to improving health care outcomes for Aboriginal and Torres Strait Islander peoples is poor access to primary health care services. This is why the Package includes an emphasis on factors which limit Aboriginal and Torres Strait Islander people's access to and use of, mainstream health care services. The Package addresses issues such as cost, location or transport problems, and the provision of culturally sensitive services.[3]

The Package also provides more support to the health sector to help tackle the challenges many health services face when providing care to Aboriginal and Torres Strait Islander peoples. These include understanding who their Aboriginal and Torres Strait Islander patients are, time and cost pressures

involved in managing complex and chronic conditions, ignorance of the specific health needs of Aboriginal and Torres Strait Islander peoples, and lack of resources for case coordination.

Only by addressing the known barriers to better health care outcomes can the goal of closing the gap in life expectancy be realised. Over its first four years, this Package will start addressing these barriers by promoting and supporting good health for Aboriginal and Torres Strait Islander peoples, building the capacity of primary health care providers to deliver more effective health care, and improving access to essential follow-up services such as allied health and specialist care.

The Indigenous Chronic Disease Package in 2009-10

The Indigenous Chronic Disease Package began on 1 July 2009. The first 12 months included extensive consultation with stakeholders, peak bodies and experts to ensure it was developed in a coordinated way that will result in real improvements in health outcomes for Aboriginal and Torres Strait Islander peoples.

Implementation in 2009-10 focused on funding and recruiting the first wave of a new workforce which will lay the groundwork for the future and support the implementation of new components of the Package in coming years.

Looking forward: The Indigenous Chronic Disease Package in 2010-11

In 2010-11, the primary health care workforce will continue to be expanded, and new healthy lifestyle and tobacco action workers will be recruited to target the risk factors which cause chronic disease.

This prevention workforce will be supported by a targeted national campaign to increase Aboriginal and Torres Strait Islander people's awareness of chronic disease risk factors and build understanding of the health systems in place to help them improve their health. Local, community-run health campaigns will also promote better health and wellbeing from within communities.

Aboriginal and Torres Strait Islander peoples with an existing chronic disease will receive more support and education to help them manage their condition more successfully. Those needing more complex chronic disease management will receive help to access necessary services through the new Care Coordination and Supplementary Services Program.

The following year will also see more expanded training and professional development opportunities in the Indigenous health sector, as well as communication campaigns to encourage more Aboriginal and Torres Strait Islander peoples, particularly secondary school students, to consider taking up a career in health.


Nunkuwarrin Yunti
of South Australia Inc
"Working Together"

Working in Partnership

Working in Partnership

Overcoming generations of Indigenous disadvantage needs a long-term commitment. Careful planning now will ensure the initiatives in the Indigenous Chronic Disease Package produce tangible benefits for Aboriginal and Torres Strait Islander communities in the long term.

The Australian Government is committed to working in partnership with both the mainstream and Indigenous health sectors to develop and implement this Package, taking feedback on board where possible to reflect the best available advice.

The National Indigenous Health Equality Council brings together Indigenous and non-Indigenous health experts from across the country to provide advice to the Ministers for Health and Ageing and Indigenous Health on the implementation of, and progress towards, the Australian Government's commitments to closing the gap in health inequality. This includes providing overarching policy advice for the Package.

The Australian Government has worked with Indigenous Health Partnership Forums in each state and territory to ensure that the Package targets regional priorities and does not overlap or duplicate existing service delivery. The forums provide advice on implementing the Package and include representatives from the Australian Government Department of Health and Ageing, state and territory governments and the Aboriginal community controlled health sector. Representation from the Divisions of General Practice Network has also been included in considering implementation of the Package.

In 2009-10, some of the key achievements of the forums include:

- Agreement on priority areas for the first new Indigenous health workforce positions;
- Early identification of issues and risks, and strategies or solutions to manage these; and
- Coordination of complementary Commonwealth and state and territory activities to avoid duplication.

