National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan

Jurisdiction: South Australia

1. TABLE OF CONTENTS

1. TABLE OF CONTENTS **2**

2. BACKGROUND AND CONTEXT **3**

3. NATIONAL REFORMS **6**

4. IMPLEMENTATION PLAN

Key to Implementation Plan **10**

Implementation Plan **12**

4. RISK MANAGEMENT **42**

5. REVIEW AND EVALUATION **42**

APPENDIX A **43**
Service Delivery Principles

APPENDIX B **46**
National principles for investments in remote locations

APPENDIX C **47**
Iga Warta Principles

REFERENCES **48**

2. BACKGROUND AND CONTEXT

On 20 December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage[1]. Through the *National Agreement on Closing the Gap in Indigenous Health Outcomes*[2], the South Australian Government and other Australian governments agreed to closing the gap in life expectancies within a generation and halving the gap in mortality rates for Indigenous children under five within a decade.

SA Health is committed to improving the cultural, spiritual, physical, emotional, social and economic wellbeing of Aboriginal South Australians through addressing the health inequities faced by Aboriginal people and improving access to culturally respectful health services provided by a culturally competent health workforce[3].

To overcome Indigenous health disadvantage, a holistic life stage approach is required that builds sustainable social change and embeds system reform. The implementation plans set out in this document describe a package of evidence based health reforms encompassing this principal. These reforms will:

- Tackling smoking through social marketing and expansion of quit smoking support through communities, focusing especially on pregnant women.
- Provide improved primary health care and chronic disease management and services such as well health checks and early intervention in chronic disease, and management of the interactive impacts of different health programs.
- Improve the patient journey, and in particular that of country residents, by a range of safety, quality and continuum of care measures, Statewide patient liaison, technical measures to reduce the need for travel and provision of supported accommodation options in country and metropolitan areas.
- Direct service provision, education, community development and opportunities for participation for youth, including young offenders, to improve mental, sexual and reproductive health in all areas of South Australia.
- Provide integrated, evidenced based early childhood education and health services and build local capacity through the delivery of targeted and effective local environmental health programs in various metropolitan, country and remote areas.

The *National Indigenous Reform Agreement*[4] provides further impetus through COAG, in addressing Aboriginal health inequities through a holistic and coordinated approach of the Australian and South Australian Governments, and through cooperation with community controlled services.

The benchmarks set out in that document will provide the evidence for change in addressing the gaps in life expectancy, infant mortality, employment and high school attainment levels.

It is recognised that these program initiatives do not stand alone and require full integration with other COAG reform initiatives as defined by the current suite of National Partnerships and Agreements under development.

Context

The *National Agreement on Closing the Gap in Indigenous Health Outcomes*[5] complements *South Australia's Strategic Plan (SASP)*[6], to which reference of specific targets has been made throughout the Implementation Plan. *SASP seeks to* increase Aboriginal healthy life expectancy, coordinate efforts across the whole of Government to address the social determinants of Aboriginal health, and attain other Aboriginal specific targets related to areas such as developing leadership, improving overall health and wellbeing and increased participation in the public sector workforce.

SA Health's contributions to these efforts are outlined in a suite of policy and strategic documents which focus on promoting population health and preventing illness. These include *South Australia's Health Care Plan 2007 – 2016*[7], the *SA Health Aboriginal Cultural Respect Framework,* the *SA Aboriginal Health Policy*[8], the *SA Health Statement of Reconciliation*[9], the *Aboriginal Health Impact Statement*[10] and the *Aboriginal Workforce Development and Reform Strategy*[11].

The *Aboriginal Health Policy*[12] includes a set of principles which are applicable to all projects in this package, and include:

- Promoting good health to achieve equity through health service delivery.
- Localised decision making through which health authorities share decision making with local Aboriginal communities to define health needs and priorities and work together to address these.
- Accountability for effective service provision and improved health outcomes, including effective resource application through long-term funding and meaningful planning and sustainable development in genuine partnership with communities.
- Accessible and equitable health services, responsive to population needs which are culturally appropriate and which include consideration of the complex needs of Aboriginal people living in rural and remote settings.
- Working together to combine the efforts of government, non-government and private organisations to address and influence the broader determinants of health.

These principles are congruent with the service delivery principles for programs and services for Indigenous Australians as set out in the National Indigenous Reform Agreement **(Appendix A)** and the National Principles for Investments in Remote Locations **(Appendix B).**

SA Health monitors Aboriginal health outcomes, reporting annually to State and Commonwealth Governments on progress towards achievement of targets in these key policy and strategic documents.

The *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*[13] priorities of; 'tackling smoking', 'healthy transition to adulthood', 'primary health care services that can deliver', 'making Indigenous health everybody's business', and 'fixing the gaps and improving the patient journey' become apparent through their application in the new initiatives set out in this document.

The implementation plans that detail these initiatives have been developed in accordance with the four *SA Health Strategic Directions* identified in the *SA Health Strategic Plan*[14]. These are to:

- improve Aboriginal health
- strengthen primary health care
- enhance hospital care
- reform mental health care.

The critical enablers to these *Strategic Directions* include health workforce and partnerships.

