FLINDERS HUMAN BEHAVIOUR & HEALTH RESEARCH UNIT

FLINDERS CLOSING THE GAP PROGRAM™
FINAL REPORT TO JUNE 10TH 2014

SUBMITTED TO

THE COMMONWEALTH DEPARTMENT OF HEALTH

JUNE 10TH 2014

SUBMITTED BY

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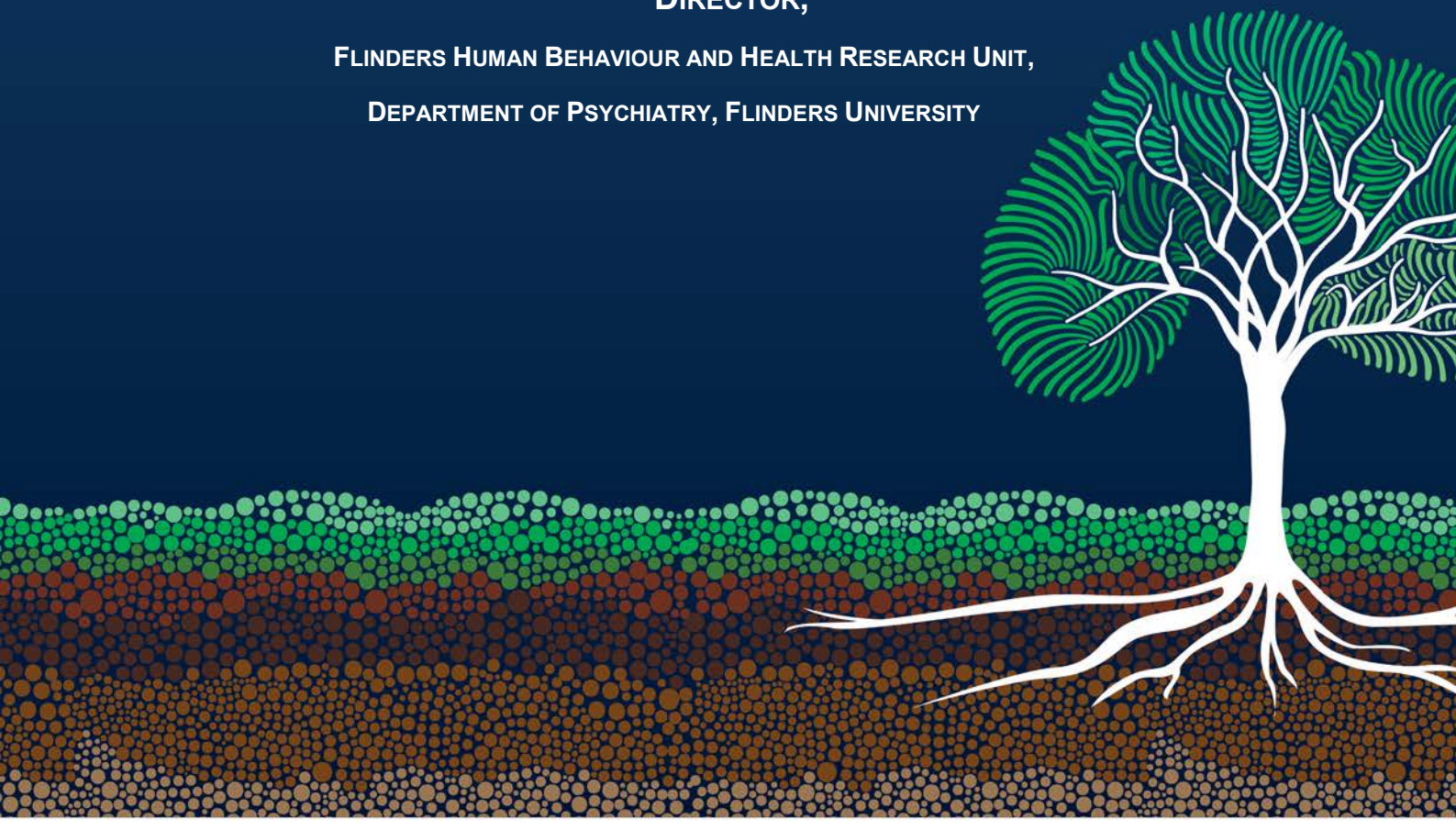

ACKNOWLEDGEMENTS

The Flinders Closing the Gap Program™ team wishes to acknowledge the Aboriginal and Torres Strait Islander volunteers from across Australia who provided their time and advice to trainers and trainees in workshops. Their support made the training successful. The framework of success was provided by the wise analysis and support offered by many welcome to country advisers who launched the workshops, set the scene and the context of local health issues. The support of Aboriginal Medical Services, General Practices, Medicare Local networks and state health services, in particular the Aboriginal Health Council of South Australia (AHCSA) and Port Lincoln Aboriginal Health Service is acknowledged. Without their broad based goodwill and active support the training would not have been possible.

The extensive behind the scenes work and dedication of the entire Flinders Closing the Gap Program™ team is also recognised.

This project of national reach and significance is enabled through the funding provided by the Commonwealth Department of Health under the Closing the Gap in Indigenous Health Outcomes Initiative.

Submitted by Professor Malcolm Battersby and the Flinders Closing the Gap Program™ team.

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EXECUTIVE SUMMARY

This report describes a range of achievements by the Flinders Human Behaviour and Health Research Unit (FHBHRU), Flinders University from May 2010 - December 2013 to provide training and implementation in the national Flinders Closing the Gap Program™ (FCTGP) with a focus on training health practitioners and health workers in self-management support.

This training program aimed to improve the self-management capabilities of Aboriginal and Torres Strait Islander people with chronic diseases and conditions across Australia, so that they together with their health workers and health practitioners could improve their health outcomes and ultimately close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the general Australian population. We cannot emphasise enough how the active involvement of our National Advisory Group (NAG) comprising mainly Aboriginal and Torres Strait Islander health workers and consumers has informed our programs' content and delivery.

Deliverables

The program of work had three components:

- to adapt and deliver the FCTGP training in each state and territory
- to engage with organisations to implement the FCTGP to ensure its use in practice and to enhance its sustainability
- Adapt the FCTGP for smoking cessation and provide this training to those who had previously received FCTGP training and to any new trainees.
- The FCTGP has met all of its deliverables in these three areas:

1. Training

Training in the FCTGP has been provided to 825 health practitioners with 61 progressing through the process of becoming an Accredited Trainer. 20 Accredited Trainers identify as being Aboriginal or Torres Strait Islander, with a further 12 expressing interest in becoming trainers in 2014. This exceeds the target of 400 health practitioners trained in the program and 20 receiving Accredited Trainers training. In addition a suite of training materials has been created including an educational DVD, manuals and a comprehensive website. Ten online learning modules have been designed with testing in the final stages and release planned for mid-June 2014.

2. Implementation

Currently 157 health services have been engaged by the FCTGP with 79 in phase one, 33 in phase two, 13 in phase three and 32 requesting engagement in 2014. A total of 6,866 care plans and 59,611 occasions of service have been recorded which exceeds the target of 50,000 occasions of service. This achievement is the result of a systematic implementation program provided to each health service to encourage change in the management of health services.

3. Living Well, Smoke Free Program

Training in the Living Well, Smoke Free Program has been provided to 120 health practitioners including 90 who have already received training in the FCTGP and 30 new trainees. 59 of the

trainees identify as being Aboriginal or Torres Strait Islander. In addition,38 Accredited Trainers have received training in Living Well, Smoke Free.

Training materials such as DVDs, training manuals and posters have been developed with online education modules due for completion in mid-June 2014. Resources designed to assist health practitioners engage with their clients have also been designed and include posters, flip charts and brochures. Extensive consultation with the community and cultural advisors was sought in the development of these materials.

This report provides examples of curriculum development, the education resources developed, the innovative implementation model and evaluation of these programs.

In the last 12 months of the program which focused on implementation, the national training and implementation teams had a rapid escalation of interest from organisations many of whom had previously received training, in having refresher training, and training for their own trainers with the adapted set of care planning tools. This has been facilitated by the signing of a memorandum of understanding between FHBHRU and each organisation to document agreed expectations, roles and deliverables in implementing the FCTGP. This revised national process resulted in 116 organisations participating in implementation in one of three phases and over 40 organisations providing care planning and occasions of service data for our reporting requirements.

We have now developed a successful culturally appropriate clinical and training model in self-management support, complimented by an implementation process which is flexible and adaptable to each organisation whether it is an AMS, community, general practice or state based organisation in rural, urban or remote sites.

The training model has been successfully adapted for smoking cessation and as expected from the timelines, delivery of the smoking cessation training is in its early phase of a national roll out. The second component of this program of work, a community engagement process around tobacco cessation has just been completed and the third component, tobacco cessation for health workers curriculum development is under way.

Future options

An additional 32 organisations have expressed interest to participate in our FCTGP implementation program if the program is to be extended in 2014. We believe the training and implementation models are now at a stage of maturation that a full national rollout is warranted. Our proposed work plan includes:

1. engagement of a further 80 organisations in implementation over the next 3 years
2. further integration of the Flinders Program™ tools into medical software
3. further development of our on-line education programs
4. adding the collection of clinical outcome data to our data collection capability to demonstrate changes in health outcomes
5. adaptation of the Flinders Program™ tools and training to include other lifestyle risk factors in addition to smoking ie activity, diet, and alcohol
6. adaptation of the Flinders Program™ process to include mental health and psychiatric conditions to address co-morbidity of physical and mental health, and drug and alcohol problems

OUR TEAM

The Flinders Closing the Gap Program™ team is comprised of a diverse range of individuals who bring a variety of skills, knowledge, experience and ideas. The diversity of the team members enables the project to be adaptive and responsive, but it is the uncompromising desire of each team member to improve the health of Aboriginal and Torres Strait Islander people that has made the project a success. A full list of team members can be found at

http://www.flindersclosingthegapprogram.com/about/team

The Flinders Closing the Gap Program™ team

NATIONAL ADVISORY GROUP

Throughout the project we have consulted with Aboriginal and Torres Strait Islander communities in each state continuously. To formalise consultation, the National Advisory Group (NAG) was assembled with the first meeting held in February 2013. This meeting provided an opportunity to gather feedback and to maintain the continued validation of the project. The meeting was attended by members from Queensland, Victoria and South Australia representing their communities. Members were consulted on a range of issues including the curriculum of the Living Well, Smoke Free Program (LWSF), design of the FCTGP tools and community engagement opportunities. The group also elected Nathan Campbell (QLD), Lyn Warren (VIC) and David Copley (SA) as the co-chairs of the National Advisory Group (see image below).

A second meeting of the NAG was held in September and provided an excellent opportunity for the group to meet face to face and learn about the achievements and development of the project. The theme of the meeting centred on development of education materials for the LSWF Program and receiving cultural feedback about the materials.

In between meetings of the NAG, members were regularly kept up to date with project developments and asked to provide advice on various issues.

We are very grateful for the input and advice we have received from all NAG members and appreciate the time they have committed to ensuring the project works towards improving the health of their people.

National Advisory Group co-chairs include (from L-R)

Nathan Campbell (QLD), Lyn Warren (VIC) and David Copley (SA).

1.0 TRAINING

Introduction

This report summarises training developments and outcomes of the Flinders Closing the Gap Program of Chronic Condition Management (FCTGP-CCM), focusing on activities undertaken in 2013.

The focus of the education and training team has been to further develop training materials and the My Health Story care plan, as well as providing strategic targeted training and support. This includes an emphasis on extensive training and mentoring support to new and existing Accredited Trainers to ensure a succession of trained health practitioners and aid in the implementation of the program.

We believe that we have successfully achieved all contracted deliverables pertaining to training and have created an education program that is culturally sensitive, adaptable and academically sound as well as being professionally relevant. Table 1 lists the achievements against each deliverable.

Deliverable	Status	Achievement
400 health practitioners trained	Complete	825 health practitioners trained including 240 Aboriginal Health Practitioners
Flinders Program™ expanded to meet different learning styles & cultural preferences as well as being locally appropriate & culturally safe	Complete	
Development of web resources	Complete	Comprehensive website developed visit www.flindersclosingthegapprogram.com
Comprehensive online learning program	Release date 16th June 2014	fctgp.flinders.edu.au
Development of educational DVDs`	Complete	Ethel educational DVD
Provide appropriate materials for health practitioners to distribute to their clients	Complete	My Health Story
Pilot the expanded program with a sample of health practitioners	Complete	Program piloted in 2010
Consult with appropriate indigenous communities & stakeholder organisations	Complete	National Advisory Group Consultation at a local level with indigenous communities
Utilise the assistance of appropriate cultural consultant and elders	Complete	Elders invited to do welcome to country and participate in the workshop. Local Aboriginal and Torres Strait Islander mentors are also invited to speak at each workshop.

Table 1- Training deliverables

1.1 EDUCATIONAL MATERIAL DEVELOPMENT

The FCTGP is an adaptation of the Flinders Program™ which is a structured process and set of tools for health practitioners to use with Aboriginal and Torres Strait Islander clients. The tools assess self-management behaviours, identify strengths, worries and goals to develop individualised self-management care plans. A major focus for the past year has been the continual improvement of the program tools (My Health Story) and development of new resources.

Revision of the tools and training materials came about in response to feedback from participants indicating that a more visual approach which condensed some of the questions and components would improve client engagement. Extensive consultation with Aboriginal and Torres Strait Islander health practitioners, community members, National Advisory Group members, experienced trainers and medical and cultural researchers to develop the new tools and training resources was conducted with the result being the creation of 'My Health Story'. Additional concepts relating to 'strengths' and 'family connections' were also included. These concepts were influenced by literature and a variety of national resources including the Menzies Institute Aboriginal and Islander Mental health initiative (AIMhi) tools. We acknowledge the contribution of "My Mob" and "Strengths" tools by Professor Tricia Nagel of the Menzies Aboriginal and Islander Mental health initiative and the NT Department of Health.

The new tools were piloted in the Northern Territory (see summary in section 4.6) and trialled across Australia between February and April 2013. After further adaptations the new tools and training resources were rolled out nationally. The result is a comprehensive care plan which health practitioners feel comfortable using and engages clients. The accompanying training materials have also been designed to visually complement the My Health Story and designed in such a way that they can be adapted for delivery to a variety of audiences in different settings.

My Health Story and the revised training materials have been well received by participating health services with positive feedback received from both practitioners and their clients. Complete versions of all training materials have been provided electronically, see appendix one for details.

Online training development

Providing participants with a quality online education program is important to the projects sustainability as it will provide accessible training resources. The development of such a program will also take advantage of the suite of materials already developed and offer a flexible alternative to traditional face to face learning.

When developing the project brief, important factors such as adaptability to allow for additional learning materials and program advances were important. Other considerations included the need to ensure content is appropriate for a variety of audiences and navigation is user friendly. The decision to contract Nine Lanterns as the educational design company was made due to their reputation and ability to meet these needs.

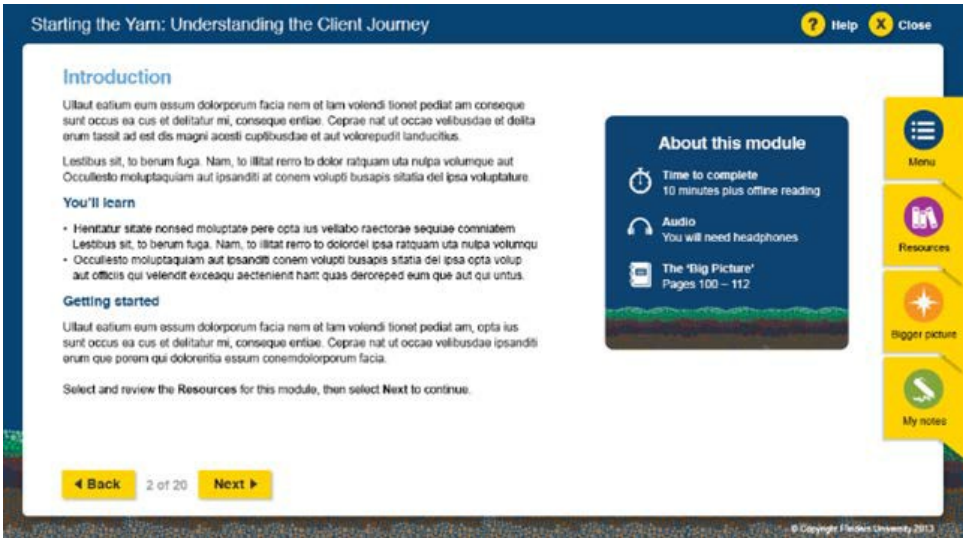
The revised online learning program will consist of ten modules, designed to accommodate participants who would like a blended learning option (online + face to face) or a completely online experience. The program will also have the added benefit of allowing participants to learn at their own pace and in their own time. Participants will also be able to use the online learning program as a 'primer' prior to attending face to face training as well as a 'refresher'

after completing training.

When designing the course it was important to take into account the diverse range of learners and their educational and professional background as well incorporating the concepts of adult and self-directed learning. Ensuring content is culturally appropriate and respectful underpinned all design and educational content. The branding and overall look and feel is consistent with the suite of FCTGP educational materials and the online program takes full advantage of the DVDs and resources already developed to create a visually inviting and interactive learning environment. Picture 1 and Picture 2 provide examples of the styling and layout.