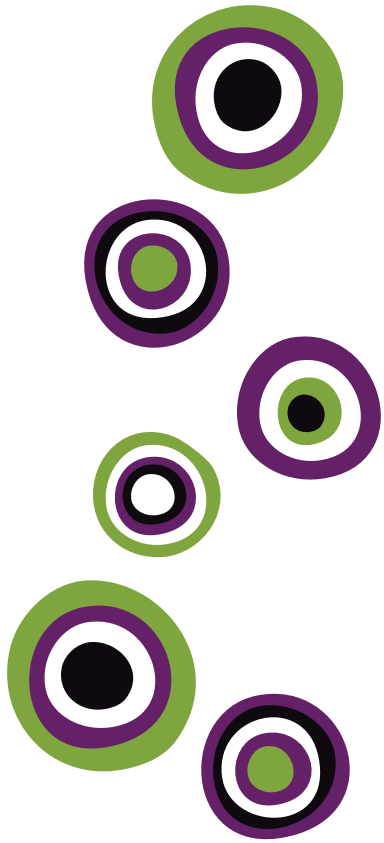
In some jurisdictions, forum sub-groups have been established to provide a more specific focus on implementation issues and a greater level of expert advice on individual elements of the Package. These sub-groups have been able to bring 'on the ground' and clinical expertise into the decision-making process to better inform the rollout of measures under the Package.

Forums and their sub-groups have also helped strengthen the relationships between the mainstream and community

controlled sectors. This has not only benefited implementation of this Package, but will also serve to improve the quality and coordination of all health care provided to Aboriginal and Torres Strait Islander peoples.

A number of national-level technical reference groups were also established to ensure the implementation of each measure is informed by the latest expert advice. These groups have provided valuable feedback which has shaped and guided the development of new initiatives.

The Department of Health and Ageing has also consulted directly with local stakeholder organisations on implementing the Package. In Queensland, the forum agreed to make south-east Queensland a key priority, which led to the Department consulting with the Institute for Urban Indigenous Health. By working with a locally-based organisation, the Department was able to identify the best areas in the region to implement new initiatives, which will improve service delivery for the Aboriginal and Torres Strait Islander peoples of south-east Queensland.



Highlights & Challenges

CHALLENGE: Developing implementation strategies across a range of sectors with diverse views on how closing the gap should be achieved.

HIGHLIGHT: A total of 294 new positions added to the Indigenous health workforce:

- 83 Aboriginal and Torres Strait Islander Outreach Workers
- 41 Healthy Lifestyle Workers
- 21 Tobacco Action Workers
- 20 Tobacco Action Coordinators
- 34 additional Practice Manager and other health professional positions in Indigenous health organisations
- 95 Indigenous Health Project Officers

HIGHLIGHT: The number of follow-up services that can be claimed by an Aboriginal Health Worker or practice nurse following a health assessment increased from five to 10. In 2009-10, 3,564 services were provided by Aboriginal health workers and practice nurses, an increase of 611% on 2008-09.

HIGHLIGHT: The new Practice Incentives Program (PIP) Indigenous Health Incentive began in May. By 30 June 2010, around 850 PIP practices and Indigenous health services had joined the incentive, and around 2900 patients had been registered.

HIGHLIGHT: 29,799 Indigenous adult health checks provided, an increase of 26.1% on 2008-09.

CHALLENGE: Developing a clear and easy to understand Monitoring and Evaluation framework for a complex Package, including extensive input from a range of stakeholders.

HIGHLIGHT: Multidisciplinary health professional outreach teams provided 148 services in rural and remote Aboriginal and Torres Strait Islander communities as part of the expanded Medical Specialist Outreach Assistance Program.

CHALLENGE: Incorporating stakeholder feedback on the tackling smoking and healthy lifestyle measures, leading to a revision in the way these work together. This has meant a short delay in the introduction of this workforce from May 2010 until July 2010.

HIGHLIGHT: 38 additional general practitioner registrar training posts have been filled in Indigenous health services.

CHALLENGE: Changing the way the complex mainstream health system responds to the needs of Aboriginal and Torres Strait Islander patients and fostering a coordinated effort between mainstream and Aboriginal community controlled health services when implementing measures.

HIGHLIGHT: Dr Tom Calma engaged as the National Coordinator for Tackling Indigenous Smoking.

HIGHLIGHT: Chronic Disease Management Package items were utilised by 131,030 Indigenous clients.

The Indigenous Chronic Disease Package

Tackling Chronic Disease Risk Factors

The prevention of chronic disease and associated risk factors is critical to closing the gap in life expectancy. The Indigenous Chronic Disease Package is helping Aboriginal and Torres Strait Islander peoples to adopt healthy lifestyles by reducing smoking rates, improving awareness of lifestyle risk factors and increasing access to services which promote better health and wellbeing.