Programs for Implementation

Tackling Smoking
A comprehensive program of tobacco control initiatives aims to reduce smoking prevalence amongst Aboriginal people and will help to provide a sustained, consistent and realistic approach to lowering smoking rates among Aboriginal people through targeted social marketing campaigns and quit smoking support.

Primary health care service that can deliver
Preventing chronic disease and disease progression can reduce the burden of chronic disease on the health system, particularly limited and costly acute services. Interventions designed to change at risk behaviour have been found to be most effective for high risk groups.

Access to quality primary health care will be provided through approaches such as the implementation of the Aboriginal Well Health Program and culturally appropriate application of the Vulnerable Infants Service Strategy.

Care planning is essential for effective disease management and self management support, and specific strategies are needed to support new and existing programs and the audit of clinical practice in line with quality improvement processes.

Risk reduction programs that target individuals at high risk of diabetes and other chronic diseases have had significant positive outcomes in Australia and internationally. Early detection and disease management can improve health outcomes and quality of life; reduce adverse complications and unplanned hospital admissions.

Fixing the gaps and improving the patient journey
Improved clinical outcomes will be achieved through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management. Initiatives include the development of a country metropolitan liaison service, enhancement of step down services and piloting of a metropolitan, rural and remote area specialist service support program.

Healthy transition to Adulthood
The transition to adulthood is a key point in the life course as it is the period when young people form risk taking or protective behaviours that will have a significant long term impact on their health and the health of the families. New initiatives will address the social, emotional, physical and spiritual well-being of Aboriginal children, adolescents, their families and communities through the establishment of Child and Adolescent Mental Health Services on the remote Aboriginal communities in South Australia's North West. These initiatives also include the provision of a mental health and wellbeing program for young offenders and the expansion of existing programs that provide relationship education, health literacy education and the promotion of health-protective behaviours.

Making Indigenous health everyone's business
Aboriginal children and families will gain increased access to health promotion services and health promoting environments, particularly in remote locations, through building the health literacy and living skills of parents and families and by improving access to early detection and intervention support services. In addition, environmental Health Workers will address a number of Aboriginal health issues by improving environmental conditions and also contributing to community capacity building, real employment and personal development opportunities for members of these communities.

3. NATIONAL REFORMS

The five reforms identified below reflect system-level changes to support combined efforts to close the gap in Indigenous health outcomes. A number of these reforms are being pursued through mechanisms outside of the National Partnership Agreement (NPA), while others rely upon joint and/or complementary activity by the Commonwealth and state and territory governments through the NPA. Further detail on specific activities to address national reforms is embedded within the implementation plan.

3.1. National minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations

Ensure all organisations providing primary health care services to Aboriginal and Torres Strait Islander people meet national minimum service standards

- The SA Government will work within a national framework to ensure that minimum service standards are achieved for primary healthcare providers through:
    - Providing a consultative forum to implement national initiatives – involving South Australian representation from the Commonwealth, State government and the Aboriginal community controlled health sector.
    - Supporting accreditation.
    - Supporting an organisational and clinical audit program (*Primary health care services that can make a difference 4.2.4*).

3.2. Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets

Improve the quality of data, and therefore the evidence base; to assess progress against targets and inform the development of policy and programs for Aboriginal and Torres Strait Islander people.

- The SA Government will focus on improvements to Indigenous identification and data collection through three key approaches:
    - improving existing systems data capture
    - data collection training for staff
    - improved survey data capture.

- Work will be undertaken to enable connectivity between the following computer systems:
    - the SA Health Client Management Engine
    - Communicare
    - Medical Director.

  These enhancements will support the improved capture of data about Indigenous people, including improved compliance with the national standard for establishing Indigenous Status.

- Additional training will be provided to improve Indigenous identification and data collection for KPIs in hospitals, mainstream primary care services and Aboriginal Medical Services. The training will focus on front line staff, data managers, client liaison officers, nurses, as well as other service providers and cover both hospital as well as community health settings.

- As part of the improvements to data collection SA Health will increase the sample size of Indigenous people in population surveys undertaken using the Health Omnibus Survey.
- These initiatives will build an established Out-of-Hospital Services Minimum Data Set. The data set, which includes the National Data Dictionary definition of Indigenous status, represents the agreed core elements that are collected for describing out-of-hospital care services in South Australia. Outcomes of this project contribute to:
    - Development of a standard approach for classifying services provided within the out-of-hospital services sector.
    - The determination of substitution of services between the acute and primary sectors.
    - Development of mechanisms to provide a data linkage service across out-of-hospital services agency data to support statistical analyses.
    - Provide access to a consolidated and centrally-managed data set for out-of-hospitals service data.

3.3 Infrastructures to support transitions and linked records between primary, in-patient and specialist services

Ensure continuity of health care and timely access to information for providers of care to Aboriginal and Torres Strait Islander people, by improving the transition of care arrangements between different levels of health service delivery.

- The South Australian Government is contributing towards shared electronic health records compliant with the national standards and guidelines of the National eHealth Transition Authority (NeHTA), including data collection and linked admission and discharge information between primary, in-patient and specialist services.
- The South Australian Government has assisted three Aboriginal health services to develop, submit and gain approval of their business case to replace their ageing Patient Information Recall Systems (PIRS) and is currently initiating a project to implement the Communicare PIRS in line with the major Community Controlled Aboriginal Health Services around Australia.