Included in the revised online learning program are two modules based around the Living Well, Smoke Free Program. This is covered further in the report along with working draft examples of screen types to be used in the online courses. A full list of module descriptions has also been provided electronically, see Appendix 1 for further information.

Picture 1- Online learning program screen shot



Picture 2 - Online learning program screen shot

We anticipate the first module to be available for user testing in mid-December, with the remaining modules being completed in June 2014.

Educational DVD Production

A suite of educational DVDs have been produced to illustrate the use of My Health Story and the care planning process. The DVDs are based around the fictitious character ‘Ethel’ andher story of living with chronic conditions. In the planning stage we consulted with various members of the community to ensure the DVD was both ‘true to life’ and culturally safe. Participant feedback has been very positive and we believe the suite of DVDs adds value to the training and overall educational experience. The ‘Ethel’ DVD is available electronically please see appendix one for details.

Picture 3- Ethel DVD cast

Web resources

In 2013 the website underwent a transformation and was developed to be a ‘one stop shop’ for program participants, health practitioners and clients. The program site now includes the latest curriculum information, resources and training materials as well as a short Partners in Health assessment for clients. The website can be accessed by visiting www.flindersclosingthegapprogram.com

1.2 WORKSHOP DELIVERY

Local Aboriginal and Torres Strait Islander protocol is followed when planning and conducting the training with a local Elder invited to conduct Welcome to Country, providing a specific regional focus to the training. Each workshop includes guest speakers and motivators arranged by negotiation with key stakeholders for each workshop. Speakers include Aboriginal and Torres Strait Islander Elders, Aboriginal or Torres Strait Islander health practitioners with previous experience in care planning and implementation, volunteers, peer leaders, regional health and human service managers and leaders. Having guest speakers and motivators has the dual function of providing context for workshop participants and provides community endorsement for the program.

The principles of chronic condition self-management (KICMRILS) and how they can be used by health practitioners with Aboriginal and Torres Strait Islander clients with chronic conditions are introduced through a fictitious client 'Ethel'. Ethel's history and experiences are brainstormed on a whiteboard by participants of each workshop to reflect local contemporary Aboriginal and Torres Strait Islander experience.

My Health Story, including the new integrated tools 'Important People in My Life/My Mob' and 'I am Strong Because'are demonstrated through the 'Ethel' case study. Aboriginal and Torres Strait Islander people who have chronic conditions are invited to become a volunteer client in the training with participants working with them to develop their Health Story during the workshops. Volunteer feedback has been positive about the experience both in the training and in developing their care plan using My Health Story. Motivational interviewing is the overarching technique provided to participants to enable the practice of chronic condition self-management.

The addition of implementation support to FHBHRU's project brief led to the ongoing review of the training content to address health service training capacity issues and the implementation of the program into everyday practice. Different modes of training delivery also allow negotiation of training modes suitable to diverse health service needs as well as allowing time for participants to consolidate their learning and achieve their certificates of competency and reflect on changes needed to implement this approach in their workplaces.

Modes of delivery

Training has been designed to be adaptable to the needs of the participants, taking into account their professional background, time available for training and level of previous exposure to the Flinders Program™. The training course is modular in format, consisting of nine short courses of around 2. 5 hours duration which can be run consecutively over two and half days or delivered by a local trainer via separate training sessions when convenient. Participants also have the option of undertaking online learning or a blended learning option of online learning and face to face training. Additional support and follow up is provided where necessary by local trainers and/or local champions.

With the roll out of the new My Health Story a one day training program has been offered to participating organisations to up skill health practitioners who have attended training previously. This has also included second day training in LWSF and follow up support to practitioners to gain competency in the use of the tools. The addition of this upskill training has had the dual benefit of re-engaging participants and organisations with the view to offering further implementation support and access to the newly developed educational resources as well as assisting participants to identify gaps in their learning including gaining a certificate of competence or progressing further to Accredited Trainer level.

1.3 ACCREDITED TRAINERS

Since the inception of the Program 61 health practitioners have commenced requirements to become an Accredited Trainer and are in varying stages of completion. This has significantly exceeded the contracted requirements.

Geographically Accredited Trainers are located in every state (see Table 2) which allows for training to be delivered locally by local trainers. Having qualified trainers located around the country enables regional workshops, up skilling in My Health Story training and implementation support that sustains change.

FCTGP – Accredited Trainers by work place state	
NSW	6
QLD	17
SA	16
TAS	2
VIC	10
WA	10
Grand Total	**61**

Table 2 - Accredited Trainers by work place state

Currently 20 Trainers identify as being Aboriginal and Torres Strait Islander (see Table 3) with the remaining Trainers having considerable experience in working in Aboriginal and Torres Strait Islander communities and health services. The number of Aboriginal and Torres Strait Islander Trainers has increased dramatically from 2012 where there were 9 trained. Currently there is a waiting list of twelve Aboriginal and Torres Strait Islander health practitioners from across Australia waiting to become Accredited Trainers.

FCTGP-Accredited Trainers who identify as being Aboriginal or Torres Strait Islander	
Aboriginal &/or Torres Strait Islander	20
Neither	39
Not Collected	2
Grand Total	**61**

Table 3- FCTGP Accredited Trainers who identify as being Aboriginal or Torres Strait Islander

Peer education has become an important part of the training bringing forward the cultural knowledge of the Aboriginal and Torres Strait Islander health practitioners. Regular Accredited Trainer meetings and forums continue to be facilitated by FCTGP and allow for the cross fertilisation of ideas amongst the training group. Providing additional training in the delivery of the My Health Story and LWSF has also proved to be of benefit to Accredited Trainers as it allows for continual development.

1.4 TRAINING OUTCOMES

Since the beginning of the FCTGP in late 2010, 1225 occasions of training have occurred with 825 individuals including Accredited Trainer training, FCTGP-CCM training and LWSF training.

Training cases provided	
Accredited Trainers Living Well,Smoke Free	38
FCTGP Aimhi (NT)	26
FCTGP Online	33
FCTGP-CCM	779
FCTGP Refresher	7
CTG AT Up Skill	31
FCTGP Trainer Accreditation Workshop	59
FCTGP Up Skill	132
Living Well, Smoke Free Module 1	120
Grand Total	**1225**

Table 4 - Training cases provided

A total of 825 participants have received training including 252 participants who identify as being Aboriginal or Torres Strait Islander (see Figure 1). 34% of participants worked in Aboriginal Health Services with 240 participants being Aboriginal Health Practitioners and 255 being nurses see Table 6.

From 825 participants, 29% work in Victoria and 22% in Queensland (see Table 7- Participants by workplace state).

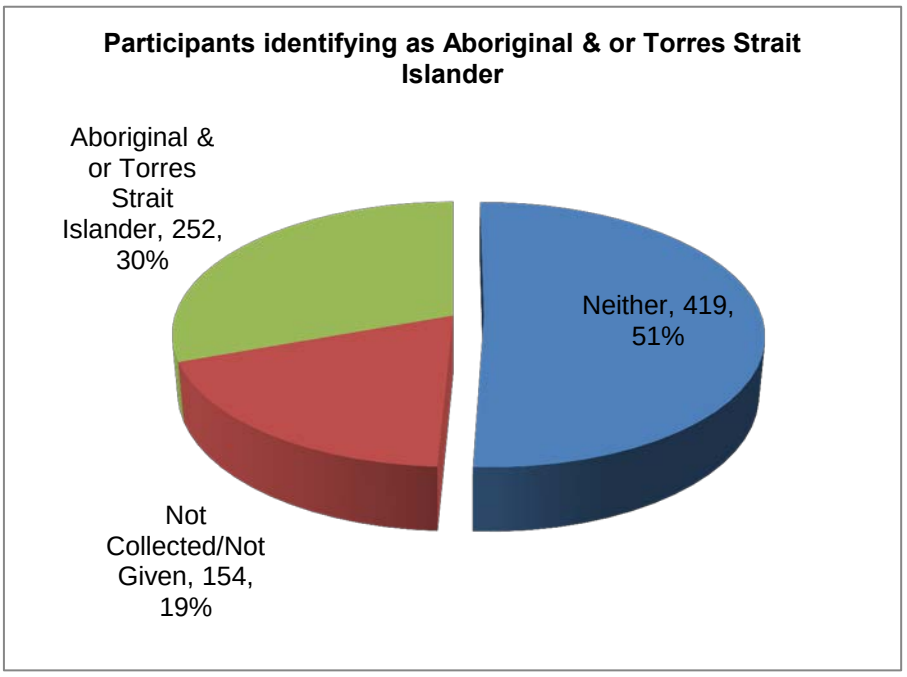


Figure 1- Participants identifying as Aboriginal & or Torres Strait Islander

Participants by organisation type	
Aboriginal Health Service	284
Medicare Local/Division of General Practice	131
Other	76
Private Practice	66
State Based Health Service	268
Grand Total	**825**

Table 5- Participants by organisation type

Participants by occupation	
Aboriginal Health Worker	240
Administration	16
Allied Health	95
Chronic Condition Worker	66
Doctor	45
Educator	24
Health Worker	2
Management	35
Nursing	255
Other	16
Project / Program - Manager / Coordinator	21

Not provided	10
Grand Total	**825**

Table 6- Participants by occupation

Participants by workplace state	
ACT	5
NSW	91
NT	60
QLD	183
SA	102
TAS	10
VIC	237
WA	137
Grand Total	**825**

Table 7- Participants by workplace state

1.5 The Impact of the Flinders Closing the Gap Program™

The impact of the FCTGP both for clients, health practitioners and managers has been very positive. Comments collected through a series of interviews show genuine change in the way clients think about their health as well as the way practitioners work with their clients to achieve better health outcomes.

A Health worker provided the following story after introducing the My Health Story to their client:

> *"We've been working with this patient, this individual, for three or four years and nothing had improved in their healthcare or anything like that. Reluctant to come in, reluctant to talk or communicate even with that person that has been talking to them and dealing with them for the last three or four years. Do that Care Plan, the next day that patient and the daughter were in here asking for Quit Smoking patches and Champix to quit smoking. They asked the health workers about diabetes, their diabetes that they've had for years, asking them about their Insulin, they didn't know what diabetes was even though they've had it for 10, 20 years. It was instantly, the next day, because someone had started talking to her about her emotional and social issues and stuff like that, but the Flinders model, My [Health] Story, gave them a chance to bring that stuff up and to get it off their shoulders…" (Health Worker)*

Another client also commented on the process of setting goals and developing a plan:

> *"I think the end product, the goal and having an action plan going on, on how to change some things, I thought that was great. And I thought I came up with some ideas today that…I need to act on". (Client)*

2.0 LIVING WELL, SMOKE FREE

Introduction

This progress report summarises outcomes for the Tobacco Cessation component of the FCTGP. The intention of the project is to extend the skills and knowledge of health practitioners, including Aboriginal health practitioners, to address tobacco use with clients. The tools and processes have been adapted from the FCTGP-CCM model, and are based on successful interventions in Aboriginal and Torres Strait Islander communities to address problematic gambling. A similar cognitive behavioural approach to tobacco care planning and management has been adopted by the project team.

Key outcomes to date include:

- promotional materials including a series of posters featuring Tom Calma
- development of curriculum plans and teaching materials
- translation of core curriculum and communication resources into film and on-line learning and community education materials
- implementation of training linked to existing FCTGP sites around Australia
- recruitment of research and evaluation staff to assist with implementation and evaluation of training materials
- ethics committee initiatives to facilitate data collection and reporting in relation to training delivery processes and impacts upon communities
- establishment of initial networks and protocols to facilitate patient data collection to monitor the clinical impacts of the LWSF care planning process.

The program now having been established and evaluated in relation to training and training delivery, is now set to embark on Phase 3 of the longer term plan to integrate community and health interventions and skill the health workforce to deliver more advanced interventions to address tobacco use in smokers with complex needs, such as those with mental health or other addictions.

2.1 AGREED OUTCOMES

The project to June 2013 has four specific components: now extended to Dec 2013.

Deliverable 1 - All of the FCTGP Flinders Uni based staff to be trained in LWSF

Status: Met

Achievement : All in-house Flinders Trainers have been up skilled (n = 14, two workshops).

Deliverable 2 - 50 % of the FCTGP train the trainer trained health practitioners will be trained in Living Well, Smoke Free (target =10).

Status: Exceeded

Achievement: This target has been purposefully exceeded to ensure sustainability of the program beyond the funding period. Baseline at project initiation was 20; therefore target was10.

The importance of increasing the Accredited Trainer workforce is recognised in terms of program sustainability, and in spite of additional numbers of trainers being inducted in the final stages of the project, there has been significant efforts made to ensure that more than 50% of trainers are up skilled to deliver LWSF.

Up skilling is completed over three stages; the trainer's origins and progress is shown below:

	Intro tour	In-depth up skilling	Workshop delivery
QLD	5	5	2
VIC	9	7	2
WA	5	5	1
SA	3	0	0
TAS	2	0	0
FHBHRU	14	14	3
TOTAL	38	32	9

Deliverables 3 & 4 – PARTIALLY MET

- 25% of health practitioners trained in FCTGP (Baseline 400)
- 150 HPs drawn from all future students. Targets are 100 FCTGP-trained HPs; 150 new HPs. Training has been offered to maximise:

    a. Geographic spread to regions, across states and territories
    b. Consolidation of training through the provision of multiple follow up visits by the training team. This was given priority over recruiting new training sites or participants, and is reflected in lower than initially anticipated training numbers.
    c. Work with a range of organisations, including those from the ACCHO sector, Medicare Locals, hospital services, community-based health and other service

organisations including private GPs and health practitioners.

d. Partnership with the implementation process to promote application of learning of participants.

Training participants external to the Flinders based team commenced in May 2013. The table below includes all training completed or scheduled before 31st December 2013.

State	Location	Sessions	Date	Total	Existing	New	ATSI
QLD	Gold Coast	2	16/06/2013	6	6	0	2
			23/08/2013	8	8	0	4
	Cairns	1	23/09/2013	3	3	0	1
	Townsville	1	07/11/2013	4	3	1	3
	Bundaberg	1	19/11/2013	5	5	0	0
VIC	Warrnambool	1	15/05/2013	4	4	0	1
		Follow-up	26/06/2013	-	-	-	-
	Mildura ML	2	13/06/2013	3	3	0	1
			23/07/2013	2	1	1	1
	Mildura MDAS	1	18/09/2013	4	0	4	2
	Mildura HARP	1	17/10/2013	7	3	4	6
	Bendigo HARP	1	20/11/2013	17	11	6	0
WA	Wiluna	2	20/06/2013	4	1	3	1
			12/09/2013	4	0	4	1
	Bunbury	4	30/07/2013	6	6	0	6
			23/09/2013	6	2	4	4
			08/10/2013	6	4	2	6
SA	Adelaide Nth	1	09/10/2013	8	8	0	6
		Follow-up	25/11/2013	-	-	-	-
NSW	Blacktown	1	16/08/2013	11	11	0	6
		Follow-up	04/09/2013	-	-	-	-
	Lightning Ridge	1	10/10/2013	12	11	1	8
Total		**20**		**120**	**90**	**30**	**59**
Pending	Clovelly Park	2	26/11/2013	8			
			28/11/2013	8			
	APY Women's Program	1	13/12/2013	3			
	Bundaberg	1	08/12/2013	10			
	Bunbury	1	Dec	5			
TOTAL TO END OF YEAR				**154**			

Pending training

There are a number of organisations that have completed new or refresher training in the FCTGP-CCM recently and have nominated to undertake subsequent training in LWSF. Not all organisations could be accommodated in this funding period. The organisations affected are Country North Medicare Local (SA), Hunter Urban Medicare Local (NSW), Bundaberg Aboriginal Wellness Centre and the Royal Flying Doctor Service (QLD).

Other organisations that have expressed interest in future training have been assigned to a wish-list, and will be re-contacted subject to funding.

2.2 CURRICULUM PLAN AND IMPLEMENTATION MODEL

During the initial consultation phase of the tobacco funding, a number of areas of need in terms of training were identified by health representatives and organisations from the Indigenous sector. These were:

a. Skills and knowledge to provide direct assistance to individuals to help them address smoking behaviour. This assistance needed to be comprehensive in its approach, and could be delivered on a one-to-one basis or in group format;

b. The means to address high rates of smoking among the Indigenous health workforce and in health workplaces;

c. Skills and resources to deliver an 'all-of-community' approach to enhance knowledge and change attitudes towards tobacco smoking, particularly in communities where tobacco smoking is highly prevalent but not considered a priority health issue.

In addition to this, health workers requested advanced skill training for people working extensively with addressing tobacco smoking in clients. Specific requests were made for knowledge about third-generation behavioural approaches, involving mindfulness and urge reduction techniques. This usually arose in discussions of how to help clients with more complex needs, such as those who use smoking primarily as a stress reduction measure.

The other key area that existing training failed to address was the association between tobacco and other substance or behavioural addictions, such as problem gambling. Requests for this have continued to be made throughout the training period; especially once trainees have applied the tobacco tools to clients. Many of the participants comment on the power of the tools to engage resistant clients, and can see a similar approach being useful in addressing all addictions.

2.3 CURRICULUM DEVELOPMENT

Priority was given to developing the central module focused on the provision of direct assistance to individuals, empowering their clients to make positive changes to their tobacco use. In organisations that expressed greater interest in adopting a community approach, we recommended this training ahead of time, ensuring that once community action was underway a solid, well trained health workforce would be available to community members requesting assistance.