2009-10 activity overview and key achievements

Tobacco smoking alone is responsible for 20% of all deaths for Aboriginal and Torres Strait Islander peoples.[3] To address this, new initiatives began in 2009-10 to provide Aboriginal and Torres Strait Islander people with access to culturally appropriate smoking cessation services and support.

Getting the message out

In 2009-10, comprehensive market research programs were conducted as the first step in developing targeted communication activities for local Aboriginal and Torres Strait Islander communities. These campaigns will encourage smoking attitude and behaviour change and increase Aboriginal and Torres Strait Islander peoples' awareness and understanding of the risk factors for chronic disease. This includes the importance of making healthy lifestyle choices and knowing how local health services can help prevent or better manage chronic disease.

Tackling smoking workforce

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

By 30 June 2010, funding had been provided in 20 regions and the ACT for the first wave of a new workforce that will establish a national network of regional Tobacco Coordinators and Tobacco Action Workers. Under the leadership of the National Coordinator, this workforce will operate in teams alongside Healthy Lifestyle Workers to implement a range of community-based prevention and cessation support activities tailored to the need and circumstances of local Aboriginal and Torres Strait Islander communities.

Support for healthy lifestyles

Along with the tackling smoking workforce, funding was also provided for the recruitment of new Healthy Lifestyle Workers, who will focus on improving nutrition and physical activity for individuals, families and communities. They will work with the tackling smoking workforce as a team to reduce the key lifestyle risk factors that are the main contributors to the development of preventable chronic disease.

Next Steps: Looking forward to 2010-11

In 2010-11, the tobacco control and healthy lifestyle workforces will be expanded into a further 20 regions. Up to 200 existing health workers and community educators will also be trained to deliver interventions to reduce smoking.

Locally-run Indigenous community campaigns to promote better health will also begin in 2010-11.

Dr Tom Calma, National Coordinator for Tackling Indigenous Smoking.

Meet Dr Tom Calma, the first National Coordinator for Tackling Indigenous Smoking

Dr Tom Calma is well known to many as a champion for Indigenous rights in Australia. Dr Calma was the Aboriginal and Torres Strait Islander Social Justice Commissioner from mid 2006 to February 2010. His passion and his determination are now being applied to tackling the challenge of tobacco smoking, having accepted the position as the first ever National Coordinator for Tackling Indigenous Smoking.

"A major focus of the Indigenous Chronic Disease Package is to cut smoking rates in Indigenous communities and my role as National Coordinator is to lead this initiative. The Package is providing the resources to make this work; we need to develop strategies to get the right messages out in a way that's appropriate to the life experience of an Aboriginal or Torres Strait Islander person. So that's the first thing."

Dr Calma described his role as being a coordinator and a leader, working to develop partnerships between Aboriginal and Torres Strait Islander people, governments and the community.

"Things don't change overnight because the Government says 'let's stop smoking'. It's a mindset change and a societal change. It's a change that's going to take place over a lifespan...But to make it work, it requires everybody to work together and that's what my role's going to be – to try and facilitate that process," he said.

Dr Calma is an Aboriginal elder from the Kungarakan tribal group and the Iwaidja tribal group whose traditional lands are south west of Darwin and on the Coburg Peninsula in the Northern Territory. He has been involved in Indigenous affairs at a local, state and national level and has worked in the public sector for more than 38 years.

Improving Chronic Disease Management

Improving the detection and treatment of chronic disease and addressing barriers to accessing health care by Aboriginal and Torres Strait Islander peoples is a central focus of the Package. New initiatives are assisting primary health care services to provide better health care for Aboriginal and Torres Strait Islander peoples, with a focus on earlier detection and treatment of chronic disease and associated risk factors.

2009-10 activity overview and key achievements

In 2009-10, significant work was done to address the barriers Aboriginal and Torres Strait Islander peoples face in accessing primary health care, to get more people to see their health care providers.

Supporting primary care providers

An important milestone for the Package was the introduction of the Practice Incentives Program (PIP) Indigenous Health Incentive in May 2010. This new payment supports accredited general practices and Indigenous health services to provide more comprehensive and coordinated care to their Aboriginal and Torres Strait Islander patients. It also encourages mainstream services to make their practices more culturally appropriate for Aboriginal and Torres Strait Islander peoples, helping to address one of the major barriers to better health care.

Health services and general practices participating in this program will also be able to refer Aboriginal and Torres Strait Islander clients needing more complex chronic disease management to the new Care Coordination and Supplementary Services Program which will come on-line progressively from late 2010.