  SA Health has engaged the Vendor to modify their product to enable multiple Services to share a single database, but maintain security and reporting requirements of each of the individual Services. This will:
    - Enable the future sharing of patient information (i.e. a single Health record) between participating services.
    - Support standardisation of the delivery of clear standard processes, protocols and clinical processes across Aboriginal Health organisations and assist in accreditation of the Services and Aboriginal Health Workers.
    - Have National significance for all services using the Communicare product (in excess of 80 Services) enabling centralisation and standardisation.
    - Increase the sustainability of the services through increased revenue via higher capturing of Medicare MBS Items.
    - Assist and greatly enhance the levels of Patient Care Planning in relation to chronic disease.
    - Provide timely recalls to follow up on chronic and significant disease management practices

Envisaged further locally planned enhancements of the product, will improve the ability of Communicare within the SA Health environment to exchange information with hospital systems as an interim measure whilst SA Health works towards achieving a standard Out of Hospital system that links all data systems to a single patient record system across the State.

- Concurrently, SA Health is assisting and supporting the Aboriginal Health Council (SA)'s 5 year Strategic Plan to develop an Aboriginal Health ICT network capable of sharing Communicare and other systems of the 11 dedicated Aboriginal Health Services to enable transfer and sharing of electronic records between Services in the community controlled sector.
- Implementation of this plan will be the State enabler for sharing information in this sector.

3.4 Workforce: increase the number of Aboriginal people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms.

The provision of culturally appropriate and responsive services for Aboriginal people and communities is pivotal in closing the gap in health outcomes. As the main service provider for health and well being in this State, SA Health is committed to changing the way it does business, including building a workforce dedicated to better servicing Aboriginal people and communities across South Australia.

- Following the 2007 COAG announcement that began the Close the Gap campaign, SA Health developed and launched its Aboriginal Employment Policy.
- The SA Health Aboriginal Employment Policy requires that:
    - Each Region and Division within SA Health develops an Aboriginal Employment Strategy in collaboration with the Aboriginal Health Division (AHD) Workforce Support & Development Unit to address recruitment and retention issues specific to their portfolio responsibilities. The development of strategies will be closely linked and guided by Regional Health Service Agreement processes and the SA Health Aboriginal Workforce Reform Strategy 2009 - 2013 and will be central to the development of Aboriginal Health Improvement Plans.
    - The development and implementation of Aboriginal Employment Strategies will be an integral element of Executive Performance Agreements.
    - An Aboriginal Health Impact Statement is prepared for any workforce development, reform and planning in regions and divisions.
- In addition, the SA Health Aboriginal Workforce Reform Strategy 2009 - 2013 has enabled the development of workforce initiatives and programs to align with COAG agendas, the needs of the South Australian Aboriginal community and SA Health. The Strategy addresses systemic change, leadership, engagement and attraction, recruitment and retention. A number of initiatives and actions have already been developed with a few more in the early stages of development. These include the Aboriginal Maternal Infant Care workforce, Oral health workforce and pre-employment programs for Aboriginal youth from year 9 in high school.

3.5 Cultural Security: Improved cultural security in health service delivery in all organisations providing care to Aboriginal and Torres Strait Islander people.

Improved cultural security in health service delivery in all organisations providing care to Aboriginal and Torres Strait Islander people.

SA Health remains committed to providing culturally acceptable health services as a key factor to improving Aboriginal health outcomes.

- The SA Health Aboriginal Cultural Respect Framework (ACRF) is set around four key result areas:
    - Policy and program development – a suite of landmark policy documents and frameworks developed and implemented.
    - Services reform – Aboriginal community engagement, partnerships with community controlled health services and staff training about cultural awareness.
    - Workforce development and reform – employment and training strategies for Aboriginal people, scholarships and traineeship programs.
    - Monitoring and evaluation – requirement for assessment and reporting of cultural awareness activities.
- All programs within this NP will conform to the principles outlined in the ACRF.

4. IMPLEMENTATION PLAN

Key for the structure of the Implementation Plan and the performance benchmarks referred to from the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

Initiative	Key	Performance benchmarks
Tackling Smoking • Social marketing campaigns • Quit Smoking initiatives • Enforcement activities	S1	Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments.
	S2	Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals.
	S3	Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities.
	S4	Number of service delivery staff trained to deliver the interventions.
Initiative implemented in partnership with the Commonwealth Government		
Primary Care Health Services that can deliver • Vulnerable Infants Services Strategy (VISS) • Aboriginal Well Health Programme • Aboriginal Family Wellness Group • Audits of CDM Practice • Downstream Impacts on Health Services	P1	Number of Indigenous and non indigenous specific health services meeting national minimum standards.
	P2	Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check
	P3	Number of new allied health professionals recruited.
	P4	Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities.
	P5	Improved patient referral and recall for more effective health care, and in particular, chronic disease management.
	P6	Improved/new IT systems operational to support interface between systems used in primary health care sector and other parts of the health system.
	P7	Evidence of implementation of cultural competency frameworks across the applicable health workforce.
Initiative implemented in partnership with the Commonwealth Government		
Fixing the gaps and improving the patient journey • Country metropolitan liaison officers • Aboriginal Step down • Pilot metropolitan, rural and remote area specialist service support program	F1	Number of new case managers/ Indigenous liaison officers recruited and operational.
	F2	Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions.
	F3	Key results of strategies to improve cultural security of services and practice within public hospitals.
	F4	Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place.
	F5	Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease.
	F6	Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion).