At this stage of the project training has been provided to health workers in the provision of direct smoking cessation interventions, and the community and workplace modules are being developed through a process of consultation with Aboriginal and Torres Strait Islander communities, the NAG and health representatives. The main focus of the community modules highlights best practice across Australia while introducing a structured approach to planning and implementation of health promotions. An emphasis on bridging the gap between health promotions and the delivery of health interventions is also made.

The training module to support services in developing and refining their health promotion activities is under development and has required extensive community consultation to ensure

its meet the needs of communities. The main objectives of the training program are to provide an opportunity for health services to undertake a community assessment of the impact of smoking and the effectiveness of current promotional activities, allowing them to become more strategic in terms of selecting target groups, messages and medium. A guide to evaluation is included as part of the planning process and to assist communities there is also a showcase of national Indigenous resources, encouraging the sharing of ideas and energy.

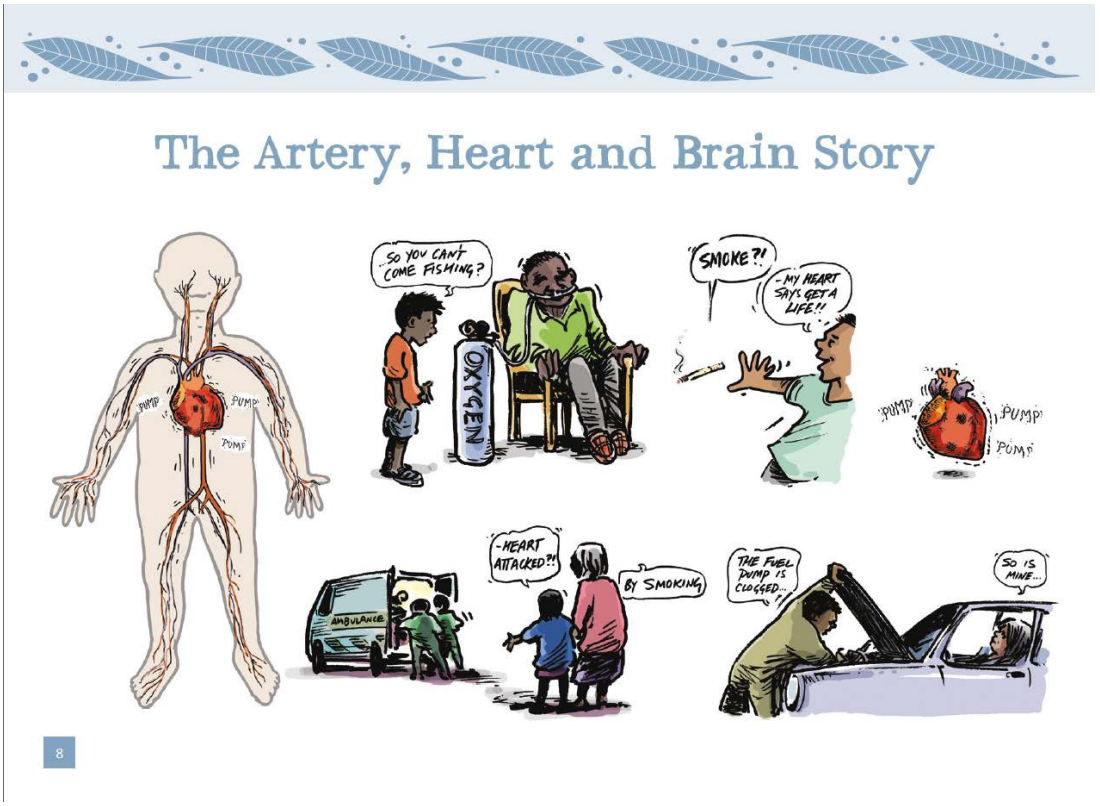
The intention is that this training will be made available to health services who wish to develop a stronger partnership between health promotions and interventions around tobacco smoking. There are a number of organisations who have expressed interest in this module once it is available".

Training and curriculum materials including manuals, instructional DVDs and PowerPoint presentations have been developed. The first DVD provides a step-by-step guide to using the Living Well, Smoke Free tool kit with clients. The second demonstrates Aboriginal health practitioners applying the principles of Motivational Interviewing to help engage Aboriginal and Torres Strait Islander clients in making changes to their tobacco use. A third DVD has been planned; this DVD will demonstrate community and workplace changes that support smoking cessation. The NAG have been consulted in preparing a production brief but any further work has been placed on hold, subject to future funding.

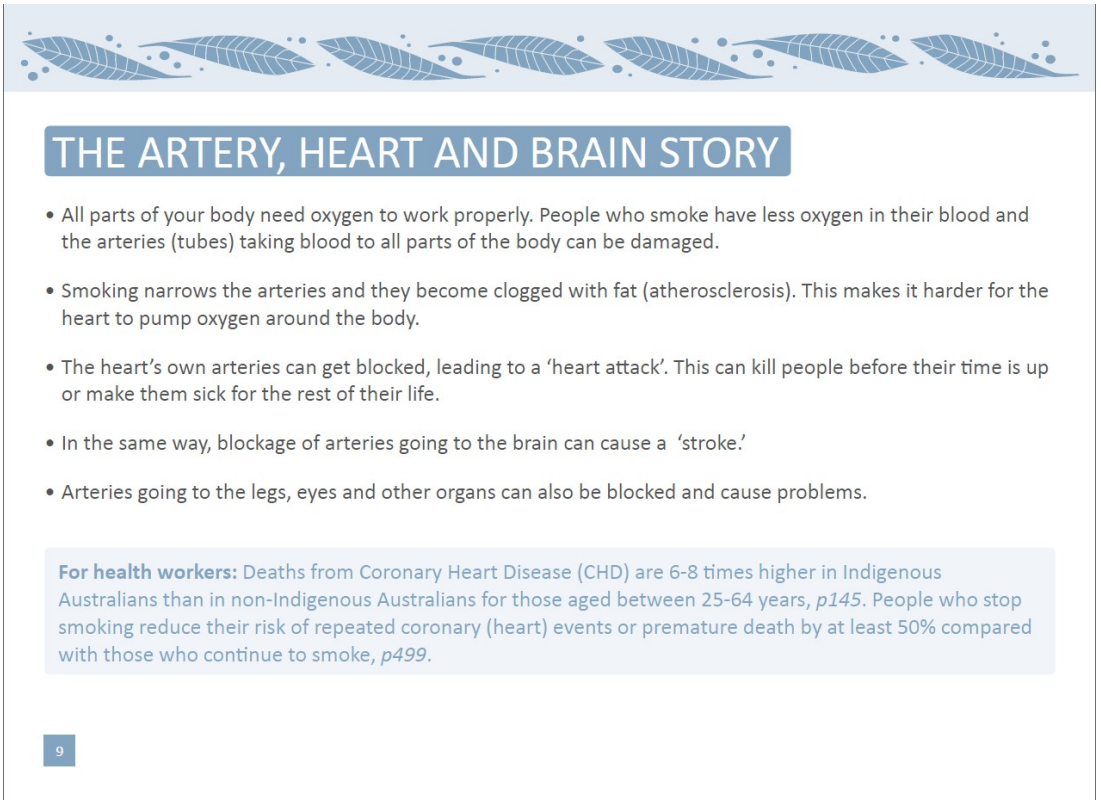
Picture 4- Davey yarning with his health worker

Picture 5 - Demonstrating Motivational Interviewing

A suite of health promotion resources such as tally cards, posters, brochures and flipchart have been created after extensive consultation with the community. Gender issues and sensitivity about some health issues were taken into consideration. At this stage these resources are available in paper-based form, but once the content has been tested in community focus groups, the information could be made available in a variety of formats using audio. The material has been designed to present information in increasing depth, commencing with posters, moving onto brochures which provide a little more health information, and culminating in the 'Stories about your health and smoking tobacco' flipchart, which provides more comprehensive information about the impact of smoking on health and wellbeing.



Picture 6- Example from the stories about your health flip chart



THE ARTERY, HEART AND BRAIN STORY

- All parts of your body need oxygen to work properly. People who smoke have less oxygen in their blood and the arteries (tubes) taking blood to all parts of the body can be damaged.
- Smoking narrows the arteries and they become clogged with fat (atherosclerosis). This makes it harder for the heart to pump oxygen around the body.
- The heart's own arteries can get blocked, leading to a 'heart attack'. This can kill people before their time is up or make them sick for the rest of their life.
- In the same way, blockage of arteries going to the brain can cause a 'stroke.'
- Arteries going to the legs, eyes and other organs can also be blocked and cause problems.

For health workers: Deaths from Coronary Heart Disease (CHD) are 6-8 times higher in Indigenous Australians than in non-Indigenous Australians for those aged between 25-64 years, *p145*. People who stop smoking reduce their risk of repeated coronary (heart) events or premature death by at least 50% compared with those who continue to smoke, *p499*.

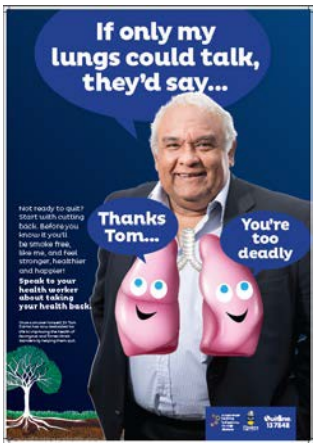
9

Picture 7- Example from the Story about your health flip chart

In response to the evaluation of the NT project, we have also developed a simpler, adapted version of the tobacco tool kit to be tested for use with the Anangu Pitjantjatjara Yankunytjara population. This will be pilot tested with a small group of participants in the second week of December.

A series of four posters featuring Dr Tom Calma (see Picture 8) were created and have been distributed to participating health services to promote the program to clients and health practitioners. All of these materials will be discussed within the planned community interventions module and can be used by those who've participated in the training program to promote their service.

Picture 8- Tom Calma poster series



More recently, an opportunity to develop on-line training in smoking cessation has become available as part of the broader on-line portal development. Two modules for Brief Interventions for Indigenous Smokers have been designed and are currently being built. Expected completion date is June 2014.

Copies of all training resources are available electronically, including significant draft materials, refer to appendix one for more information.

2.4 Strategy for training provision

An emphasis has been placed on up skilling the existing pool of FCTGP Accredited Trainers to deliver training in the central tobacco module, to maximise the distribution of training and sustainability of the program.

Training has been offered by the FCTGP-NBIT, as part of their engagement with organisations. In most cases training in LWSF has been delayed until organisations have received refresher training in the My Health Story tools.

Where possible, the training team is providing follow-up sessions within one month of face to face workshops. Email and phone calls are also provided to assist trainees become competent is using the tools in their workplace. Where implementation issues arise post- training, these are noted and passed onto the FCTGP-NBIT.

The creation of the training DVDs facilitates the future development of on-line training, providing follow-up support for those who have attended face to face training, and for health workers who are less able to access face to face training due to time constraints and remoteness.

Given the high prevalence of smoking in the Indigenous population and its relevance to the management of chronic conditions, subject to funding, the plan is to better integrate the two training programs, using tobacco as an exemplar in chronic condition training. The newness of the LWSF training, and its need to be trialled independently initially, prevented this from occurring earlier.

2.5 Mapping of competencies

All of the planned LWSF modules have been developed with the National Quality Training Framework in mind. The central module has been successfully mapped against national competencies, and a similar process will be adhered to as the other modules are finalised.

This is considered vital to supporting the Aboriginal and Torres Strait Islander health workforce to gain recognition for their participation in training as part of Primary Health, Drug and Alcohol or Community Services VET certificate programs.

Evidence of the mapping process has been provided electronically and includes:

- Accreditation plan (item 6.1)
- LWSF Module One competency mapping (item 6.2)
- LWSF Accreditation letter (item 6.3)

Two on-line modules are currently being developed specific to tobacco. Completion of these two modules will provide recognition for National Module HLTPOP403C – Provide information on smoking and smoking cessation, articulating into Cert IV ATSI Primary Health (Community Care), Cert III/IV in Population Health or Diploma ATSI Primary Health (Community Care).

2.6 The impact of the Living Well, Smoke Free Program

Although the LWSF Program is in its infancy the comments from participants, managers and clients have been very positive. Some of the comments from participants also highlight that the strategies and ideas taught in training also resonated on a personal level, prompting participants to consider their own smoking habits.

The researcher noted that in one remote community the attitudes of staff had altered with more emphasis on health and making a change.

> *"It's a good sign that a few colleagues are wanting to change, you know, wonderful!" (Health Worker)*

Positive comments from clients have also been received with one client reporting that after trying many other health interventions, the LWSF program provided a new way of thinking about health and smoking:

> *"This process allows you to fall off the wagon… and it's, you know, how do I get back on then, what was the environment that made you want to smoke, what happened…" (Client)*

The confidence of the workers to administer smoking interventions after training in the LWSF program was also noted:

> *"Well, put it one to ten, I'd say before I did this…I wouldn't have any confidence at all in trying to help people…but, now I can sort of say I'll be around maybe 5-6, I need more information I guess, more practice" (Health Worker).*

3.0 IMPLEMENTATION

Introduction

The Flinders Closing the Gap Program – National Business Implementation Team (FCTGP-NBIT) comprises of 8 staff members based in strategic regional locations nationally. The team has been assembled based on their knowledge and experience of the health care system, connection with health services in their region and a commitment to improving the lives of Aboriginal and Torres Strait Islander people.

The FCTGP- NBIT team work collaboratively with the wider FCTGP team to support the continued creation of a holistic program which includes implementation into practice, training and evaluation. Areas of collaboration include the online learning program, integrations of self-management clinical indicators into Patient Information Systems (PIMS), curriculum development for the Living Well, Smoke Free Program, training, evaluation and data integrity. Collaboration between the various arms of the project promotes knowledge sharing and assists in the continual development of an academically sound adaptable program that can be used in health service practice.

The role of the FCTGP-NBIT is to provide support to organisations in the implementation of the FCTGP as outlined in the Deed of variation number 2. The key activities and strategies to achieve the requirements of this deed are outlined in Table 8 with the corresponding key activity, the evidenced based strategies utilised and the outcomes achieved expanded upon below.

Deliverable	**Strategy to achieve deliverable**
3.1 – The provision of support to health services in the implementation of the Flinders care planning process, which may include conducting a system audit and the integration of chronic condition care planning into the health service point of care and patient information system software	Staff recruitment Communities of Practice & Key stakeholder collaboration Memorandum of understanding Resource development Mentoring Local change managers Implementation Phases System Audit's
3.2 - Implementing changes, in the management of the health services, which include ensuring that training in the expanded Flinders Program™: a) Forms part of health professional staff position description and or job descriptions b) Is included in the initial period of staff induction if health workers employed by a health service have not already been trained in implementing or conducting chronic condition self-management care planning	Strategic plans Developing Models of care across the continuum Policy development
3.3 – The participant will ensure that participating health services will include effective development and implementation of data collection, both in regard to care plan's that are conducted by trained staff and the following session delivery.	Memorandum of understanding Defining/categorising data collection Monthly reporting
3.4 - The participant will ensure that trained health workers will conduct, as a minimum, a	Review procedures are clearly documented in organisational policy

further 5 consultations or sessions with Aboriginal and Torres Strait Islander patients to review their progress. The initial care plan will be reviewed within the first 3 months from provision of the session, to ensure any appropriate readjustment of the patient self-management goals.	Health checks, GPMP, referral pathway and review documented in care plan Transition and exit plans support ongoing management and communication to GP Case Studies
3.5 – The participant will monitor session activity, collect data provided by participating health services on session delivery targets and report results to the Commonwealth.	

Table 8- Contracted deliverables & strategies to achieve deliverable

3.1 THE PROVISION OF SUPPORT TO HEALTH SERVICES

FCTGP identified that 157 health services across Australia had workforce participants registered as attending the FCTGP training. These organisations were made up of Aboriginal Community Controlled Health Organisations (ACCHO), Medicare Locals (ML), Government Community Health Services and Non-government Organisations (NGO)Table 9, illustrates the number and percentage of Health service representation.