Next Steps: Looking forward to 2010-11

The cost of medicines is a key barrier to Aboriginal and Torres Strait Islander people properly managing chronic disease and risk factors. To help with this, changes to the Pharmaceutical Benefits Scheme (PBS) were introduced on 1 July 2010. These will allow many more Aboriginal and Torres Strait Islander peoples to access more affordable – and in some instances free – PBS medicines.

In 2010-11, promotional activities will be implemented to increase the uptake of specific Medicare Benefits Schedule (MBS) items which provide appropriate early intervention to prevent, or delay the onset of chronic disease; help with early diagnosis; and provide a path into ongoing management of existing chronic diseases.

Substantial planning was undertaken in 2009-10 to develop new chronic disease self management programs. In 2010-11, up to 100 existing health workers will be trained to deliver chronic disease self management sessions, assisting Aboriginal and Torres Strait Islander peoples receive the support they need to manage their chronic conditions more successfully.

Supporting comprehensive care

Primary health care services across Australia are rapidly discovering the benefits of the new Practice Incentives Program (PIP) Indigenous Health Incentive.

The South West Aboriginal Medical Service (SWAMS), based in Bunbury, Western Australia, is one of the organisations already taking advantage of this program.

Quenten Jackson, Health Service Manager at the service, has been involved in Aboriginal health for more than 30 years and is excited about the benefits this new program presents for both the service and its clients.

"The PIP will provide enormous benefits to our organisation because, apart from providing that continuity of care to our Aboriginal patients, the income derived from those payments will actually go towards subsidising many of the other things that we do for our Aboriginal patients at SWAMS, for example transport and health aids.

The incentive for us now is to move forward with our dream of providing a comprehensive health service and increasing and enhancing the continuity of care."

Quenten Jackson, South West Aboriginal Medical Service

Improving Chronic Disease Follow-Up Care

The Package is encouraging better management of chronic disease, with more coordinated care and better access to specialist and allied health services for Aboriginal and Torres Strait Islander people with chronic disease.

2009-10 activity overview and key achievements

Access to ongoing care, including specialist care provided by members of a multidisciplinary team, is important to good chronic disease management. Many Aboriginal and Torres Strait Islander people cannot afford the specialist and allied health services they need to ensure their chronic diseases are well managed. Workforce shortages, lack of transport and cost mean clients often have difficulty accessing specialist care.

Aboriginal and Torres Strait Islander people who receive a health assessment are now eligible for more comprehensive follow-up and preventative care. In 2009-10, the maximum number of MBS-funded follow-up services provided by a practice nurse or registered Aboriginal Health Worker increased from five to 10 services per year following a health assessment. Early data already suggests there has been a significant increase in the number of health checks completed in 2009-10 compared to previous years.

In addition, new specialist outreach programs developed in 2009-10 are now connecting Aboriginal and Torres Strait Islander peoples at risk of or living with a chronic disease with the specialist and allied health care they need, wherever they live.

Urban and Regional Australia

The first Urban Specialist Outreach Assistance Program (USOAP) services were provided in Armidale, NSW in May 2010. This initiative supports outreach services by specialists focusing on chronic disease for Aboriginal and Torres Strait Islander peoples living in urban areas.

Rural and remote Australia

An expanded Medical Specialist Outreach Assistance Program (MSOAP) was also launched in 2009-10, with 148 services provided in Western Australia, New South Wales and Queensland by 30 June 2010. This initiative provides outreach services by multidisciplinary health teams in rural and remote Indigenous communities. The composition of the teams varies depending on the specific health and treatment needs of each community, and can include specialists, general practitioners and allied health professionals.

Next Steps: Looking forward to 2010-11

Planning has begun for further MSOAP services in 2010-11, including consultations with local Aboriginal and Torres Strait Islander communities, health services and the Indigenous Health Partnership Forums in each jurisdiction.

Support will be available to general practices and Indigenous health services participating in the PIP Indigenous Health Incentive to help in providing their Aboriginal and Torres Strait Islander clients with more proactive follow-up care through the new Care Coordination and Supplementary Services Program. This will improve the quality of care provided to Aboriginal and Torres Strait Islander people with a chronic disease by addressing the barriers people face in accessing the full range of care set out in their care plan.

Expanded MSOAP Services in Western Australia

Aboriginal and Torres Strait Islander people living in the Kimberley region of Western Australia now have increased access to specialist and multidisciplinary team follow-up care through the expanded MSOAP measure. Starting in June 2010, a multidisciplinary renal team comprising a renal physician, nurse and Aboriginal health worker, have provided 15 consultation services to this community.