	F7	Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets.

Healthy transition to adulthood • CAMHS in APY Lands • Journey Home • Aboriginal focus schools and investing in Aboriginal Youth	H1	Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period.

Making Indigenous health everyone's business • Children's Services • Indigenous Environmental Health Worker Program		Nil Benchmarks identified in NPA

Data collection and evaluation		Nil Benchmarks identified in NPA

4.1 TACKLING SMOKING

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.1.1 Social Marketing Campaigns Prevent chronic disease through the delivery of effective anti-smoking campaigns which increase awareness of the harms associated with tobacco use and encourage quit attempts. **Contribute to SASP targets** **T2.1, T2.5, T6.3, T2.6**	▪ Coordinate the adaptation and delivery of nationally developed social marketing activities throughout the Indigenous community across South Australia. ▪ Links to 4.2.7; Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing.	▪ Communication materials, including social marketing campaigns targeting Aboriginal people are recommended as likely to be effective in reducing smoking prevalence.[15]	▪ Drug and Alcohol Services South Australia (DASSA) ▪ Communications Division, South Australian Department of Health. ▪ Aboriginal Health Council of South Australia.	**2009-10** ▪ Employ one Campaign Coordinator based at DASSA ▪ Write campaign implementation plan. ▪ Recruit key partners. ▪ Develop supportive creative material. ▪ Annual evaluation commences. **2010-11** ▪ Implement campaign plan. ▪ Review plan following evaluation. ▪ Annual evaluation. **2011-12** ▪ Implement campaign plan. ▪ Review plan following evaluation. ▪ Annual evaluation. **2012-13** ▪ Implement campaign plan. ▪ Review plan following evaluation. ▪ Annual evaluation.	**Benchmark: S1** *Measurement*: ▪ Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments.	**2009-10 - $220 000** **2010-11 - $610 500** **2011-12 - $577 000** **2012-13 - $542 000** **Total - $1 949 500**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.1.2 Expansion of Quit Smoking Initiatives ▪ Reduce tobacco smoking among Aboriginal people in South Australia, including a focus on Aboriginal pregnant women. ▪ Reduce the burden of disease for Aboriginal communities, and achieve a reduction in the number of low birth weight babies.	▪ Expand quit smoking support through Aboriginal communities, focusing especially on pregnant women. ▪ Appoint health service staff within the non-government sector. ▪ Recruit a team of tobacco control coordinators for training workers (targeting Aboriginal health workers in particular). ▪ Links to Commonwealth initiative 4.1.5*; reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities*. ▪ Links to Commonwealth initiative 4.2.8; *support Indigenous Australians to better manage or self-manage their chronic disease.*	▪ Training of the Aboriginal health workforce and the delivery of culturally relevant tobacco cessation programs targeting Aboriginal people, are key recommendations to reduce Indigenous smoking prevalence.[16,17] Programs that are developed and delivered in collaboration with Aboriginal communities and services are the most effective way to support smoking cessation at the local level.	▪ Aboriginal Health Council of South Australia.	**2009-10** ▪ Employ one smoke-free pregnancy Registered Nurse & four Quit smoking coordinators. ▪ Engage the ATSI community. ▪ Commence training workers in tobacco control brief intervention. ▪ Coordinate development of culturally appropriate resources. **2010-11** ▪ Ongoing training of 50 workers in tobacco control brief intervention. ▪ Distribute culturally appropriate resources. **2011-12** ▪ Ongoing training of an additional 100 workers in tobacco control brief intervention. ▪ Distribute culturally appropriate resources. **2012-13** ▪ Ongoing training an additional 100 workers in tobacco control brief intervention. ▪ Distribute culturally appropriate resources.	**Benchmark: S2** *Measurement*: ▪ Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals. **Benchmark: S4** *Measurement*: ▪ Number of service delivery staff trained to deliver the interventions.	**2009-10 - $590 000** **2010-11 - $611 700** **2011-12 - $633 557** **2012-13 - $656 500** **Total - $2 491 757**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.1.3 Enforcement Activities ▪ Increase legislative and regulatory compliance of the sale, supply and use of tobacco products in regional and remote Aboriginal communities in South Australia. ▪ Assist in the achievement of better coordinated regulatory approaches to reducing the impact of smoking.	▪ Development and implementation of a communication strategy that is inclusive of Aboriginal community stores and of rural and remote areas. ▪ Establish a tobacco surveillance program to monitor compliance with the *Tobacco Products Regulation Act 1997* to affect consistent enforcement of the regulations across South Australia. ▪ Establish a process for regular surveillance of the sale, supply and use of tobacco. ▪ Enforcement activities to increase legislative and regulatory compliance through a harmonised regulatory framework.	▪ Strong regulatory control is a key aspect of successful tobacco control strategies,[18] however regulation of tobacco product points of sale does not occur in rural and remote Aboriginal communities in South Australia. Anecdotal evidence suggests that poorly controlled sale and distribution of tobacco products has a negative impact on the health of Aboriginal people in remote South Australia.	Applied Environmental Health, South Australian Department of Health. Aboriginal Health Council of South Australia. Drug and Alcohol Services South Australia.	**2009-10** ▪ Not applicable **2010-11** ▪ Engage and Consult with key partners. ▪ Develop enforcement implementation plan. ▪ Recruit staff. ▪ Conduct training. **2011-12** ▪ Undertaking enforcement activities. ▪ Disseminate outcomes of regulatory activity & promote public health messages around tobacco control. **2012-13** ▪ Undertaking enforcement activities. ▪ Disseminate outcomes of regulatory activity & promote public health messages around tobacco control.	**Benchmark: S3** *Measurement*: ▪ Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities. **Benchmark: S4** *Measurement* ▪ Number of service delivery staff trained to deliver the interventions.	**2009-10 -** Not applicable **2010-11 - $235 800** **2011-12 - $243 430** **2012-13 - $251 335** **Total – $730 565**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.1.4 Evaluation of Smoking Initiatives ▪ Establish an effective monitoring system to evaluate outcomes.	▪ Baseline measures will be established in order to monitor the effectiveness of social marketing initiatives, smoking cessation programs and compliance monitoring.	