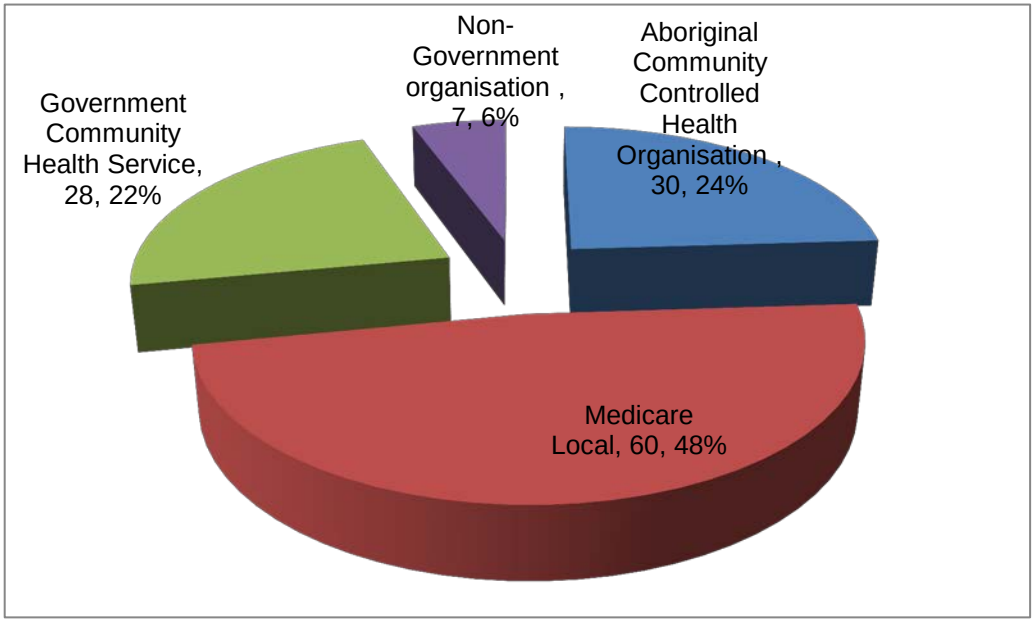


Table 9 - Health service types

FCTGP developed an implementation working plan to enable the provision of support to each partnering health service in the implementation of a chronic care planning model that incorporates self-management and the delivery of the FCTGP. Key components of the 2013 Implementation working plan included:

- Staff recruitment
- Key stakeholder collaboration
- Memorandum of understanding (MOU)
- Resource development
- Mentoring local change managers
- Implementation phases

Each component of the implementation plan is outlined further below.

In the development of the implementation working plan, the concept of 'Lean thinking' defined by Womack et al. (2005) as three key concepts consisting of Leadership, Culture and Process was adopted. **Leadership** is explained as requiring strong change management approaches throughout the entire organisation to support change. This process requires clear leadership, vision, efficient communication across the organisation team and clearly defined roles. The health service **Culture** moves from functioning silos of service delivery to interdisciplinary teams, managers coach and enable rather than direct, quality improvement is based on outcome evaluation not individual performance and health services are consumer focused. **Process** supports organisations to develop external and internal procedures ensuring each step is valuable, capable, available, adequate, and flexible and linked by a continuous flow for the client.

Staff recruitment

Eight Implementation Officers from different regions were employed to provide timely and effective support to the health services who had accessed training. The role of the implementation Officer is to support the concepts of lean thinking, providing leadership, mentoring and enabling clear process from a regional perspective. A full list of FCTGP staff is available in on our website http://www.flindersclosingthegapprogram.com/about/team . Table 10 illustrates the regional focus of each team member.

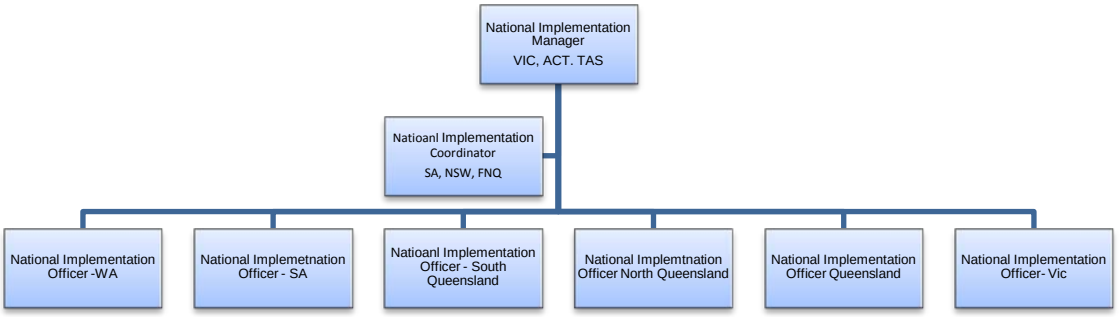


Table 10- FCTGP-NBIT regional locations

The role of the Implementation officer is to provide support to participant health services by:

- Acting as a facilitator to support implementation of the FCTGP™ through mentorship, improving communication, facilitating meetings and helping develop leadership skills and staff empowerment
- Presenting best practice and sharing case studies and outcomes from other organisations
- Bringing knowledge about external resources and tools that may complement
- FCTGP care planning
- Act as a change agent to help organisations adopt evidence-based practice
- Listen to barriers from managers, and health practitioners and support problem solving
- Act as a conveyor bringing groups of staff members together to work through barriers

- Plan strategic approaches, agendas and help keep organisations on track with implementation tasks
- Building skills and empowering the Aboriginal and Torres Strait Islander workforce
- Mentoring and empowering practices to 'own' practice development and change through provision of tools and information that will enable and guide them
- Helping health services collect and use measurement data

The work of the implementation team has been invaluable in supporting organisations to implement the Program. Ruth Fox, Community Service Manager at Robinvale District Health Service provided the following quote as a testimonial to having Implementation Officers available to support her organisation through the change management process and implementing chronic care self-management plans into service delivery.

> *… "I thought that when my staff had been trained in chronic disease self- management job done!!*
>
> *… "training alone does not lead to change, the work that Flinders did in assisting us to develop our systems and lead the change process was essential in moving from knowledge to implementation and embedding." (Ruth Fox 2013)*

Communities of Practice, Key stakeholder collaboration and relationships

Using evidenced based best practice principles of social learning theory as outlined by Wenger and Snyder (2000) and Li et al. (2009) Communities of Practice were developed and facilitated across Australia by the FCTG-NBIT. The Function of each Community of Practice was to provide a forum allowing health practitioners to come together in an informal learning environment based around the commonality of implementing the FGTGP. The need to facilitate these meetings was born out of recognition that often services have a willingness to work together, but didn't have the right time, right place way of bringing relevant parties together.

Each session was structured to support the principles of 'engagement', 'imagination', and 'alignment' and aimed to support coordination transparency and negotiability of chronic care management models using the principles of the FCTGP. Table 11 outlines the guiding principles of the FCTGP-NBIT Community of Practice workshops.

	Coordination	**Transparency**	**Negotiability**
Engagement	What opportunities exist for joint activities and, problem solving to Implement the FCTGP.	Ensure that there is enough variety of experience, and joint activities to generate learning's from each practice	Activities are structured in such a way that there is a meeting of minds and mutual respect and understanding of skills qualifications and cultural experience
Imagination	Sharing barriers, success and mentoring/support culture change.	Identify stories, experience, documents and models available from a regional perspective to allow people to identify with learn, and contemplate change.	Ensure that all attendees see themselves as members of the overarching health sector, have common interests and needs.

Alignment	Are instruction, goals and methods interpretable into action across the health sector	Ensure that the agenda of the communities of practice are clear, reveal common ground and differences in perspective and expectations.	Identify decision makers in change process and support communication and confidence across the workforce structure.

Table 11- FCTGP-NBIT Community of Practice guidelines

A Total of 23 Communities of Practice have been facilitated across Australia to support local change managers of our partnering organisations.

State	Number of Community of Practice meetings held
Victoria	7
New South Wales	1 (in partnership with AMLA)
Tasmania	3
South Australia	4
Western Australia	4
Queensland	4

Table 12- Communities of Practice locations

Another seven are in the planning phase at the time of this report.

Change in the ownership and development of agendas, activities and progress, driven by each organisation's adaptation and approach to the FCTGP implementation process can already be seen, which highlights the success of these meetings.

Tasmania Medicare Local (TML) has been involved in three 'Community of Practice' meetings with the following feedback provided.

> *'TML has greatly appreciated the support of the National Implementation team in assisting TML to establish a Community of Practice for our Closing the Gap Care Coordination network which has included sharing resources to assist with the implementation of the Flinders model for Chronic Condition Management and the Flinders Tools. The Flinders team have supported the implementation of this framework strategically as well as operationally by providing mentoring support to the workforce and management team. The relationships with the entire Flinders team has been an extremely positive and productive one in terms of improving our capacity to deliver quality, integrated chronic condition management services.'*
>
> *(Deb Burden – Closing the Gap Program Coordinator, Tasmania Medicare Local).*

Examples of the collaborative working groups assembled in various regions have been outlined below.

Far North Queensland

The Far North Queensland working group started as a Community of Practice by teleconference. The inaugural call had 16 participants; however the complications associated with mass teleconferences were highlighted and the group agreed video conferencing would be an improvement. Whilst video conferencing was an improvement, accessing this technology was problematic for some participants and a face to face meeting was deemed to be the best

option. An interim meeting was held with Cape York Health & Hospital Services who identified their Weipa Change Project would benefit from an intimate leadership group consultation based on FCTGP Implementation and Training modules, with the aim of identifying and assessing specific needs prior to adopting a desktop plan.

Following consultation with the wider group, the FCTGP-NBIT arranged a third meeting in Cairns, hosted by Apunipima at their offices. Whilst the invitation was targeted at change managers and leadership for the purpose of discussing the innovations and barriers of expected change, the FCTGP-NBIT encouraged the group to invite its teams. The result was a full one day workshop attended by leadership, managers and workforce. A follow-up workshop was held on the 19th of November with another planned in December and 2014.

Lead organisation:

Cape York Hospital & Health Service (CYH&HS) (+ cohorts by invitation) (MOU)

(CYH&HS Weipa Change Collaborative sites: Weipa, Napranum, Mapoon and Arakun)

(CYH&HS Weipa Change Collaborative: Apunipima, FNQ ML, RFDS)

FCTGP NBIT – Implementation Leadership Group

Cape York Hospital & Health Service

Apunipima Cape York Health Council (+ cohorts by invitation) (MOU)

Far North Queensland Medicare Local (+ cohorts by invitation) (MOU)

RFDS, Cairns (+ cohorts by invitation) (MOU)

South Australia

Country Health SA Local Health Network – Mental Health contacted FCTGP- NBIT directly to present the Flinders Model as adapted for Closing the Gap to leadership. This resulted in a brief to Cabinet and request to present further to the Mental Health Cabinet. Cabinet agreed and endorsed to implement the FCTGP in its mental health policy state wide. A leadership meeting agreed 4 sites would be offered a short-term pilot (3-6 months) opportunity before implementing state wide. Their project officer and FCTGP-NBIT then planned a week of presentations, extending an invitation to other teams, interested parties and key stakeholders. Each pilot site has accepted the opportunity and planning is underway to conduct FCTGP Phase 1 tasks, essentially collecting baseline population health data and ACIC systems assessments.

Lead organisation:

Country Health SA Local Health Network – Mental Health (Cabinet endorsed October 2013) (MOU)

Cohort Country Health SA Local Health Network services:

- Aboriginal Health Directorate, Workforce Development and AHAC
- SA Health Aboriginal Health Branch (representing Adelaide & Central Community
- Health Aboriginal Health Services)

Pilot 1 – Riverland Mental Health Services Team

Collaborative organisations:

- Relationships Australia
- Life Without Barriers (requesting MOU in 2014)
- Riverland Division of GP's (requesting MOU in 2014)

Pilot 2 – Yorke Peninsula Mental Health Services Team Collaborative organisations:

- Country North SA Medicare Local (MOU)
- Narungga Community Health Service
- The Station, Wallaroo

Pilot 3 – Murray Bridge Mental Health Services Team

- Collaborative organisations:
- Aboriginal Primary Health Care Unit – Murray Mallee Community Health Services
- (requesting MOU in 2014)
- Murray Bridge Hospital – Aboriginal Services (requesting MOU in 2014)
- Uniting Communities
- Life Without Barriers (requesting MOU in 2014)
- Murray Mallee GP Network (requesting MOU in 2014)
- Country South Medicare Local (requesting MOU in 2014) **Pilot 4 – Pt Augusta Mental Health Services Team Collaborative organisations:**
- Pika Wiya Health Service (ACCHO) Mental Health & Bringing them Home (requesting MOU in 2014)
- Uniting Care Wesley
- Country Health SA – Pt Augusta Hospital – Tobacco Management

South Australia

The Country North SA Medicare Local (CNSAML) CTG workforce team are leading the development of person centered chronic condition self-management through committed implementation of the FCTGP. CNSAML is the result of 5 divisions combining and has the largest geographical coverage of any South Australian Medicare Local and most dense percentage of disadvantaged population. The team are working to develop a holistic chronic condition response through education, intervention, prevention and detection for the specific needs of each community across its health network, whilst seeking to develop partnerships with other interested parties. The objective is to provide a consistent model of care across health services using the FCTGP to support engagement, referral and patient pathway options via their Chronic Care Supplementary Services (CCSS).

Lead organisation: Country North SA Medicare Local (MOU)

Regional offices*:* Ceduna, Clare, Coober Pedy, Kadina, Nurioopta, Pt Augusta, Pt Lincoln, Whyalla

Cohort organisations:

- Aboriginal Health Council of SA
- Country Health: Nurrunga, Pt Pirie, Gawler Aboriginal Health Services – Inner

- North Community Health/Gawler Hospital, Pt Augusta Community Health
- Community Controlled Aboriginal Health Services:
  - Port Lincoln
  - Ceduna Koonibba
  - Tullawon
  - Oak Valley
  - Tjuntjuntjarra
  - Yalata
  - Nunyara
  - Nganampa – APY Lands
  - Umoona

Northern Territory

Following overwhelming response to presentations at events in Darwin (Chronic Disease Network Conference 9/13 and AMSANT CQI Workshop 11/13) implementation consultation is developing with the Northern Territory Medicare Local. The Flinders AIMhi NT Chronic Conditions Self-Management Program, now in the evaluation stage is acknowledged at these events. The Northern Territory Medicare Local (NTML) Closing the Gap Team are leading change in the way person centred chronic condition self-management is applied. NT ML directly sought the support of the FCTGP-NBIT and have an MOU with AMSANT to work in partnership throughout the Territory. A further presentation is planned in December 2013 in Alice Springs, by invitation of the NT ML.

Lead organisation:

Northern Territory ML (requesting MOU in 2014)

Cohort organisations:

AMSANT (representing 23 ACCHO membership organisations)

Australian Medicare Local Alliance (AMLA),

FCTGP-NBIT has developed a close working relationship with AMLA to support and enhance the CTG workforce. The FGTGP-NBIT works closely with the National Principle Advisor – CTG workforce–Elaine Dunn and National advisors, attending monthly team meetings and working collaboratively through communities of practice and site visits.

Currently the FCTGP-NBIT is working with 31 Medicare Locals across Australia in different phases of implementation, with a MOU currently being finalised between AMLA and FCTG-NBIT to support the CTG workforce in the other 30 Medicare Locals.

The Australian Department of Health (DoH) supports the workforce development of the CCSS workforce building care coordination skills and capacity by endorsing the FCTGP training in the CCSS program Implementation Guidelines August 2013.

Maintaining relationships

In order to find a national adaptation to acknowledge and respect the traditional custodians of Australian ancestral lands the FCTGP-NBIT sought guidance from its NAG on the right way to pay respect and engage with cultural authority of Aboriginal and Torres Strait Islander people and also the best way to listen, speak, present and share space, information and resources

including that from other places (which might include totems and reference to different lands and customs). The FCTGP-NBIT also sought cultural guidance directly from staff living and working locally in their communities, but also travelling out of country, in support of their national implementation roles. This way has worked to make new, maintain and share respectful partnerships through integration and improvement of service delivery towards better health outcomes, whilst developing a robust workforce.

FCTGP-NBIT advocate the Commonwealth's publication "***National Aboriginal and Torres Strait Islander Health Plan 2013-2023"*** as a reference guide to reinforce discussion on the Council of Australian Governments' (COAG) approach to long-term evidence based policy framework for Closing the Gap in Indigenous health disadvantage to close the life expectancy gap in a generation by 2031. Evolving health policy remains both an innovation and a barrier in developing flexible yet evidence based best practice chronic condition frameworks adaptable to whole of workforce; whilst responding to the continuum of care across the lifespan for integrated community population specific and holistic health education, intervention, detection and prevention. Sustainable clinical governance and continuous quality improvement of best practice is a growing health economy, we support many organisations through this in Phase 1, 2 and 3 in response to the underlying lack of capacity determined in the initial ACIC systems assessment pre-Implementation of FCTGP self-management. The publication's "Health Plan at a Glance" (page 6-7) sets a precedent that has been well received in discussion with FCTGP organisations, in particular the confidence and reinforcement of sound implementation process.

Memorandum of Understanding (MOU)

The changeability of the health workforce due to new initiatives, funding streams, staff mobility and changing workplace capacity, create a continually changing focus and sense of priority around care models. It is because of the changing workforce that communication becomes a vital component of project management, leadership and culture change.

Ensuring continual, consistent communication with an organisation has become an important challenge to work towards overcoming.To support communication of prior discussions and agreements between CEO's and managers, each health service has been requested to sign a Memorandum of Agreement(MOU). This document, even though it is not legally binding has provided a powerful form of communication that illustrates the respectful partnership between the FCTGP team and the health service.

Since August 2013 the FCTGP team have negotiated 30 MOU's with health services. Some MOU's, represent collaborative networks of organisations that are under a common funding stream, such as CCSS and AMLA. An example of a collaborative MOU arrangement is displayed in Table 13 below. Individual MOUs with health services have also been negotiated.