This initiative has enabled specialist services to expand their reach, and support the growing Kimberley Renal Support Service to extend complementary multidisciplinary team care targeting chronic renal disease across the region. The main regional centres in the Kimberley, including Broome, Derby, Fitzroy Crossing, Halls Creek and Kununurra, are serving as hubs and drawing in patients from small nearby communities.

Through the expanded MSOAP, 11 very remote communities in the Ngaanyatjarra Lands are also receiving much needed additional health care by a dedicated multidisciplinary team comprising a general physician, chronic disease nurse and Aboriginal health worker. This has increased services for these communities by 50%. With ongoing up-skilling also provided to the health staff at the various communities, funding provided through this initiative will in turn increase the capacity of Indigenous health organisations to provide better continuity of care for Aboriginal and Torres Strait Islander people with chronic and complex health conditions.

Workforce Expansion, Training and Support

A strong and culturally competent primary care workforce is a key component of a health system that can respond effectively to the needs of Aboriginal and Torres Strait Islander people. Building the capacity of the health workforce and of primary care services will improve Aboriginal and Torres Strait Islander people's access to comprehensive, coordinated and culturally appropriate health care.

2009-10 activity overview and key achievements

A shortage of people working in Indigenous health who are trained in the specific needs of Aboriginal and Torres Strait Islander people contributes to lower rates of Aboriginal and Torres Strait Islander people accessing primary health care, specialist and allied health services. Funding a new workforce, providing additional training and professional development opportunities, and expanding key Indigenous health services have been the first steps in building the capacity of primary care services to ensure Aboriginal and Torres Strait Islander peoples have access to quality health care.

Expanding the Indigenous health workforce

The new workforce introduced nationally in 2009-10 includes 95 full-time equivalent (FTE) Indigenous Health Project Officers in Divisions of General Practice, the Australian General Practice Network, the National Aboriginal Community Controlled Health Organisation (NACCHO) and their state and territory affiliates. Project Officers are working to increase the focus on Indigenous health at the local level and help mainstream primary care providers deliver culturally sensitive services to Aboriginal and Torres Strait Islander peoples.

A total of 83 FTE Aboriginal and Torres Strait Islander Outreach Workers have been funded in Divisions of General Practice and Indigenous health services. These positions will help connect Aboriginal and Torres Strait Islander people to services and build their knowledge and confidence in using the health care system.

Indigenous health services were also funded to employ an additional 20 practice managers and 14 health professionals to develop their capacity to meet the expected increase in demand for services.

Building capacity and excellence in Indigenous health

An additional 38 general practitioner registrar training posts were established in Indigenous health services and all positions have been filled.

Capital works programs were also funded in 2009-10 to extend an existing Indigenous health service clinic at Rumbalara in Victoria, and to build a new clinic and staff housing facilities in Wiluna, Western Australia.

With the objective of building the capacity of the health care system to be more responsive to the needs of Aboriginal and Torres Strait Islander people, market research was completed in 2009-10 that will inform a national communications campaign to encourage more young Aboriginal and Torres Strait Islander people to pursue a career in health. This research provided valuable insights into Aboriginal and Torres Strait Islander students' levels of knowledge and interest in pursuing health-related careers, and has highlighted the barriers, motivators and potential supports for educational and vocational pathways into the health sector.

Next Steps: Looking forward to 2010-11

The Indigenous health workforce not only needs to be skilled and competent, it also needs to be sustainable. It is important to encourage Aboriginal and Torres Strait Islander peoples to consider taking up a career in health, and for more health professionals to think about Indigenous health as a career path.

The next step in building the capacity of this workforce will start in 2010-11, when a new national communications campaign will be launched which encourages more young Aboriginal and Torres Strait Islander peoples to think about careers in health.

The existing workforce will also be bolstered in this next year through the recruitment of more Aboriginal and Torres Strait Islander Outreach Workers.

A national, multi-disciplinary orientation package will be developed over the next year for workers in the Indigenous health sector.

An additional 50 nursing clinical placements and 50 professional development scholarships in Indigenous health services will be available in 2010-11. This will provide student nurses with exposure to and training in Indigenous health and support nurses currently working in Indigenous health services to enhance their skills.