▪ Comprehensive evaluation that is culturally appropriate and represents multiple perspectives is a key component of the National Indigenous Reform Agreement's service delivery principles for Indigenous Australians. ▪ Evaluation should also link to South Australia's Strategic Plan Targets 2.5 Aboriginal healthy life expectancy – Lower the morbidity and mortality rates of Aboriginal South Australians. Strategy 3: Improving Aboriginal birthing outcomes and Child Health, Strategy 4: Improve the responsiveness of the health system to the needs of Aboriginal people, and Strategy 5: Reduce the health impact of Tobacco.	Drug and Alcohol Services South Australia will commission evaluation work through an agency with experience in evaluating Aboriginal Health interventions.	**2009-10** ▪ Engage services of an evaluation agency with experience in culturally appropriate evaluations. ▪ Establish the reporting targets & timeframes for S1, S2, S3 and S4. ▪ Determine baseline measures of key benchmarks for S1, S2, S3 and S4. **2010-11** ▪ First report of annual progress against National Partnership Agreement on closing the gap in Indigenous Health Outcomes. ▪ Review actions and recommendations of evaluation report. **2011-12** ▪ Second report of annual progress against National Partnership Agreement on closing the gap in Indigenous Health Outcomes. ▪ Review actions and recommendations of evaluation report. **2012-13** ▪ Third report of annual progress against National Partnership Agreement on closing the gap in Indigenous Health Outcomes. ▪ Review actions and recommendations of evaluation report.	**Benchmark: S1** *Measurement*: ▪ Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments. **Benchmark: S2** *Measurement*: ▪ Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals. **Benchmark: S3** *Measurement*: ▪ Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait	**2009-10 - $90 000** **2010-11 - $162 000** **2011-12 - $166 013** **2012-13 - $170 165** **Total - $588 178**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
					Islander people and communities. **Benchmark: S4** *Measurement* ▪ Number of service delivery staff trained to deliver the interventions.	
4.1.5 Joint Initiatives with the Commonwealth to address Smoking ▪ Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities. (Joint Initiative) ▪ This initiative will be implemented in partnership with the Commonwealth government measure (A1) and the State/Territory government initiatives 4.1.1, 4.1.2, 4.1.3 and 4.2.3	SA Health to work with the Commonwealth and NGOs to: ▪ Establish a national network of tobacco action coordinators. ▪ Adapt national materials for local campaign activities/grants. ▪ Consult and engage with local communities. ▪ Sponsor community events and establish quit smoking role models and ambassadors. ▪ Provide workforce training and development for tobacco cessation and broader health areas that impact on smoking and provide ongoing follow up support. ▪ Enhance Quitline to provide culturally sensitive services. ▪ Train and recruit health workers and community educators as tobacco action	▪ If the smoking rate among Indigenous Australians was reduced to the rate of the non-Indigenous population, the overall Indigenous burden of disease would fall by around 6.5%, and save around 420 Indigenous lives per year. This equates to an additional four extra years of life expectancy. ▪ Evidence from New Zealand in reducing Maori smoking rates and national formative research commissioned under the Indigenous Tobacco Control Initiative will inform this priority area.	SA Health in partnership with Population Health and Business Group (DoHA), Indigenous and non-Indigenous health and community organisations.	▪ Refer to Commonwealth implementation plan for detail.	**Benchmark: S1** *Measurement*: ▪ Number of Regional Campaign coordinators funded. *Measurement*: ▪ Number of Indigenous participants in smoking cessation and support activities. **Benchmark: S4** *Measurement*: ▪ Number of health workers and community educators trained in smoking cessation and broader health areas that impact on smoking.	**This measure will be funded by the Commonwealth.**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
	and health promotion officers ▪ Implement targeted tobacco cessation programs.					
4.1.6 Joint Initiatives with the Commonwealth to address chronic disease Assist Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices. This initiative will be implemented in partnership with the Commonwealth government measure (A2) and the State/Territory government initiatives 4.1.2., 4.2.2, 4.2.3 This element forms a continuum with *Helping Indigenous Australians improve their self management of established chronic disease (B4)* to effectively reduce	SA Health to work with the Commonwealth and NGOs to: ▪ Recruit and train up to 100 healthy lifestyle workers in consumer-focussed risk reduction programs. ▪ Fund the delivery of programs/activities to 25 000 individuals and families to encourage self-management of chronic disease risk factors. ▪ Program evaluation.	▪ Chronic disease can be prevented or delayed through intervention, effective management and lifestyle change.[21,22] ▪ Access to affordable risk reduction and self-management programs is a barrier to good health outcomes for Indigenous Australians, and significant ongoing personalised support is needed to encourage self-management of lifestyle risk factors and prevent chronic disease.[23]	Primary and Ambulatory Care Division (DoHA) in partnership with state and territory governments, Indigenous and non-Indigenous health and community organisations.	Refer to Commonwealth implementation plan for detail.	*Measurement*: ▪ Number of risk reduction programs/ activities conducted. **Benchmark: S4** *Measurement*: Number of healthy lifestyle workers funded and trained.	**This measure will be funded by the Commonwealth.**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
the impact of chronic disease.						
4.1.7 Joint Initiatives with the Commonwealth to deliver social marketing campaigns Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing. This initiative will be implemented in partnership with the Commonwealth government measure (A3) and the State/Territory government initiative 4.1.1, 4.2.1, 4.2.2, 4.2.3 and 4.2.4.	SA Health to work with the Commonwealth and NGOs to: ▪ Consult with communities and develop local-level information and education resources. ▪ Implement local strategies, including media placement.	▪ The World Health Organization's Ottawa charter recommends a five pronged approach for health promotion, including public awareness campaigns.[24] ▪ Health promotion is an important factor in reducing risk factors at the population level.[25]	Business Group (DoHA) in partnership with state and territory governments, Indigenous and non-Indigenous health and community organisations.	Refer to Commonwealth implementation plan for detail.	**Benchmark: S1** *Measurement*: ▪ Number and type of targeted activities undertaken. ▪ Number and type of culturally appropriate information resources developed. Description of dissemination of information undertaken.	**This measure will be funded by the Commonwealth.**
Total South Australian investment for Priority Area 4.1 TACKLING SMOKING						**$5 760 000**