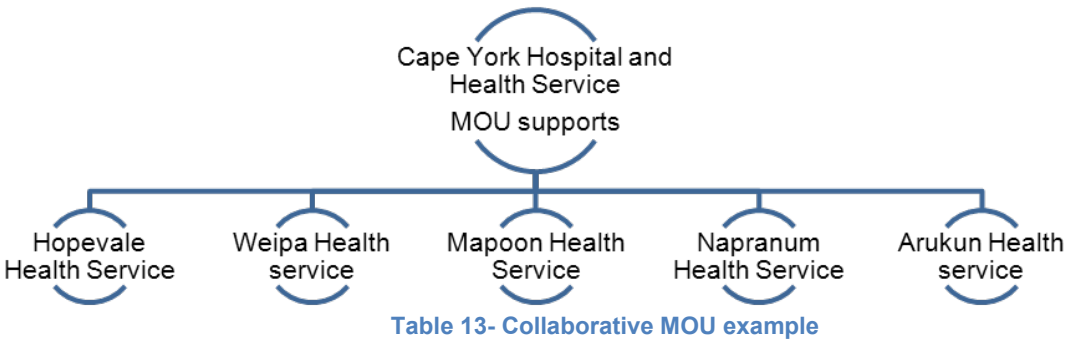


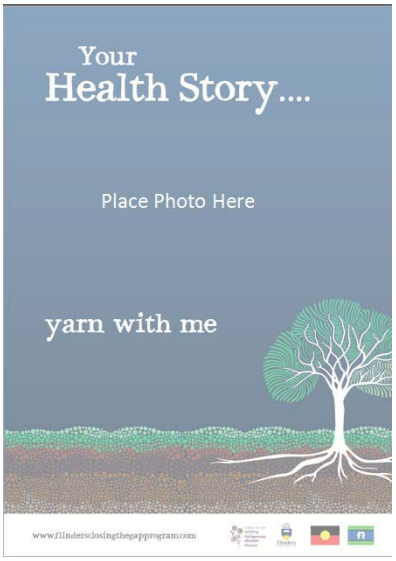
Table 13- Collaborative MOU example

Resource Development

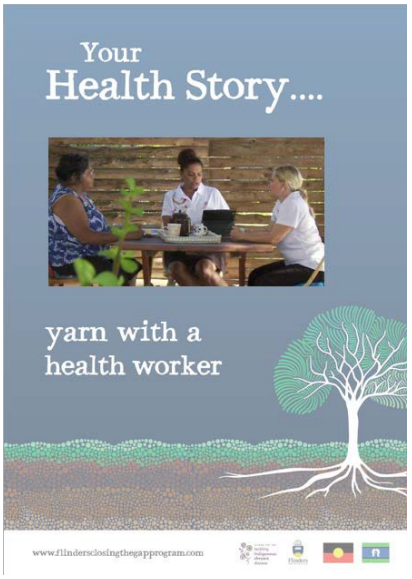
A number of resources were developed to support health services and organisations to facilitate the process of empowering Aboriginal and Torres Strait Islander people to manage their chronic condition in a way that is culturally respectful and supports their values. The resources include:

- A series of posters (Yarn with me)
- Ethel DVD introduction
- Clinic wall chart
- National Implementation Procedure manual
- Flinders Closing the Gap Program™ Implementation kit for organisations

The 'Yarn with me poster' (see Picture 9 and Picture 10) and 'Ethel' DVD was developed to raise patient awareness of a change in care delivery from acute to chronic and the care planning process. Providing targeted marketing material which promotes the program, the role of the health worker and raises interest is an important part of promotion.



Picture 9- Yarn with me poster



Picture 10- Yarn with a health worker poster

The Flinders Closing the Gap Program™-National Business Implementation kit was developed in consultation with Aboriginal Health Practitioners, General Practitioners, Health Service Managers, Medicare Locals, Allied Health Workers, Chronic Care Coordinators and relevant State and Territory department of Health representatives. Consultation was completed through numerous Communities of Practice, face to face meetings and feedback from workshops and follow up site visits.

From this kit a number of wall charts have been requested and are currently being designed to support health practitioners. An example of a wall chart which outlines the visual process of implementing the FCTGP is provided below (Figure 2- Implementing the FCTGP). A copy of the Implementation kit can be found on our website http://www.flindersclosingthegapprogram.com/?portfolio=implementation

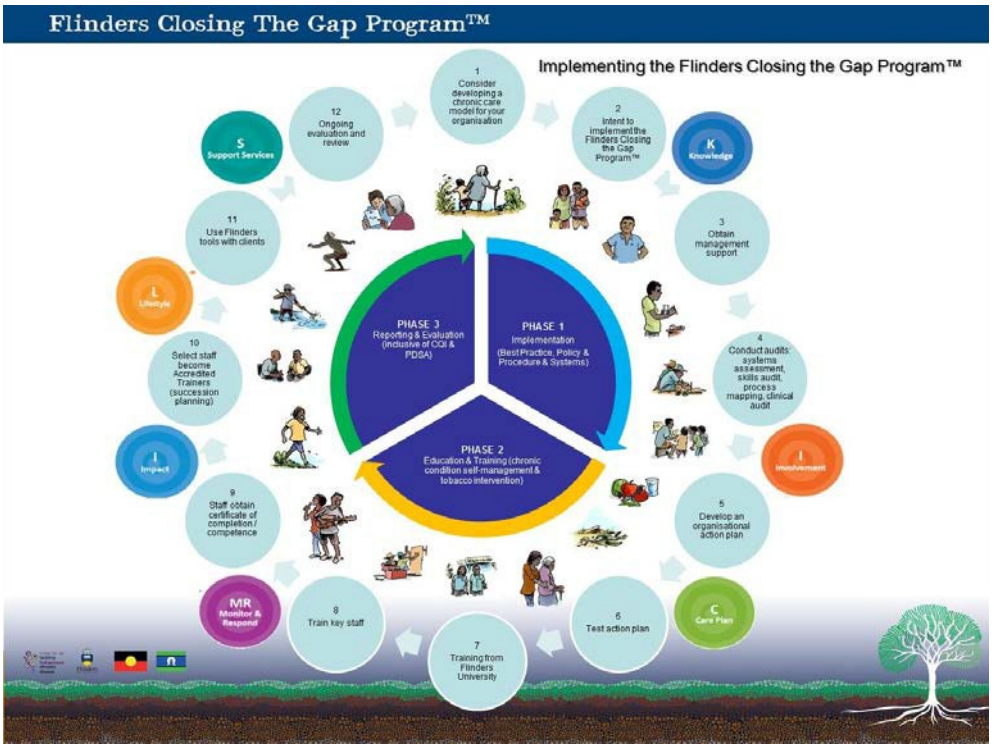


Figure 2- Implementing the FCTGP

The Flinders Closing the Gap Program™ National Business Implementation Procedure Manual, was developed as an internal process to effectively and efficiently support health services integrate the FCTGP by providing:

- An overview of the role of the Implementation Officer and examples of how this support assists health services procedures and activities
- A list of accompanying templates and reporting requirements to be used in the implementation Process.

The manual accompanies two complementary documents:

- A comprehensive report *'Implementation into Practice: A Practical Guide for Managers of Change'*. A guide that outlines a twelve step process, managers of change can use to efficiently support the development of a strategic approach to improving chronic condition clinical care through the implementation of the FCTGP.
- A toolkit *'The Flinders Closing the Gap Program™ Implementation Kit'*. The kit provides

a snapshot of how the FCTGP complements the client journey from acute presentation or health check to proactive management of care and behaviour changes. Policy and procedure examples are provided in this kit to support health services with the development of their own chronic condition governance and clinical guidelines.

'Implementation into Practice: A Practical Guide for Managers of Change' can be found on our website www.flindersclosingthegapprogram.com . Copies of materials developed for implementation has been provided electronically, refer to appendix 1 for detail.

Mentoring Local change managers

We currently have a pool of 85 change managers including Accredited Trainers and key employees supporting change at a local level.

The concept of having identified change mangers is consistent with Womack et al (2005) lean thinking concept of management style of having clear leadership and line of communication. One of the barriers to implementation identified by the sector in the snapshot completed in 2012, was lack of mentoring support for change managers and chronic care coordinators. Facilitating community of practice meetings provided an ideal forum for identified local change managers to meet and form positive networks.

Implementation Phases

FCTGP implementation is a three phase process and has been developed by drawing on evidenced based practice and peer learning.

The steps outlined below provide a template for the implementation of the FCTGP.

Phase I: Laying the Foundation (time line two months)	Phase II: Active Business Implementation (time line five months)	Phase III: Evaluation and Transition (time line one month, ongoing data management)
• Introducing yourself to the leadership of the organisation • Learning about the Chronic Care Management process of the organisation including enablers, barriers and facilitators of quality improvement • Getting acquainted with the members of the team	• Pre work assessment • Observational assessment • Planning session • FCTGP training refresher • Ongoing coaching on a fortnightly basis	• Monthly data management/reporting • Post work assessment • Report writing and presentation to management group • Ongoing partnership with the FCTGP

Over the past six months, organisations have reported their movement through the phases of Implementation on a monthly basis. The length of time each organisation takes to complete a phase and series of activities is dependent on priority, culture, workplace capacity, and project capacity.

System Audit

To support organisations to develop chronic care implementation proposals and monitor organisational change over time, the Assessment of Chronic Illness Care (ACIC) was used with

organisations as a baseline and review audit tool.

The content of the ACIC was derived from specific evidence-based interventions for the seven components of the chronic care model (community resources, health organisation, self-management support, delivery system design, decision support and clinical information systems). Like the chronic care model, the ACIC addresses the basic elements for improving chronic illness care at the community, organisation, practice and patient level.

The ACIC provides a subscale score that correspond to each element in the chronic care Model as well as an overall score. Version 3.5 divides the overall score by seven as this represents the number of the subscales in version 3.5. Although the ACIC was developed as a practical tool to help teams improve chronic illness care, it has also been used for research purposes with positive results (Wagner et al. 2001; Bonomi et al. 2002; Glasgow et al. 2001).

Figure 3 - Assessment of Chronic Illness Care outcomes, illustrates the mean average score of *n*= 21 health organisations. The average score for each of the seven audited sections is illustrated on the radar graph shown below. The ACIC was adopted by the FCTGP-NBIT team as a validated tool that would support health services to evaluate their change in Chronic Condition Management over the course of the project. A pilot trial was conducted between August 2013 and November 2013, with the audit being offered to organisations as a way of understanding what they do well already and how they would prioritise future quality improvement activities in the next three months to improve the ACIC score. The audit wasan internal assessment facilitated by the FCTGP-NBIT officer and generally completed with consultation from the CEO, managers, and front line staff.

Twenty four organisations have currently agreed and completed the ACIC assessment. Twenty one health services have gone through the process of three monthly reviews. Some organisation indicated a reduced mean average score at the three month review. This is explained by the MacColl Institute for Health Care Innovation (2000) as 'typical', because health services become more aware of what it means to have an 'effective chronic condition self-management care system', understanding of the assessment and what a good chronic condition self-management system looks like are reflected in the scoring even though there have been improvements.

Overall the FCTGP-NBIT showed a 20.9% improvement across the *n = 21* health care organisations across the seven domains of the ACIC improvement is show in the radar graph below.

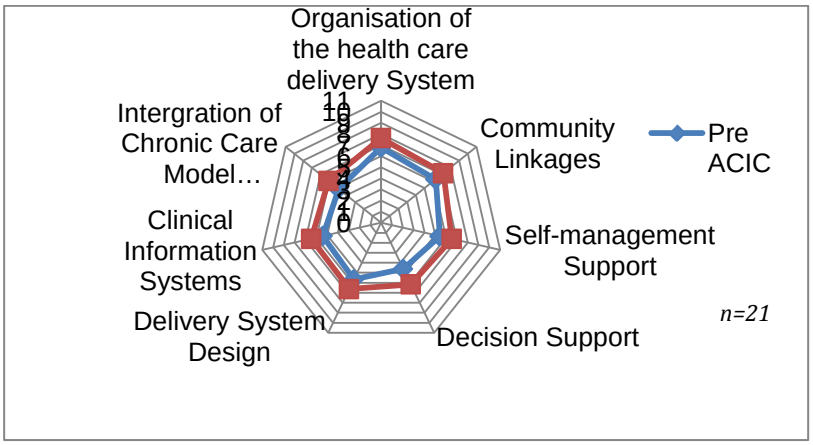


Figure 3-ACIC outcomes

Improvements indicate that on average health services have moved from a basic level of Chronic Condition care to a reasonably good support level of chronic illness care (MacColl Institute for Health Care Innovation, 2000). Each health service has received an implementation proposal outlining key strategies available from the FCTGP-NBIT and how they will support quality improvement against the ACIC. Major improvements nationally to date have been shown in the ACIC areas of self-management support 20.25%, Decision support 33.6%, and Integration of chronic care model components 34.7%.

Kalwun Health Service is a positive example of improvement in ACIC scores following implementation support.

Kalwun Health service has been working through their strategic plan for improving chronic care management. A base line ACIC was completed on the 16th of June 2013 and indicated a mean average score of 6.2 indicating that the health service was already providing reasonably good support, based on the MacColl Institute for Health Care Innovation (2000) evidence based assessment tool.

Following support and mentoring from the FCTGPNBIT and the Kalwun Health Service project working group the 3 month review ACIC indicated a mean average of 8.8. This is a 29.5% improvement in the organisations Chronic Care management and only .2 away from the organisation showing that they are fully developed in their corporate and delivery model of Chronic Care management.

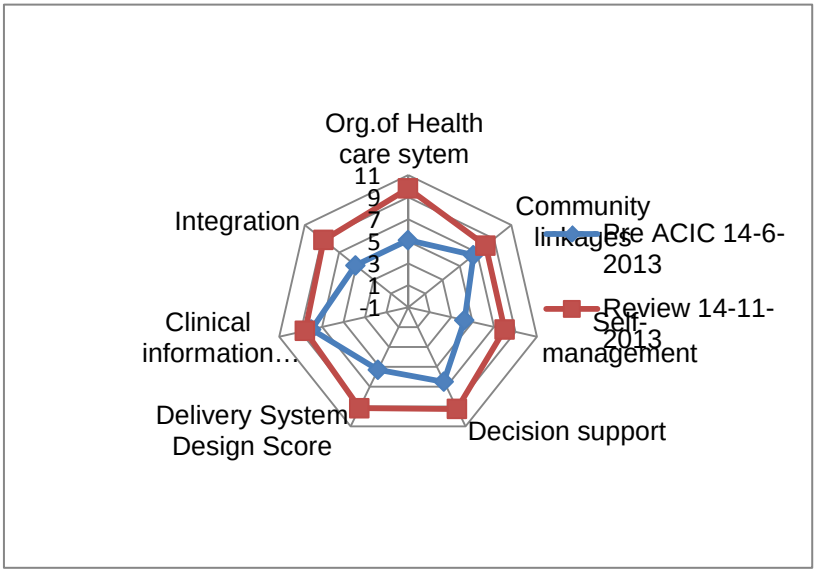
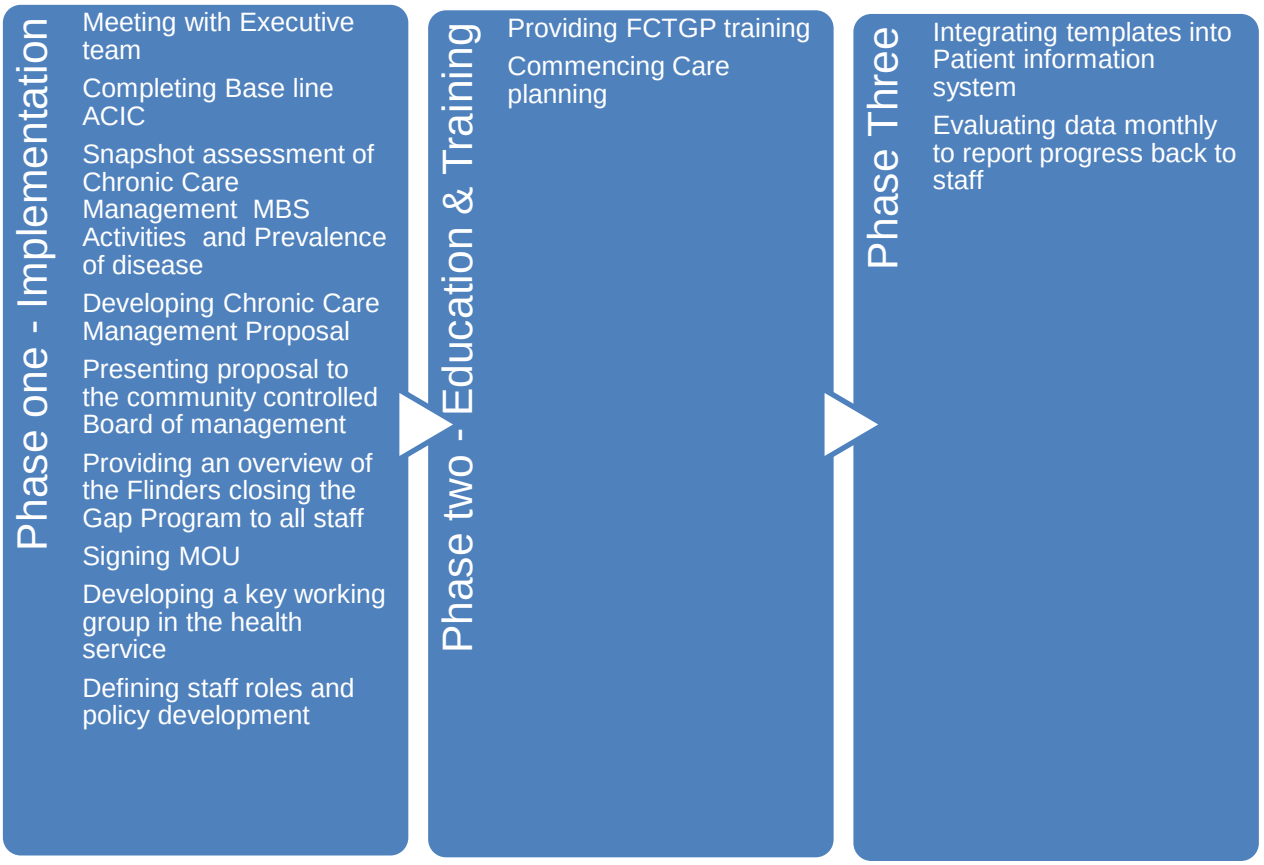


Table 14- ACIC Average score 8.8

Key activities that have occurred in the past three months to support the Kalwun Health service achieve this outstanding result include:



To support the sustainability of Kalwun's model of care the health service has a staff member in the process of completing their Accredited Trainers certificate. This will ensure that past staff will have availability to refresher training and new staff will be orientated to the FCTGP model of care.