In 2010-11, a new Primary Health Care Resource will be launched to link health professionals with the latest information and best chronic disease detection, identification and treatment practices to improve the quality of care they provide to their Aboriginal and Torres Strait Islander clients.

Creating partnerships

New health workers are now in place across Australia, filling gaps in service delivery and ensuring Aboriginal and Torres Strait Islander people receive more coordinated care.

Karen Waigana is the new Indigenous Health Project Officer for the Rockingham Kwinana Division of General Practice in Western Australia.

"The Indigenous health and lifestyle role for Rockingham Kwinana is exciting – because even though it's a national program, we get to mould it locally so we're doing what's best for own community," Karen, locally raised and mother of two, says. "I think it's a good thing for Aboriginal health. It's about creating partnerships and doing things the Indigenous way – 'cause then it creates a genuine commitment."

'Creating partnerships' is precisely what Karen and her co-worker Aboriginal Outreach Worker Emma Castle, who has also joined the Rockingham Kwinana Division of General Practice under the Indigenous Chronic Disease Package program, are doing. They share common goals and objectives.

"My new role is to help people access medical appointments, allied health appointments and access pharmacists and complete their prescriptions. But it's also about addressing issues to do with transport and access to their appointments," Emma says.

Local Division of General Practice CEO Peter Cook is pleased to have both Karen and Emma on board.

"Karen and Emma have come together as a team and I think just the respect they have in the community, the fact they have been able to bridge us Wadulas with the Gnungar community, has been terrific in being able to say this is a true partnership," he says.

Emma Castle and Karen Waigana,
Rockingham Kwinana Division of General Practice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JANSSEN-CILAG

Monitoring and Evaluation

Monitoring and Evaluation

It is important that the progress of the Indigenous Chronic Disease Package is monitored closely to ensure its outcomes and intended benefits are achieved.

For this reason, the Package includes a comprehensive monitoring and evaluation component. There are three key elements of this measure; the development of a monitoring and evaluation framework; the sentinel sites project; and the development of a web based reporting system.

Monitoring and evaluation framework

The draft monitoring and evaluation framework was developed in 2009-10, and will be finalised in early 2010-11.

It will guide the ongoing monitoring of activities under the Package as well as the overall evaluation to be undertaken in 2012-13.

The framework will also guide an assessment of the effectiveness of the Package in reducing chronic disease-related morbidity and mortality in Aboriginal and Torres Strait Islander people in the longer term – beyond the scope of the final Package evaluation to be completed in 2012-13.

It will not only help define the impacts and outcomes of the Package, but also identify the key lessons learned about how to design, manage and implement a complex inter-related package of measures like this one, which is delivered across multiple settings and sectors.

The sentinel sites project

Sentinel sites are a key tool for monitoring the progress of the Indigenous Chronic Disease Package. They are defined geographic areas across Australia that will cover metropolitan, regional and remote areas, and will enable the collection of information regarding the implementation and early outcomes of the Package.

Organisations participating in this project will help to inform the ongoing implementation of the Package, identifying outcomes and providing feedback on any barriers or enablers impacting implementation.

Web based reporting system

National key performance indicators for Indigenous specific primary health care services are being developed by the Australian Government Department of Health and Ageing, in partnership with state and territory health departments, and in collaboration with the Australian Institute for Health and Welfare.

These indicators are on track for agreement by the Australian Health Ministers in 2011. Development of a web-based reporting system is under way to enable ongoing reporting against these indicators in an efficient, nationally consistent way.


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Implementation Progress

Progress Against Benchmarks and Deliverables

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities (A1)	Number and key results of culturally secure community education/health promotion/social marketing activities to promote quitting and smoke-free environments Number of service delivery staff trained to deliver the interventions Data against the benchmarks will be reported in 2010-11	Partnership, program and funding arrangements agreed with jurisdictions.	As agreed with state and territory governments, funding for tackling smoking workforce will be provided directly to appropriate organisations
		National formative campaign research undertaken	Formative market research to inform the development of social marketing activities has been completed, and a marketing strategy is under development
		National Coordinator appointed	Dr Tom Calma has been appointed the National Tackling Smoking Coordinator
		Funding provided for enhanced culturally sensitive services delivered by Quitline	Funding provided for the enhancement of Quitlines in all states and territories except Tasmania and the Northern Territory. Funding for Tasmania and the Northern Territory will be provided in 2010-11
		Regional tobacco action coordinators recruited to cover 20 sites	Funding provided for a tackling smoking workforce in 20 regions and the ACT and rollout of the workforce will commence in July 2010