Internal Governance and Management	South Australia will coordinate and manage the implementation of its initiatives in this Priority Area through an overarching internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination. This group will be supported by agencies with responsibility for coordinating each initiative in this Priority Area, including; Drug and Alcohol Services South Australia, South Australian Department of Health (Aboriginal Health Division, Applied Environmental Health, Communications Divisions), and Aboriginal Health Council of South Australia.
Linkages and Coordination	An Implementation Advisory Committee will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State

	government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives. At a jurisdictional level, coordination across government with other Indigenous reforms will be provided through the Indigenous Reform Inter-Departmental Committee (IDC). A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments (i.e. Department of Education and Children's Services [DECS], Department for Families and Communities [DFC]) as well as with the Australian Government. These mechanisms will be supported by regular communications between agencies with responsibility for coordinating each initiative in this Priority Area.
Community/ Stakeholder Involvement	The Implementation Advisory Committee will provide advice on key policy issues and community engagement strategies to SA Health and to the Minister for Health. Indigenous Australians will be formally involved in the development, implementation and monitoring of services that can deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and the Commonwealth Government. A tobacco control reference group has been formed with Aboriginal and non-Aboriginal representatives to ensure community and stakeholder involvement, and to assist with key advice in this Priority Area. The group is coordinated by the Aboriginal Health Council of South Australia and includes government and non-government representation.