Kalwun Health Service chronic care team continue to seek knowledge of chronic care models and regularly seek networking opportunities from benchmark organisations.

3.2 IMPLEMENTING CHANGES, IN THE MANAGEMENT OF HEALTH SERVICES

Implementing changes, in the management of the health services, which include ensuring that training in the expanded Flinders Program™:

a) Forms part of health professional staff position description and or job descriptions

b) Is included in the initial period of staff induction if health workers employed by a health service have not already been trained in implementing or conducting chronic condition self-management care planning

Chronic conditions pose a significant burden on the health and wellbeing of Aboriginal and Torres Strait Island people, families and communities (World Health Organisation (WHO), 2005).The term 'Chronic Condition' has been used instead of 'chronic disease' as it includes mental disorders and disabilities. The burden of these diseases on health services is expected

to reach 80% of the total health care delivery system by 2020. (National Health Priority Action Council (NHPAC), 2005).

Chronic conditions and the impact of chronic conditions are amongst the most preventable health conditions. Chronic condition management and self- management often requires the holistic management of co-morbid health conditions, related complication and psycho-social impacts.

Primary health care services need delivery care systems that support early detection, treatment and active collaboration with the patient to delay complications and disability (Glasgow et al. 2001; Glasgow et al. 2003) This is best achieved where chronic condition self-management support is integrated into the patient care delivery system, including access, initial needs identification, assessment, care planning, referral, review and maintenance.

The skills of the primary care workforce are essential for effective chronic condition self-management support across the life span. The WHO has identified core competencies required by health practitioners and health care systems to deliver effective care to those at risk of developing or have a chronic condition. These competencies include;

- Adopting a public health perspective
- Empowering individuals towards adopting behaviour changing self-management strategies
- Patient-centred care
- Case management with the client family and other health practitioners

FCTG-NBIT support the development of sustainable implementation plans for each organisation. Each proposal identifies the governance structures, policy development and staff appraisal processes that incorporate chronic condition self-management as a key component of the health practitioners position description. An example of an organisational implementation plan developed by Nganagganawili Aboriginal Health Service (NAHS) can be found on our website (www.flindersclosingthegapprogram.com) and have been made available to organisations to assist in developing their own plan.

a) Forms part of health professional staff position description and or job descriptions

Each service supported by the FCTGP-NBIT is encouraged to develop policy that supports the inclusion of chronic condition self-management training as a key component in position descriptions/job descriptions and service delivery models. Organisations have sought support and guidance to develop these policies and procedures and example documents have been developed and provided as a guide. An example of such a policy has been provided by Robinvale District Health Service and is available as an electronic resource see appendix 1.

b) Is included in the initial period of staff induction if health workers employed by a health service have not already been trained in implementing or conducting chronic condition self-management care planning

The National reference group, Australian Better Health Initiative (ABHI) (2009) emphasised that all carers and their families receive care from health practitioners who are competent in chronic condition self-management

The core principles underpinning the development of workforce capacity and ability of health practitioners to delivery chronic care self–management include:

- Competency in supporting patients to self-manage their chronic condition and
- Health professional education
- supports work place practice supports self-management and client empowerment
- Supports ability to work in interdisciplinary teams
- Understand and base chronic care self-management support on the medical psychosocial and cultural needs of the client and their significant kin/family

FCTG-NBIT has worked closely at a local and regional level to ensure that education in the FCTGP is available in the initial staff orientation packages. To assist with this, organisations are encouraged to have a local Accredited Trainer on staff to support staff orientation. The following three examples represent how the FCTGPNBIT has support the induction of training into staff orientation programs

Local Level

Promoting that organisational policy supports and facilitates the training of new staff, has led to organisations having large numbers of the workforce having capability and understanding of chronic condition self- management. For example an Aboriginal health service in WA now has 52 staff trained in the FCTGP tools and access to an onsite Accredited Trainer.

Another example is a state funded community health service in Queensland mandating that all staff complete the FCTGP training as part of their job description within the orientation process.

Regional Level

To support a consistent chronic care planning model and workforce knowledge within a region, several organisations under a regional governing body have come together and endorsed the FCTGP as their chosen care planning pathway. Examples of this model include the Kimberley /Pilbra model involving 6 Aboriginal Health service across Western

Australia and the Primary Care Partnership in the Mallee region that has a membership of 32 organisations all endorsing that FCTGP training will be delivered throughout their organisations.

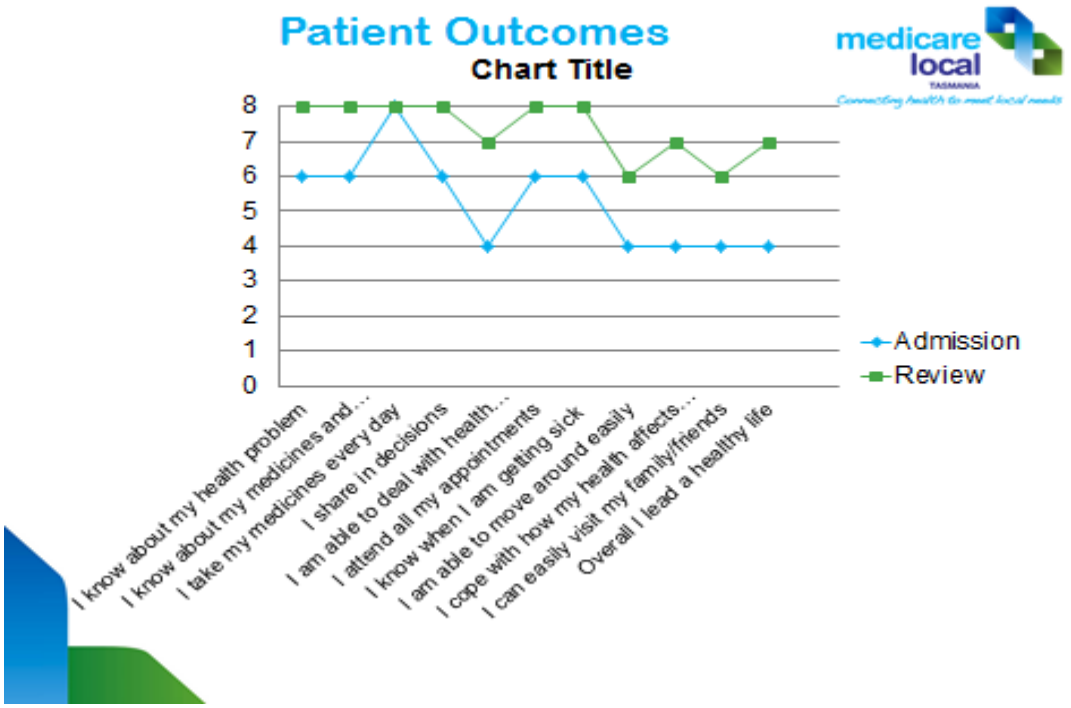
National Level

On a national level the FCTGP has been endorsed by AMLA as key workplace training for the CTG and CCSS workforce. Training has been provided to many of the Medicare Local staff.

3.3 DEVELOPMENT AND IMPLEMENTATION OF DATA COLLECTION

> *'The participant will ensure effective development and implementation of data collection in regard to care plans that are conducted by trained staff and the following session activity.'*

Each organisation is requested to report data monthly based on the number of care plans and occasions of service conducted. To manage and improve the patient delivery models, health organisations are encouraged to also collect chronic condition self-management outcomes using the FCTGP Partners in Health assessment, at the care plan follow up review. Some health organisations have shared their de identified chronic condition self- management data with the FCTGP team. The data below is an example of Partners in Health outcome data for a client working with the Tasmania Medicare Local CCSS program



The data shows an improvement in knowledge of disease to 100%, medication compliance to 100%, working with health practitioners and attending appointments 100% and an improvement of 75% in the self-management areas of visiting family and friends and being able to move around easily.

Integration into Patient Information Systems

The integration of the FCTGP with various Patient Information Systems (PIMS) is a complex process requiring careful consideration and research. The need to take into account new innovations and the ever changing demands from the market remain at the forefront of our decision to progress discussions with any provider. Our primary priority is to ensure our product is positioned to offer the most benefit to our consumers whilst maintaining product integrity, usability and compatibility. An understanding of the market and the various systems our consumers are using is also vital to achieve effective market coverage and access to our product.

At present we have arrangements with MMEx and negotiations are ongoing with a number of other provider's including Communicare. Significant progress has been made toward achieving integration; however there is further room for research, negotiation and integration opportunities.

3.4 Review and follow up

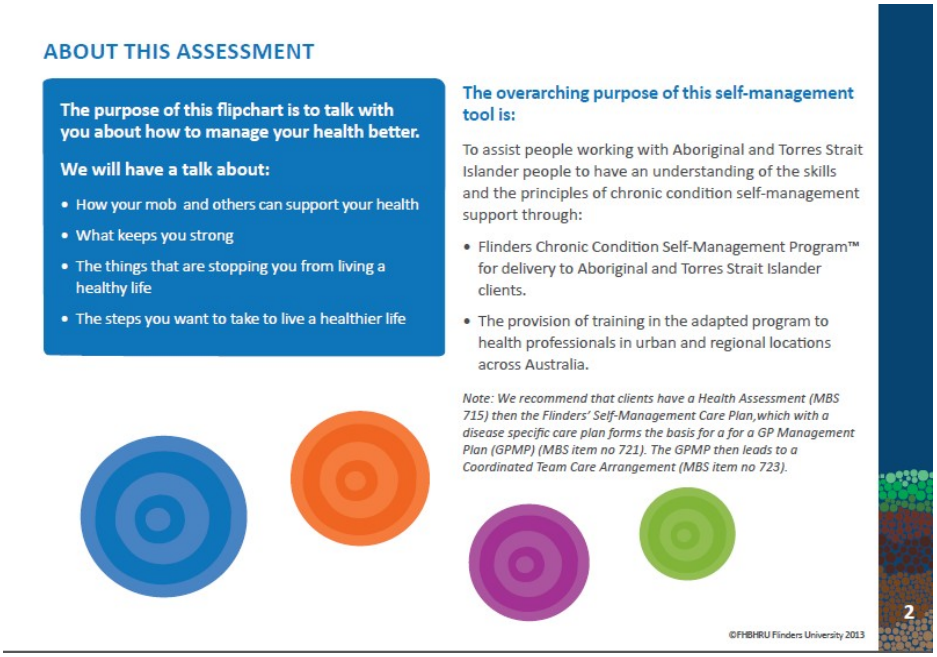
The participant will ensure that trained health workers will conduct, as a minimum, a further 5 consultations or sessions with Aboriginal and Torres Strait Islander patients to review their progress. The initial care plan will be reviewed within the first three months from provision of the session, to ensure any appropriate readjustment of the patient self-management goals.

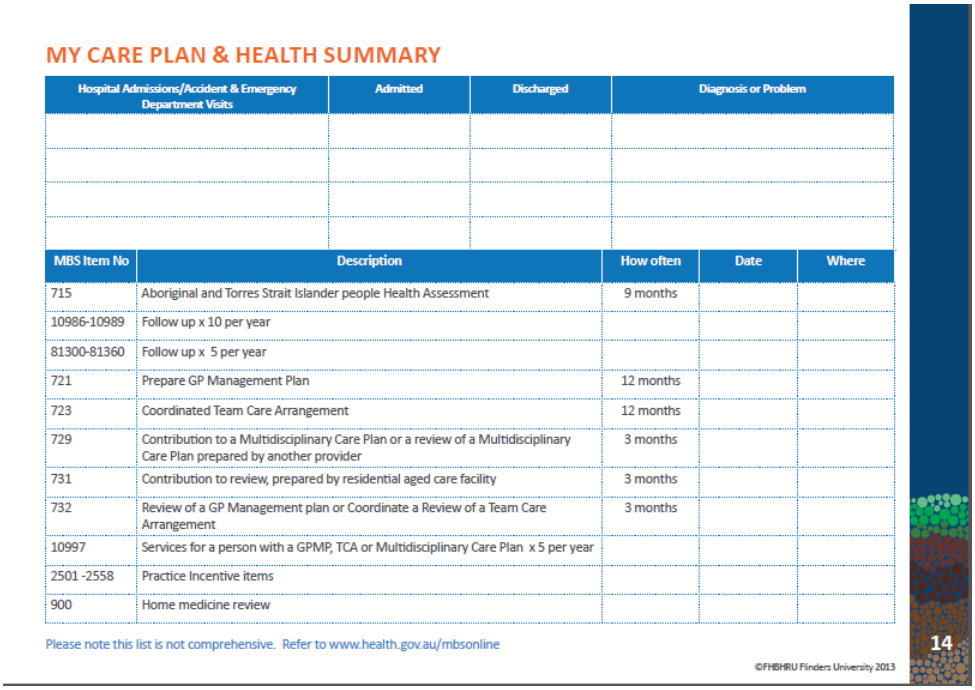
Care plan review has shown to be the key to supporting the 5 key components of patient engagement, described by Battersby et al. (2007) as communication, effective health care, alignment of objective medical information and encouragement to achieve patient centred goals. The schedule and maintenance of timely reviews is shown to provide better health outcomes for clients.

FCTGP facilitated the best practice client review process through;

- Health practitioner education,
- Explanation and inclusion of a prompt/record chart in the “My Health Story”
- Mentoring support to organisations to develop review processes into their client care pathways and policy development.
- Monthly data collection of occasions of service
- Integration of tools and review prompts into Patient Information Systems.

Regardless of the health service type the FCTGP advocates that all care plans should include the best practice activities of Health Assessment, care plan and timely reviews. Screen shots of the relevant pages included in the ‘My Health Story’ are shown below to illustrate.





MY CARE PLAN & HEALTH SUMMARY

Hospital Admissions/Accident & Emergency Department Visits	Admitted	Discharged	Diagnosis or Problem

MBS Item No	Description	How often	Date	Where
715	Aboriginal and Torres Strait Islander people Health Assessment	9 months		
10986-10989	Follow up x 10 per year			
81300-81360	Follow up x 5 per year			
721	Prepare GP Management Plan	12 months		
723	Coordinated Team Care Arrangement	12 months		
729	Contribution to a Multidisciplinary Care Plan or a review of a Multidisciplinary Care Plan prepared by another provider	3 months		
731	Contribution to review, prepared by residential aged care facility	3 months		
732	Review of a GP Management plan or Coordinate a Review of a Team Care Arrangement	3 months		
10997	Services for a person with a GPMP, TCA or Multidisciplinary Care Plan x 5 per year			
2501 -2558	Practice Incentive items			
900	Home medicine review			

Please note this list is not comprehensive. Refer to www.health.gov.au/mbsonline

The following case study illustrates the story and outcomes of a care coordinator continuing to review the client goal, and advocating her choices and culture in chronic care management allowed this client to move from high level permanent care back to her home.

Client case study – Gaye

Background – care coordinator managed scenario

Gaye (fictitious name) is a 69 year old woman, living in a remote area. Her significant other is also her carer however, also has a current acute condition. Gaye presented with co-morbidities: Type II Diabetes, Cardiomyopathy, Hypertension, Reflux, Rheumatoid Arthritis and Renal failure. Gaye was eligible for Care Coordination & Supplementary Services (CCSS) and was placed on a waiting list for mitral clip surgery, interstate. While waiting for this surgery Gaye's general health and well-being deteriorated culminating in acute renal failure. Gaye was admitted to an acute facility where her renal and cardiac failure were addressed and stabilized. However, this delayed her original presenting need for surgery for a mitral clip.

After a lengthy stay Gaye was discharged to an acute bed in a regional facility. Over a few weeks Gaye's general mobility had improved through remedies including physiotherapy. At a case conference with family, care coordinator, nursing and physiotherapy staff it was established that Gaye was highly motivated to rehabilitate her mobility with the use of a frame, and set to working towards the goal of her much needed mitral clip surgery. Gaye's GP encouraged her rehabilitation and supported realistic intervention goals for Gaye as determined by her with her care coordinator in her My Health Story care plan.

Ultimately Gaye required placement in a more permanent facility due to her home and carer capacity.