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Assist Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices (A2)	Number of service delivery staff trained to deliver the interventions Data against the benchmark will be reported in 2010-11	Nationally recognised and accredited core competencies and training program developed for delivery by the VET sector or other appropriate education and training organisation – February 2010	Aboriginal and Torres Strait Islander Registered Training Organisation Network have identified currently available appropriate VET training courses
		Training and service provision funding agreements in place – March 2010	Edith Cowan University (HealthInfoNet) has been contracted to develop resource packs for the Regional Tobacco Coordinators, Tobacco Action Workers and Healthy Lifestyle Workers
		Recruitment of healthy lifestyle workers commences – June 2010	Funding provided for the recruitment of 41 healthy lifestyle workers in 20 regions and the ACT.
		Training of healthy lifestyle workers commences – May 2010	Host organisations are responsible for ensuring workers engage in appropriate VET training, induction training and ongoing development
Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing (A3)	Number and key results of culturally secure community education/health promotion/social marketing activities to promote quitting and smoke-free environments Data against the benchmark will be reported in 2010-11	Partnership, program and funding arrangements agreed with jurisdictions	This activity has been delayed due to additional time needed to complete the formative research and subsequent marketing strategy.
		Undertake research program	Formative market research to inform the development of local Indigenous community campaigns has been completed, and a marketing strategy is under development
		Community partnership programs developed	Funding provided to eight Divisions of General Practice State Based Organisations and eight Aboriginal Community Controlled Health Organisation Affiliates to promote MBS indigenous health assessment, chronic disease management and follow-up items

Progress Against Benchmarks and Deliverables

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Improve access to and quality use of Pharmaceutical Benefits Schedule (PBS) medicines for Indigenous Australians with chronic disease or chronic disease risk factors who attend a participating general practice or Indigenous health service in a non-remote area (B1)	No specific benchmark	Program governance arrangements established	Program governance arrangements established through the PBS Copayment Measure Technical Reference Groups
		Information technology support rolled out	Pharmacist dispensing software upgraded to permit implementation on 1 July 2010. GP prescribing software providers have been funded to provide upgrades.
		Training and education materials developed	Program guidelines and communications materials for GPs and pharmacists have been finalised and are publicly available
Provide increased funding to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to meet higher utilisation costs by Indigenous Australians accessing complementary programs in this Plan (B2)	Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check	Legislation amended to increase the cap on services for Practice Nurse/ Aboriginal Health Worker follow up items	Legislative amendment effective from 1 November 2009. 29,799 Indigenous adult health assessments provided, an increase of 26.1% on 2008-09 3,564 Indigenous specific services were provided by Aboriginal health workers and practice nurses in 2009-10, an increase of 611% on 2008-09

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Encourage general practices to provide better health care for Indigenous Australians and improve the continuity of care for those with chronic health conditions (B3)	Number of Indigenous specific health services meeting national minimum standards Improved patient referral and recall for more effective health care, and in particular, chronic disease management Data against the benchmarks will be reported in 2010-11	Business rules agreed with Medicare Australia	Business rules have been agreed with Medicare Australia
		Implementation commences May 2010	The first payments through the Practice Incentives Program (PIP) Indigenous Health Incentive were made to eligible practices in May 2010 By 30 June 2010, around 850 PIP practices and Indigenous health services had joined the incentive, and around 2900 patients had been registered
		CDMP fund holders contracted	Funding agreements are in place with all fundholders (8 State Based Organisations) for the Care Coordination and Supplementary Services Program
Support Indigenous Australians to better manage or self manage their chronic disease (B4)	Improved patient referral and recall for more effective health care, and in particular, chronic disease management	Nationally recognised and accredited core competencies and training program developed for delivery by the VET sector or other appropriate education and training organisation – February 2010 Training and service provision funding agreements in place – March 2010	Flinders University of South Australia has been engaged to develop, pilot and deliver a specialist Chronic Disease Self Management (CDSM) support training program which is suitable for delivery to Indigenous Australians in a range of settings and circumstances
		Commencement of healthy lifestyle training	In July 2010, organisations employing health workers who manage large numbers of Aboriginal and Torres Strait Islander patients will be invited to identify staff to receive the training and deliver CDSM sessions to patients
		Commencement of delivery of risk modification/ self management sessions or activities	The development phase of CDSM training will include an evaluative trial of the program design which will delay the formal commencement of service delivery until September 2010. This delay will not impact on the service delivery targets of 5,000 sessions delivered by end 2010-11