4.2 PRIMARY CARE HEALTH SERVICES THAT CAN DELIVER

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.2.1 Vulnerable Infants Support Service Provide additional service responses to highly vulnerable infants and parents experiencing active adversity through a Vulnerable Infants Support Service (VISS) **Contribute to SASP targets** **T6.1, T6.3**	▪ A new culturally appropriate and comprehensive service response will be provided to highly vulnerable infants and parents of Aboriginal and Torres Strait Islander descent experiencing active adversity. ▪ Two staff members will work in a pilot site in the northern suburbs to be expanded in an additional site in years three and four. ▪ The program will be linked to other Children Youth and Women's Health Service programs, for example Universal Home Visiting, Family Home Visiting and the new Aboriginal Maternal Infant Care (AMIC) program that will soon commence in the metropolitan area. ▪ Links to Commonwealth initiatives 4.2.7; *Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing.*	▪ Significant national and international research shows that early childhood interventions are much more effective in providing positive outcomes than remedies later in life.[19] ▪ Protective factors for children's healthy development include secure attachment and a stable positive caring relationship between parent and child, low family stress and strong cultural pride. Supporting a family before a child is born and supporting parental attachment during infancy are key strategies and of critical importance to healthy early childhood development.[20]	Children, Youth and Women's Health Service, SA Health	**2009-10** ▪ Program implementation ▪ Two staff members recruited **2010-11** ▪ Service delivery **2011-12** ▪ Two additional staff members recruited **2012-13** ▪ Service delivery	**Benchmark: P3** *Measurement*: ▪ Number of health professionals recruited **Benchmark: P4** ▪ Number of infants supported ▪ Potentially preventable hospital admissions for indigenous children 0-4yrs (SASP KPI 3.1)	**2009-10 $200 000** **2010-11 $200 000** **2011-12 $400 000** **2012-13 $400 000** **Total $1.2 million**
4.2.2 Aboriginal Well Health Checks Program Assist Indigenous Australians to have health assessments to	▪ A new team of health professionals comprising a registered nurse and an Aboriginal health worker will facilitate the provision of 'Well Health' checks by gender preference General	▪ Evidence suggests that the continued poor health and premature death of Aboriginal people can be significantly improved by increasing access to culturally responsive, holistic comprehensive primary health care services.	Partnership approach between: ▪ Department of Health, Statewide Service	**2009-10** ▪ Program implementation ▪ Two teams recruited ▪ Service delivery	**Benchmark: P1** *Measurement*: ▪ Implementation of national best practice standards and accreditation	**2009-10 $500 000** **2010-11 $1.5 million** **2011-12 $2.2 million** **2012-13 $2.6 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
detect their chronic condition early, with timely referral to appropriate diagnostic and support services through an Aboriginal Well Health Checks Program. **Contribute to SASP targets** **T2.5**	Practitioners to Aboriginal people in rural, remote and metropolitan locations. Visiting specialists will also be accessed. Funding for General Practitioners and visiting specialists will be through MBS item receipts. ▪ Aboriginal clinical co-ordinators placed within regional health services will facilitate follow up services including timely referral to specialist services and the provision of health information. ▪ Teams will provide services within Aboriginal health services and selected mainstream services across rural, remote and metropolitan locations. ▪ Links to Commonwealth initiatives 4.2.6, 4.2.7 and 4.2.8	▪ This program addresses this need, and is based on the Aboriginal Women's Well Health Program in Coober Pedy that commenced in 2004 and has expanded to include a Men's Well Health Program. Evaluation of this program identified a high incidence of previously undiagnosed illness and disease in the community, and that many participants had not previously had a full health assessment.	Strategy Division ▪ Regional health services ▪ Aboriginal health services	**2010-11** ▪ Service delivery ▪ Two additional teams recruited **2011-12** ▪ Service delivery ▪ Three additional teams recruited **2012-13** ▪ Service delivery ▪ Two additional teams recruited	processes by Aboriginal Health Services **Benchmark: P2** *Measurement*: ▪ Take up rates of MBS health checks **Benchmark: P3** *Measurement*: ▪ Number of health professionals recruited **Benchmark: P5** *Measurement*: ▪ Number of timely referrals and access to specialist services	**Total $6.8 million**
4.2.3 Aboriginal Family Wellness Groups Improve the engagement, trust and participation between Indigenous Australians and Health service providers to promote early intervention, prevention and early detection of	▪ This new initiative will be based in regional and Aboriginal health services and will engage members of the Aboriginal community using a group format. ▪ The aim of the Family Wellness Group is to increase the communities empowerment, engagement and ability to navigate through the health system, raise topics and develop problem solving skills to gain an understanding about general	▪ Increasing the communities' health literacy skills will develop skills and abilities in reading and writing which is required for understanding health information, becoming an active participant in healthcare choices and to critically analyse information about health and healthcare. These will have impacts on : ▪ Early detection of risk and early intervention strategies which can reduce the prevalence of chronic disease, delay disease progression, and improve overall health and wellbeing.	Partnership approach between: ▪ Department of Health, Statewide Service Strategy Division ▪ Regional health services ▪ Aboriginal health	**2009-10** ▪ Recruitment of Project Officer ▪ Project planning ▪ Community consultation ▪ Selection of pilot site **2010-11** ▪ Three additional staff recruited ▪ Collection of pilot site data and	**Benchmark: P1** *Measurement*: ▪ Implementation of national best practice standards and accreditation processes by Aboriginal Health Services **Benchmark: P3** *Measurement*: ▪ Number of health	**2009-10 $250 000** **2010-11 $500 000** **2011-12 $1.0 million** **2012-13 $1.5 million** **Total $3.25 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
chronic disease through the Aboriginal Family Wellness Group **Contribute to SASP targets** **T2.5**	health and wellbeing, how to seek, find, and interpret information, know what is good advice and know how to translate this into action using a participatory process underpinned by improving health literacy. ▪ Links to Commonwealth initiatives 4.2.6, 4.2.7 and 4.2.8	▪ Preventing chronic disease and disease progression can reduce the burden of chronic disease on the health system, particularly limited and costly acute services. ▪ Enhance interventions designed to manage and reduce risk taking behaviour. ▪ Improve health outcomes and quality of life; reduce adverse complications and unplanned hospital admissions	services.	evaluation of pilot site intervention. ▪ Evaluation of training program **2011-12** ▪ Three additional staff recruited **2012-13** ▪ Five additional staff recruited	professionals recruited **Benchmark: P5** *Measurement*: ▪ Number of referrals made ▪ Number of recalls	