These following issues were identified in managing Gaye's My Health Story care plan scenario:

- Flinders Closing the Gap Program™ person centred, chronic condition self-management: develop and apply education and policy to support all staff in services

along Gaye's care plan journey, and other existing or new residents wishing to self-identify in their Health Story.
- Gaye desired to not be 'permanently' placed and wanted to continue working towards self-managing and going home.
- Support finding best fit local GP care, as her normal residential aged care facility is not in her home town.
- Maintain setting realistic mobility goals with physiotherapy team.
- Build-in referral pathway to community Occupational Therapist (OT) for an 'in residence' assessment and to also assess Gaye's home environment in support of her going home.
- Manage short term actions: post-OT assessment recommendations and home modifications, aim for day trips home, progressing to overnight stays.
- Provide carer pathways and advice in support of domestic assistance in the local community such as transport for local and urban medical appointments.
- Facilitate communication between specialists and various GP's to develop ongoing management as discussed with Gaye.
- CCSS funding utilized by care coordinator to arrange immediate and timely access for an OT assessment and by-pass public waiting lists.
- Care coordinator liaise with various GP's regarding renal and other 'follow up' needs.
- Acknowledge and facilitate Gaye's desire to self-manage BSL monitoring and insulin administration.

Setting Goals:

- Care coordinator advocated on behalf of Gaye with nursing staff to establish goals and aims for her to self-manage her conditions.
- Recommendation and information provided to the aged care facility to support implementation and training, and policy to support residents self-identifying
- Access to permanent local GP (currently a locum)
- Education for GP and practice staff around issues of self-identification and Care Coordination
- Establishing a physiotherapy regime
- Referral for a Diabetic educator to visit facility
- Liaising with all involved specialists in the city and new country GP
- Acknowledging Gaye's goals regarding mobility and self-management
- Facilitate conversations between GPs, Specialists and Gaye to establish realistic medical intervention goals
- Facilitating community referrals OT, domestic assistance, transport etc.

Challenges, Access Issues, Outcomes

- Policy change regarding use of supplementary services funds for resources would assist mobility outcomes, independent living and prevention of further deterioration of chronic-condition
- Access and continuity of local GPs– Original GP left practice, followed by subsequent locums; client then relocated to a different region, had another GP when admitted to residential aged care facility.
- Increased awareness systemically of Closing the Gap Programs and in particular CCSS
- Systemic approach involving a multidisciplinary team to rehabilitate patient to potentially self-manage to maximum capacity

- Formalising consultation between rural primary health care providers and urban based specialists and facilities
- Clients improved sense of empowerment and realistic goal setting
- Bio-medical outcomes: stabilised BSL's and proficient insulin administration
- Accessing Specialists – previous appointments had been missed due to location of specialists based in different town locations with appointments only days apart.
- Consolidation of appointment times and re-referring to specialists within same regional location – not towns apart.
- Supplementary service funds utilized to access private specialist as public waiting list is lengthy.
- Gaps identified in access to allied health providers: as an inpatient Gaye was not assessed by an OT, physiotherapy or diabetic team on initial admission; when it became evident that she would not be transferred to a rehabilitation bed, despite the care coordinator liaising with them, Gaye required follow up at a 2nd acute facility and again when admitted to the aged care facility.
- At the time of writing this scenario with additional support from community based allied health providers Gaye progressed from high care to low care and has now been discharged from the aged care facility to her home with support from her carer, community services and continued involvement of Gaye's Care Coordinator to monitor Gaye's My Health Story self-management journey.

The next de identified case study outlines how the care planning review process has resulted in a client accessing health services after 20 years.

I am a National Business Implementation Officer with the FTCGP, in Victoria. I am also an Indigenous Health Project Officer for Lower Murray Medicare Local.

I first used the Flinders care plans following training, with my own clients in the Mallee area of Mildura. I had a particular client who I prepared a care plan for, including her immediate family. Some weeks later I had assisted her with working towards many of her goals. However, she rang and asked if I had time to see her sister, also for a My Health Story care plan, as she had her own health issues. This sister had a daughter aged 20 years, but as a young girl of 2 underwent surgery and was left with an ABI (Acquired Brain Injury) - 20 years before! Following the ABI, the mother brought the daughter home and kept her with her all this time, caring for her for all of these years.

I went around to her address after ringing her to let her know I was coming and she said "only you are to come please as my sister said it was ok for you to come around to help me with the books you used with her". She meant the My Health Story. I went in and completed a My Health Story care plan for her and her daughter. The outcomes have been huge, the daughter needed more operations that had not been able to be done before. She had never been given access and provision to living skills or personal hygiene skills for her ABI condition – at age 20 she was still incontinent. I went in and spoke with the mum who wouldn't or didn't like talking about her daughter's ABI. She whispered to me "we don't discuss *that".* I come from a disability back-ground and explained to her what an ABI was and that it is not something to be *"shamed"* about or not to talk about. We went over all the things that her daughter needed done right away - an operation that she needed had been getting put off so I assisted them both in bridging paths to main-stream services and assisted her to travel to and from Adelaide for this long awaited operation.

The outcomes have been great for the daughter and Mum is now allowing home care to come in and clean the house, taking a lot of stress off her as she is also not very well. The daughter is now seeing the services who she really needs and Mum is also getting the professional help she needs. I call in there every month to see if she is going along well and each time I see them both it is all good news for them both. It all came about because the sister had a Flinders My Health Story done for her and her children, and she could see what good it would be for her sister and niece.

3.5 SESSION ACTIVITY

> *"The Participant will monitor session activity, collect data provided by participating health services on session delivery targets and report results to the Commonwealth in the delivery phase progress reports set out in Item D, and on a monthly basis via email to the Commonwealth Liaison officer."*

Consultation by the FCTGP-NBIT with participating organisations proved many barriers exist to monitoring session activity and collecting data for the purpose of timely reporting. As a result, the number of organisations reporting from month to month varies, however an organisation must at least be in Phase 1 to qualify, with timely progress under way towards Phase 2, and ultimately Phase 3. In response to the individual strengths and capacity of participating organisations the FCTGP-NBIT developed a flexible, qualitative reporting format to complement the 3 Phases of Implementation. The format supports innovation, efficiency and flexibility to set a precedent that reporting will over time become the mechanism to improve evidence based outcomes.

A multipurpose MOU fact sheet was designed to outline roles and responsibilities of the parties (see appendix 1). The reportable data format follows the 3 Phases with 3 streams for capturing data as follows:

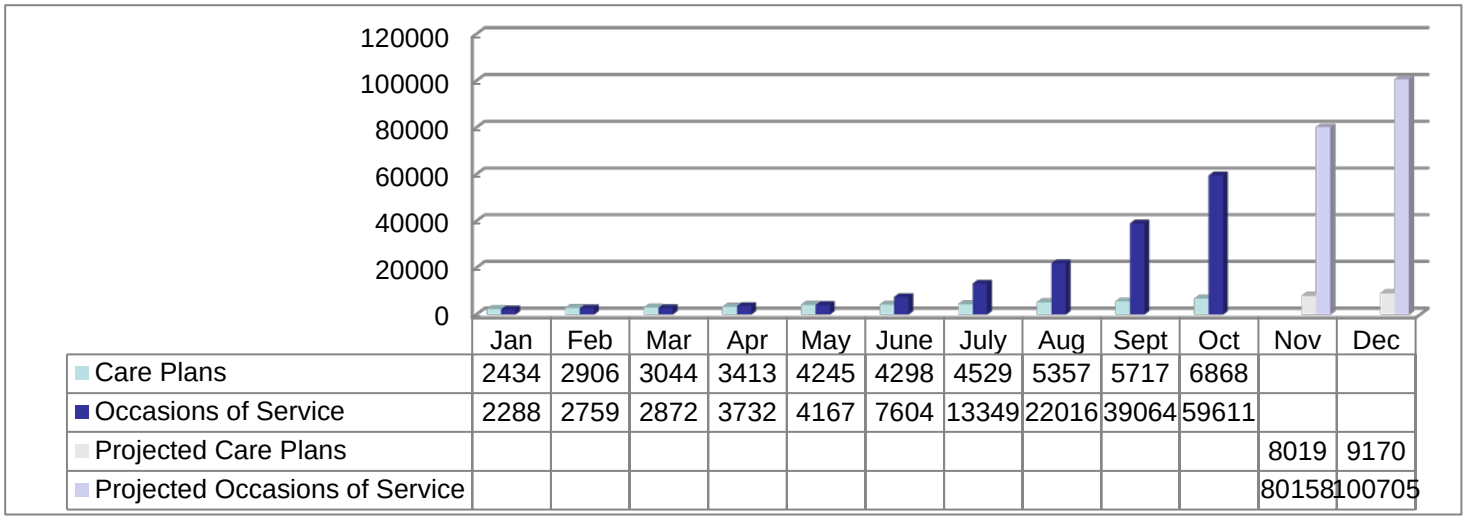
Stream 1	**Stream 2**	**Stream 3**
Flinders Principles only (occasions of service)	**Flinders Tools (occasions of service + care plans):**	**Flinders Care Planning (occasions of service + integrated care plans):**
K I C MR I L S	K I C MR I L S Partners in Health Cue & Response Problems & Goals	Stream 1 & 2 Completed consolidated care plan Review of care plan

To support data collection and alignment with the holistic continuum of care an example reporting table was designed to show alignment with other best practice key performance indicators, such as nKPI's and MBS items. The FCTGP-NBIT also consulted OATSIH's OchreStreams with the view to simplifying secondary data reporting by participating organisations directly to the FCTGP-NBIT, however, this is not yet a viable option. FCTGP-NBIT is optimistic that the use of PECHR technology will in the future support multidisciplinary reporting demands.

FCTGP-NBIT designed a monthly reporting template for the Department to reflect the methods of data capture above including a numerator against session activity and care planning validate

that from month to month (where n=40) actual capacity to report qualitative data remains an area for improvement and attention for innovation by NBIT in response to the needs of its many types of organisations, in just as many locations.

As at October 31st 2013 a total of 6,868 care plans and 59,611 occasions of service were delivered. This is above the allocated deliverable of 50,000 sessions delivered. Table 15 shows the increase in reported numbers of care plans and occasions of service in 2013.



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Care Plans	2434	2906	3044	3413	4245	4298	4529	5357	5717	6868		
Occasions of Service	2288	2759	2872	3732	4167	7604	13349	22016	39064	59611		
Projected Care Plans											8019	9170
Projected Occasions of Service											80158	100705

Table 15 - Occasions of Service

3.6 Outcomes of the Flinders Closing the Gap Program™ from a manager's perspective

Interviews with health service managers provided an insight into the value of implementing the FCTGP in the belief that it would ultimately provide their workers with the tools to assist Aboriginal and Torres Strait Islander people achieve better health outcomes.

> *"the reason that we invested in doing the Flinders training, I liked the model because it was all about giving Aboriginal Torres Strait Islander people – especially the patients that we're working with – the tools, and my workers the tools, to educate our people, to make sure that they take ownership of their health." (Manager)*

The ultimate outcome would be clients having more planned visits to the health service, greater control over their health therefore less health problems which in turn will free up health services and resources.

> *"I think in the future we could actually see a lot more clients. I think if we educate them enough we'll see clients moving a lot quicker through our tier system, so they may become a little bit more independent and knowing a little bit more about their health." (Manager)*

The implementation team has also worked with managers to highlight the financial benefit of implementing the program.

> *"…so the short term goal is to have every single client who…has active diabetes with a Flinders program plan…and to have them all seeing the diabetes educator five times in a year…and then from a financial point of view it's to ensure that we*

increase our Medicare revenue from the chronic disease management items, from the current level of $256,000 per annum, to half a million dollars per annum, by the middle of next year…" (Manager).

4.0 EVALUATION

4.1 OVERVIEW OF THE EVALUATION APPROACH

The aim was to evaluate the processes, impacts and outcomes of the training and implementation phases of the Flinders Closing the Gap Program™ (FCTGP), and to identify barriers and enablers. The purpose was to inform ongoing improvement to the Program.

Evaluation plans were developed for the training and implementation phases of the Flinders Closing the Gap Program of Chronic Conditions Management (FCTGP-CCM) during 2012, and variations to incorporate the LWSF Program were negotiated in 2013. An Aboriginal Research Consultant was engaged by FHBHRU to provide culturally specific advice and support throughout the project. Approval to conduct this evaluation work was obtained from9 human research ethics committees see Table 16. Note that evaluation of the training component carried negligible risks and therefore required approval from SA ethics committees only.

State	Ethics Committee	Date of approval		
		Evaluation of FCTGP Training	Evaluation of FCTGP Implementation	Variation for Tobacco Management
TAS	Human Research Ethics Committee (Tasmania Network)		02/01/2013	13/06/2013
VIC	Mildura Base Hospital Human Research & Ethics Committee		21/11/2012	21/07/2013
QLD	Gold Coast Health Service District Human Research Ethics Committee		26/02/2013	27/05/2013
VIC	Ballarat Health Services& St John of God Hospital Ballarat - HREC		26/08/2013	26/08/2013
WA	Western Australia Aboriginal Health Ethics Committee		29/07/2013	16/09/2013
SA	Aboriginal Health Research Ethics Committee	01/11/2012	01/11/2012	13/06/2013
SA	Social & Behavioural Research Ethics Committee	04/12/2012	04/12/2012	06/06/2013
All states	Department of Health and Ageing Departmental Ethics Committee		08/01/2013	09/08/2013
NSW	Aboriginal Health & Medical Research Council of NSW		8/3/13	

Table 16- HREC approval

A mixed methods approach was taken, triangulating findings from a desktop audit of training activities and outcomes, workshop evaluation questionnaires, on-line survey of trainees, and interviews with clients, staff and others involved in the FCTGP. Methods and outcomes to date of each of these components are outlined below.

Evaluation work was planned to extend beyond the current project funding period in order to explore longer-term impacts and sustainability, and therefore information presented here is preliminary. A summary of this section of the evaluation follows. The detailed report can be

found at http://www.flindersclosingthegapprogram.com/research . Evaluation tools for example survey forms, interview guides and consent processes are available upon request from FHBHRU.

4.2 POST FCTG-CCM WORKSHOP EVALUATIONS

Aim

The aim was to summarise the post workshop evaluations from participants of the FCTGP CCM workshops. Participants' confidence, knowledge and skills around self-management strategies and tools were explored, as well as their views about the training workshops.

Data and methods

Evaluation questionnaires were offered to participants at the end of each FCTGP- CCM workshop. Completion was voluntary and anonymous.

A combined data file was created accumulating data from all the FCTGP-CCM workshops conducted between August 2010 and September 2013. Quantitative data were summarised (frequency distributions, graphs) using the SPSS program. Qualitative data from open-ended questions were analysed thematically using the N-VIVO program.

Results

596 participants from 60 FCTGP CCM workshops held between August 2010 and September 2013 completed questionnaires, i.e. response rates were 88% of workshops and 82% of participants.

Most participants felt that all the learning objectives were entirely met, and that they had gained the knowledge to use the FCTGP assessment and care planning tools and the skills required to support chronic condition self-management. 69% felt that the learning was relevant to their work.

On completion of the workshop 64% of participants intended to complete the requirements for a certificate of competence and 22% did not intend completing the training 94% agreed or strongly agreed that they were confident to support clients to self-manage their chronic conditions using the FCTGP and 97% felt that the Flinders tools would be useful or very useful in their work and that they would use the care plan.

The most commonly mentioned challenge to implementing the tools related to lack of time, engaging clients, support of management and peers, and having to change usual ways of working.

Suggested support to assist with implementation included management backing, follow-up from the FCTGP team and peer support.

More than 90% of participants rated the structure of the course, course delivery, resources, venue and inclusiveness as good or excellent. Responses regarding improvements to the suitability of timing and duration of the course were evenly divided between generally positive comments and suggestions to shorten the course. Participants who attended workshops delivered one day at a time over a period of weeks found that arrangement very suitable. Some useful suggestions about improving the course were made.

Discussion

Participants' evaluations of the workshops were reviewed regularly, and informed on-going improvements to the course. Many of their suggestions have been taken up, e.g. adjusting the length and timing of workshops to suit the needs and contexts of participants and services, increasing the number of Aboriginal and Torres Strait Islander trainers, and developing a range of electronic and paper-based resources to support the training.

4.3 On-line questionnaire of FCTGP-CCM trainees

A summary of this component of the evaluation follows. .

Aim

The aim was to find out if and how the FCTGP training was being used.

Methods

Participants of FCTGP CCM workshops were invited to complete an anonymous on-line survey during January-March 2013. The questionnaire enquired about follow-up support after training, implementation plans and activities, barriers and enablers. Quantitative data were summarised as frequency tables and graphs, and qualitative were analysed thematically.

Results

A total of 104 on-line questionnaires were returned (response rate = 16%). The majority worked in Aboriginal or community health services and 64% had attended a FCTGP- CCM workshop within the last 12 months. 65% said they received follow-up support from the FCTGP team after the workshop, mostly to complete the care plans and achieve a certificate of competence.

Over 80% intended to implement the FCTGP in their workplaces on completion of training, reflecting their personal and workplace commitment to implementation. However, at the time of questionnaire, only 18% reported that their organisations had fully implemented all or part of the FCTGP tools into clinical practice; 30% were actively planning or beginning implementation and 32% were not implementing.

Respondents were asked to describe the processes of implementation of the FCTGP within their organisation. They described organisation-wide discussion and training, gradual integration of the tools into their client management processes, and dedicated staff roles.