Progress Against Benchmarks and Deliverables

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Increase access to specialist and multidisciplinary team follow-up care for Indigenous Australians (B5)	No specific benchmark	MSOAP guidelines enhanced following consultation with key stakeholders Communities/ chronic conditions identified for MSOAP support MSOAP service plans finalised and approved from Jan 2010.	First MSOAP services have commenced in Qld, WA and NSW, with 148 services provided across these states
		Urban outreach services to commence from May 2010	The first urban specialist outreach services were delivered in NSW in May 2010
Increase access to specialist and multidisciplinary team follow-up care for Indigenous Australians (B5)		Flexible funds pools holding arrangements available from May 2010	Flexible funding for specialist follow-up is now being managed as a component of the Care Coordination and Supplementary Services Program (B3)
Monitor and evaluate the Closing the Gap Chronic Disease initiative (B6)	Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets	Monitoring and evaluation framework developed.	Draft monitoring and evaluation framework was developed and will be finalised by early August 2010
			Consultant engaged to develop a web-based reporting tool for Aboriginal Community Controlled Health Organisations to simplify and streamline reporting on health service provision

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Build the Indigenous health workforce through education and training initiatives (C1)	No specific benchmark	Funding agreements in place with Registered Training Organisations (RTOs), nursing organisations and General Practice Education and Training (GPET)	Funding agreement is in place with Royal College of Nursing Australia to provide 50 nursing scholarships and 50 new nurse clinical placements each year over four years in Indigenous health services
		38 general practitioner (GP) registrar training posts	38 additional GP registrar training posts in Indigenous Health Services were established
		Training resources developed IOW* training and support commences *now referred to as Aboriginal and Torres Strait Islander Outreach Workers	NACCHO delivered jurisdictional workshops in WA, SA, NSW, Vic, Qld and the NT to identify orientation and training needs for Aboriginal and Torres Strait Islander Outreach Workers. Nationally consistent orientation and training programs are being developed in 2010-11 in each jurisdiction, based on outcomes from the jurisdictional workshops. In the interim, orientation is being provided at the local level to Outreach Workers where they are being employed

Progress Against Benchmarks and Deliverables

What we are aiming to do	Performance benchmark	Deliverables for 2009-10	Progress
Increase the capacity of Indigenous and mainstream health organisations to provide better continuity of care for Indigenous people with chronic and complex health conditions (C2 & C3)	Number of new case* managers/ Indigenous liaison officers (referred to as Indigenous Outreach Workers in the Commonwealth Implementation Plan) recruited and operational *referred to as practice managers in the Implementation Plan	71 positions recruited (IOWs*, practice managers, and additional health professionals) *now referred to as Aboriginal and Torres Strait Islander Outreach Workers	212 positions funded: • 83 full-time equivalent (FTE) Aboriginal and Torres Strait Islander Outreach Worker positions in Divisions of General Practice and ACCHOs • 20 practice manager and 14 additional health professional positions in ACCHOs • 95 FTE Indigenous Health Project Officer positions (87 in the Divisions of General Practice Network and 8 in NACCHO and its state/territory affiliates)
		Capital works projects to support increased activity associated with the Indigenous Chronic Disease Package and expanded workforce	Funding provided for capital works projects in Wiluna (WA) and Rumbalara (Vic)
		Three National Indigenous Health Equality Council (NIHEC) meetings conducted	Three NIHEC meetings have taken place
Encourage Aboriginal and Torres Strait Islander secondary school students to pursue a career in health. Generate interest and encourage more health professionals to work in Indigenous health (C4)	No specific benchmark	Market research program conducted	Formative research to inform the communication campaign to encourage Aboriginal and Torres Strait Islander secondary school students to take up careers in health was completed
		Advertising materials and resources developed Roadshow activities undertaken Website developed Sponsorship of health and Indigenous conferences	Delayed until 2011 due to additional time needed to complete the formative research and develop the marketing strategy
Ensure health service providers have access to relevant and culturally appropriate information to improve decision making processes and inform management options for Indigenous Australians (C5)	No specific benchmark	Consultation with experts commences and coordination across DoHA	The Primary Health Care Resource Technical Reference Group was established and is advising the Department on the development of the primary health care resource Work has already commenced on the development of the primary health care resource

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All information in this publication is correct as of 26 Nov 2010

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