The most frequently mentioned barrier to implementing the FCTGP was lack of time, followed by insufficient staff and resources, and issues related to management and organisational leadership. Some people felt that the tools were inappropriate for their clients or difficult to use in practice; others lacked confidence and wanted more follow-up. Funding was mentioned by several people.

Most frequently mentioned enabling factors were follow-up support from the FCTGP team, the training they had received, being able to use the assessment and care-planning tools, and staffing arrangements. Management support and evidence of positive outcomes for clients were also mentioned as enabling factors.

Supports that might help to progress implementation included more staff and resources, opportunities to network with peers, more support from management, and adapting tools to suit their clients and information systems.

Discussion

Most of the people who responded were keen to implement the Program into clinical practice, but actual progress towards implementation in their workplaces varied widely. Many organisations were still planning or in the initial stages of implementation. Several of the enabling and barrier factors identified were related, e.g. lack of management support was an important barrier to implementation in many organisations, whereas strong commitment from management helped to progress implementation.

4.4 Interviews with clients and staff of participating organisations

Aim

The aim was to evaluate the implementation of the FCTGP (both FCTGP-CCM and LWSF) by interviewing staff and clients about their experiences with the program and their ideas about what works well or not and why. The purpose was to inform ongoing improvement to the FCTGP.

Methods and participants

Semi-structured interviews were voluntary, confidential and all participants gave informed consent. Interviews were audio-recorded, transcribed and analysed thematically.

Recruitment of staff and clients was opportunistic, limited to places where local ethics approval and permission from organisations had been obtained. The target was to interview about 30 clients and 30 health practitioners involved in the FCGTP from urban, regional and remote health services in each Australian State and Territory. 31 health practitioners and 11 Aboriginal clients from six health services in four States have participated as at November 2013.

Results

The following themes have emerged from preliminary analysis of interviews conducted to date.

Health Outcomes for Clients

Clients indicated they felt supported, respected and understood throughout the FCTGP CCM and LWSF assessment and care-planning processes, and were able to identify health problems and set goals to improve health and wellbeing. They described how the process allowed them to identify and talk about their strengths and main worries, sometimes for the first time, and to contemplate or make lifestyle changes to address those worries. Clients talked about the beneficial outcomes resulting from their involvement in the FCTGP, e.g. increased confidence, less stress and anxiety, improved social support, and greater ability to manage prescription payments, maintain a healthy diet and exercise.

Health outcomes for health practitioners

Health practitioners reported that since attending FCTGP training they had started to eat healthier, quit smoking or consider quitting, and had started to address their own health needs. Some had also become more aware of their family members' health and social worries, and had helped them to find solutions.

Workers as Role Models

Clients thought that it would be beneficial if health practitioners addressed their own health, especially smoking. Similarly, most of the health practitioners agreed that it would be better for ex-smokers to deliver the LWSF intervention to avoid hypocrisy and criticism from the community. Workers who were current smokers felt reluctant to deliver smoking intervention for that reason.

Cultural Aspect

Clients found the FCTGP tools to be culturally appropriate and respectful, suggesting they would appreciate this approach being used by their GP or health worker. Some of the workers had concerns that the training materials could be regarded as childish, whilst acknowledging that they are aimed at both urban and remote communities, however clients found the illustrations to be useful prompts.

Age

Health practitioners often argued that the self-management approach would not work with older Aboriginal clients, believing them to be set in their ways and unwilling to change habits of a lifetime, such as smoking. However, some of the elder clients would have liked more health interventions but did not like to ask for help. They wanted more proactive support from the health workers.

Confidence Using Tools

Overall it appeared that workers' confidence pre training was low but grew with practice of using the FCTGP tools. Many of the workers wanted more education about tobacco before delivering the LWSF intervention to clients or training other staff. Accredited trainers concurred that more in-depth training is required prior to delivering the FCTGP.

Staff Attitude

Health practitioners identified that health is not a priority in some communities where clients have more urgent needs and are often in crisis, and that the FCTGP would not be appropriate in such situations. Individual workers had their own opinions regarding what approach might work best in their communities. Top-down interventions such as increasing the price of cigarettes were thought to be effective in some communities; others preferred community-level health promotion strategies. It was recognised that the skills to achieve health change are often lacking.

Managers' Attitude

The managers and CEOs of each of the health services involved in the evaluation determined how the FCTGP CCM and LWSF interventions were received and implemented. It was apparent that if the management was passionate about the health of their community and supported the program then workers were more likely to support the training and tools. Several managers wanted all staff to be trained in the FCTGP so that everyone could contribute to self-management support. Managers from both urban and remote communities deemed it important to have a team of health workers who were well connected within their communities.

Plans to implement

It appeared that where a health service had received in-depth implementation support, they had a clearer plan with distinct and measurable goals around staff training, client engagement and health outcomes. Some teams were looking at how they could include the FCTGP tools into their current assessment and care planning in order to include both medical, and social and emotional wellbeing factors. Health services had differing implementation plans and required support in order to integrate the FCTGP training and tools successfully into their practices.

Documentation

Documentation of self-management assessment and care planning with the FCTGP CCM and LWSF tools varied depending on which patient information system each health service was using. A common argument was that electronic versions of the resources would be beneficial, particularly so reviews and updates could be added more easily. Also there was a common opinion that the books would be lost or damaged if left with the client. The practical issues of having to photocopy pages of the resources for clients to take home or to send to other health practitioners was a barrier to implementation despite workers and clients appreciating the resources.

Conclusion

The FCTGP-CCM and LWSF training impacted positively on the health of both clients and workers. The importance of health workers acting as a positive role model to support clients with their health changes was noted. Enablers of the training being successfully embedded into health services include: supportive and enthusiastic management, clear goals for how the training will be incorporated into current practices, the ability to document use of the tools, and trainees practising using the tools to increase confidence. Barriers to implementing the training include: older Aboriginal clients being reluctant to access health services, high staff turnover, health workers who smoke and the inability to document and report use of the tools. Implementation support can overcome many barriers and aid the training to become embedded into health services.

4.5 Interviews with accredited trainers and implementation support workers

Data collection for this component of the evaluation has not yet begun; planned from December 2013 if funds are available. The aim is to incorporate their insights and perspectives into the overall evaluation findings.

4.6 The Flinders AIMhi NT Chronic Conditions Self-Management Program Evaluation

Background

Preventable chronic conditions account for much of the burden of illness for Aboriginal and Torres Strait Islander people. ‘Helping Indigenous Australians Self-Manage their Chronic Disease’ is a major government initiative to address this problem. The NT has committed to implement its Chronic Disease Self-management Framework. A culturally appropriate self-management tool that can be used to work with and assist the NT Aboriginal and Torres Strait Islander people was identified as a priority in the NT self-management framework.

Development of new tools

The FCTGP tools were integrated with the concepts of ‘strengths’ and ‘family’ influenced from literature and national programs including the Menzies Institute AIMhi tools. The new tools assist health practitioners to work with their clients in a structured process to assess self-management behaviours, identify client strengths, worries and goals, and develop individualised self-management care plans.

Training

22 health practitioners working in 8 NT health services were trained to use the Flinders AIMhi tools in two workshops held in Darwin and Alice Springs. Workshops were favourably evaluated. Follow-up support in the workplace was provided. Only 60% completed the FCTGP requirements for a certificate of competence.

Trial

The tools were trialled over the next 2 months. 19 of the trained health practitioners from 7 of the health services and 22 clients took part. Four of the care plans were not completed in that time.

Evaluation

Interviews with participating health practitioners, clients and managers explored the effectiveness of training, fidelity, appropriateness of the tool and the barriers and enablers of integrating a self-management into practice. A total of 37 interviews with 41 people were conducted 3-6 months following training.

Training workshops were favourably evaluated and improved knowledge, skills and confidence, but more follow-up support in the workplace was wanted. Most clients and health practitioners enjoyed the ‘My Health Story’ yarn and some worked through the whole process together; but others found the tools complex and cumbersome. Some health practitioners did not use the tools as intended because they did not fully appreciate how self-management support fits within their scope of practice, especially when the client’s main worry and goal were not directly related to health.

Overall the new ‘My Health Story’ tools were considered appropriate and useful in supporting chronic condition self-management for Aboriginal and Torres Strait Islander clients of NT health services. However it was agreed that some aspects of the tools were overly complex and long. Barriers and enablers of integration of a self-management approach identified were related to organisational leadership and support, coordination and teamwork arrangements, workforce capacity and training, documentation and information technology, and time, and are consistent with previous research.

The way forward

The NT Government is committed to a self-management framework. The tools piloted in this small project provide a structured process that aligns with those government policies. This trial indicated that the new tools and training were effective, useful and appropriate on the whole, although some modifications were suggested. Suggestions about improving ‘My Health Story’ and the training workshops have been incorporated into the revised versions developed concurrently through the national FCTGP. Similarly, many of the suggestions about integrating the tools into everyday practice are now covered by the Program’s implementation support

developments.

The following recommendations are therefore proposed:

- Strengthen and maintain high level management and leadership support for chronic condition self-management across the NT in line with the NT government policy (Department of Health and Families 2009; Department of Health 2012).
- Consider using the revised 'My Health Story' tools and trainings, implementation supports and other resources that were developed concurrently through the national Flinders Closing the Gap Program (Flinders University 2013) and that incorporate some of the suggestions from this pilot study.
- Identify specific roles and responsibilities for the various health practitioners involved in chronic condition prevention and management, and provide them with training in self-management support (which includes discussion and support around social issues that impact on health), on-going follow-up and supervision.
- Integrate self-management approach into routine care by developing agreed protocols for assessment, care planning, referrals and review. Support this by embedding key elements from 'My Health Story' into electronic patient information systems, and ensure that health practitioners view, enter and share information with others involved in the client's care.
- Develop and sustain the capacity of local health practitioners (especially those who are also Aboriginal community members) to undertake self-management assessment, coordinate self-management care planning support and provide ongoing training and support to their colleagues.

4.7 Living Well, Smoke Free workshop evaluations

During 2013 the FCTGP training team provided training workshops for health practitioners to support clients' tobacco management using the LWSF tools. Trainer accreditation workshops including the LWSF tools were also held.

Tobacco management workshops for health practitioners

Anonymous evaluation questionnaires were completed pre and post workshop by 93 participants of 16 tobacco management workshops conducted during June-November 2013.

Before the workshop participants were asked about their challenges in supporting clients to change smoking behaviour. Responses included difficulty engaging the community and clients to tackle smoking, the health practitioners' own smoking status, and lack of specific knowledge and tools.

Participants' self-rated confidence to support clients with their smoking increased significantly from 'somewhat confident' immediately before the workshops to 'confident' afterwards ($P<0.001$, Wilcoxon's matched pairs signed ranks test).

Over 95% participants said they would use the LWSF tools and that their learning needs were entirely met'. 84% responded that the training activity was entirely relevant to their work.

Participants were asked what worked well in training; responses included the relaxed and interactive teaching style, the tools and resources and volunteer clients. Suggestions for improving the learning experience were mostly around more practice using the tools and additional video examples.

At the conclusion of the workshop, 82% of participants agreed or strongly agreed that the LWSF tools could deliver effective tobacco support for clients. Anticipated challenges to using the tools mostly related to the time required for assessment and care-planning, need to practice using the tools, and engaging clients. Suggested enablers of implementation included follow-up support and mentoring, refresher training, additional visual resources, and cooperation from others in the health team.

Accredited Trainer/Living Well, Smoke Free workshops

Workshop evaluation forms were completed by 13 participants of two workshops of this type conducted in June and October 2013. All the participants agreed or strongly agreed that they had achieved the specific training outcomes, were confident to teach each of the components of the tools to other health practitioners, and to review and give feedback on their care plans.

Anticipated challenges and suggested supports for delivering FCTG-CCM/LWSF training included needing more time to practice, support from management and peers and guidance of other trainers.

CONCLUSION

The achievements in training, implementation and smoking cessation over the last three years have been made possible by the gradual, respectful and collaborative relationships between Flinders based staff and our national network of trainers and implementation officers, many of whom are Aboriginal or Torres Strait Islanders.

Wherever they operate they are supported by clearly documented project materials as well as operational and communication processes. This model of implementation has taken three years to develop and is now at a stage of maturation where we are trusted by organisations to deliver on our commitments. The fact that many individuals have changed careers to deliver the FCTGP is testimony to the power of the program to change lives. It has been the personal experience of this transformational change which has led health workers and practitioners to use the tools with their own clients then becoming trainers and implementation officers, knowing that this role is challenging, stressful and at times frustrating. They obviously believe that the risk is worth it to play a small but potentially life changing part in closing the gap in Aboriginal and Torres Strait Islander health.

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FINANCIAL STATEMENT

Please see financial statement in appendix 2.

APPENDIX ONE

FLINDERS CLOSING THE GAP PROGRAM™ - RESOURCES

All resources listed below have been provided to the Department of Health electronically.

1.0 Flinders Closing the Gap Program™ of Chronic Condition Management Training Resources

1.1 My Health Story

1.2 National workbook

1.3 FCTGP Trainers manual

1.4 Ethel DVD

1.5 Online course descriptions

Living Well, Smoke Free (LWSF)

2.0 Training resources

2.1 LWSF Care Planning Tool Kit

2.2 LWSF Individual interventions Manual

2.3 LWSF Individual Interventions Workbook

2.4 LWSF Training PowerPoint

2.5 Draft Community interventions workbook

2.6 Anangu Pitjantjatjaraku Tobacco Tool Kit

2.7 Problem and Goals Supplementary guide

3.0 DVD Resources

3.1 Davey series-How to use the LWSF tool kit

3.2 Motivational Interviewing principles

4.0 Health Promotion Resources

4.1 Client Tally card

4.2 Stories about your health and smoking flipchart

4.3 Tobacco and health brochure – Men

4.4 Tobacco and health brochure – Women

4.5 Tobacco and health poster – Men

4.6 Tobacco and health poster – Women

4.7 Worker Tobacco Yarn prompt card

5.0 Online material

5.1 Module 8 sample screen sequence

5.2 Module 9 sample screen sequence

6.0 Module accreditation

6.1 Accreditation plan

6.2 LWSF Module One competency mapping

6.3 LWSF Accreditation letter

7.0 Implementation

7.1 NAHS Implementation Plan

7.2 FCTGP Procedures Manual

7.3 Example staff training policy

7.4 MOU Fact sheet

7.5 Sample monthly report

7.6 Implementation kit for organisations

8.0 Client testimonials

8.1 Peter Rose 2010

8.2 Peter Rose revisited 2013

8.3 Terrance Reid

APPENDIX TWO

Financial Statement

Flinders UNIVERSITY

Grants Finance
Financial Services Division
GPO Box 2100
Adelaide SA 5001
Tel 08 8201 2220
Fax 08 8201 3685

Financial Statement for the period 31 May 2010 to 31 May 2014
Project Title: **Closing the Gap - Flinders Program Implementation**
Project ID: **36513 and 38292**
Chief Investigator : **Professor M Battersby**
Funding Organisation: Department of Health

Income (GST exclusive)			
Research Grant	8,715,097		
Interest Income	203,990		
Total Funds Available		**$**	**8,919,087**
Expenditure			
Salaries			
Trainers	860,080		
Project Management	940,505		
Academic Salaries	721,835		
IT Salaries	275,533		
Admin Salaries	735,827		
Research and Project Evaluation Salaries	182,009		
Consultancies	62,364		
Staff Oncosts	426,107		
Total Salaries		$	4,204,258
Non-salaries			
IT Integration and Website Development	365,646		
Media and Resource Development	497,177		
Workshop Costs	1,384,761		
Stationery and Printing	91,265		
Minor Equipment	51,183		
Unit Running Costs	654,879		
University Infrastructure Levy	1,452,812		
Total Non-Salaries		$	4,497,723
Total Expenditure		**$**	**8,701,982**
Ledger balance as at 31 May 2014		**$**	**217,106**
Commitments			
IT Integration and Website Development			
Nine Lanterns Portal Build - funds committed			62,476
Outstanding Nine Lanterns invoice 5 of 5 on existing contract			12,558
Outstanding Hosting Fees			19,876
Uni WA - funds committed			18,750
Communicare - funds committed			9,988
Media and Resource Development			
Allbiz - funds committed			8,112
Inprint Design - funds committed			27,555
Stationery and Printing			
Contingency for outstanding invoices			3,455
Finance, Admin and Project Evaluation Salaries to finalise project			
Project Evaluation			48,460
Accountant - acquittal preparation and review			2,669
Admin salary - funds committed			3,207
Total Committed Expenditure		**$**	**217,106**
Uncommitted Balance as at 31 May 2014		**$**	**-**

Flinders Closing the Gap Program™ was produced by Flinders University with funding from the Commonwealth Department of Health under the Closing the Gap in Indigenous Health Outcomes Initiative.

Flinders Human Behaviour & Health Research Unit has developed the Flinders Closing the Gap Program™ in conjunction with a nationwide consultative team including Aboriginal and Torres Strait Islander people, health practitioners and health organisations.

The success of any project depends largely on the support and assistance of many others. We would sincerely like to thank those people and groups who have been instrumental to the successful development of this program.

For more information:
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W: www.flindersclosingthegapprogram.com

CLOSING THE GAP tackling Indigenous chronic disease

Flinders UNIVERSITY