4.2.4 Audits of CDM practice Improve the quality of disease management in Aboriginal primary health care services through audits of services against best practice standards **Contribute to SASP targets** **T2.5**	▪ Place new Chronic Disease Audit Officers within regional health services. ▪ Officers integrate audit tools such as the existing Audit and Best Practice in Chronic Disease & Evaluation (ABCD & E) Tool, and the Clinical Audit Tool. ▪ Officers to use tools to audit Clinical practice to see how many clients are receiving best practice screening and management care. ▪ Results used to identify the need, and plan services to meet clinical management best practice standards. ▪ Officers will provide training and support in the use of these tools. ▪ Links to Commonwealth initiatives 4.2.6, 4.2.7 and 4.2.8	▪ This program will help services to improve patient care by learning how to identify best practice screening and management processes. ▪ The use of audit tools has benefits for clients through improved care treatment and monitoring; for the health centre through better management of caseloads while delivering health care for their clients; and for health centre staff through higher levels of satisfaction, a greater sense of control and teamwork.	Partnership approach between: ▪ Department of Health, Statewide Service Strategy Division ▪ Regional health services ▪ Aboriginal health services	**2009-10** ▪ Program implementation ▪ Two staff members recruited **2010-11** ▪ Two additional staff members recruited **2011-12** ▪ Four additional staff members recruited **2012-13** ▪ Four additional staff members recruited	**Benchmark: P1** *Measurement*: ▪ Implementation of national best practice standards and accreditation processes by Aboriginal health services ▪ Number of clinical audits undertaken **Benchmark: P3** ▪ Number of clinical audit officers employed **Benchmark: P5** *Measurement*: ▪ Number of referrals made ▪ Number of recalls **Benchmark: P6** *Measurement*:	**2009-10 $250 000** **2010-11 $500 000** **2011-12 $1.0 million** **2012-13 $1.5 million** **Total $3.25 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
					Number of clinical audits undertaken	
4.2.5 Downstream Impacts Ensure that downstream impacts of other primary health care initiatives in this Implementation Plan (e.g. increased screening, improved primary care, patient journey initiatives) are managed. **Contribute to SASP targets** **T2.5**	▪ A rigorous evaluation framework will be developed for the suite of program initiatives detailed in this implementation plan, in particular the primary health care initiatives. ▪ The evaluation framework will examine the impacts (immediate and longer term) of initiatives on health service demand. ▪ Using the evaluation results, additional services or workforce requirements will be designed to address resultant additional activity/demand in hospitals and other health services arising from these program initiatives.	▪ Good quality evaluation data is critical in monitoring the progress on closing the gap in Indigenous health outcomes. ▪ The evaluation framework proposed will, in part, focus on assessing the impacts of programs on service demand. ▪ This evidence will then inform investments to address increased activity.	SA Health, Operations Division	**2009-10** ▪ Development of evaluation framework for Primary Health Care Initiatives **2010-11** ▪ Conduct of evaluation ▪ Assessment of evaluation results and design of additional services to address demand **2011-12** ▪ Ongoing implementation **2012-13** ▪ Ongoing implementation	*Measurement*: ▪ Evaluation Framework developed ▪ Program evaluations conducted ▪ Immediate and longer term impacts identified **Benchmark: P4** *Measurement*: ▪ Service requirements designed to address additional activity	**2009-10 $502 000** **2010-11 $1.03 million** **2011-12 $2.03 million** **2012-13 $2.9380 million** **Total $6.5 million**
4.2.6 Joint Initiatives with the Commonwealth to address chronic disease self-management Support Indigenous Australians to better manage or self-manage their chronic disease. *This initiative will be implemented in partnership with the Commonwealth*	SA Health to work with the Commonwealth and NGOs to: ▪ Recruit and train over 400 healthy lifestyle workers in consumer-focussed CDSM programs. ▪ Deliver programs/activities to 50 000 individuals and families to encourage self-management of chronic disease. ▪ Program evaluation.	▪ This measure builds upon work evaluated under the Sharing Health Care Initiative to improve Indigenous chronic disease self-management (CDSM).	Primary and Ambulatory Care Division (DoHA) in partnership with State and Territory governments, Indigenous and non-Indigenous health and community organisations.	Refer to Commonwealth implementation plan for detail.	**Benchmark: P3** *Measurement*: ▪ Number of healthy lifestyle workers recruited to training. **Benchmark: P5** *Measurement*: ▪ Number of CDSM programs/ activities conducted.	**This measure will be funded by the Commonwealth.**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
government measure (B4) and the State/Territory government initiative 4.1.2, 4.2.2, 4.2.3, 4.2.4. and 4.2.5 This element forms a continuum with *Assisting Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk*					Number of participants in the CDSM programs.	
Total South Australian investment for Priority Area 4.2 PRIMARY CARE HEALTH SERVICES THAT CAN DELIVER						**$21 000 000**

Internal Governance and Management	South Australia will coordinate and manage the implementation of its initiatives in this Priority Area through an overarching internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination. This group will be supported by local implementation teams for each of the initiatives, comprising relevant stakeholders from regional health services, the Aboriginal community controlled sector and community membership where appropriate. • Aboriginal Well Health Checks Program - a steering group, including relevant stakeholders from Aboriginal communities engaged through the Aboriginal Health Council, will oversee the development, implementation, and monitoring of this program. • Vulnerable Infant Support Service (VISS) - a Reference Group comprised of relevant health and social care stakeholders and the Aboriginal community controlled health sector and community membership where appropriate will be established to oversee the implementation of the initiative. • Quality Audits to improve disease management in Aboriginal primary health services - a steering group comprising representatives from the Department of Health, regional health services and Aboriginal community controlled health services will be created to oversee the implementation of the program. • Aboriginal Family Wellness Groups - this program will be developed in partnership with SA Health, regional health services, pilot site communities, GPSA / relevant division of general practice, Aboriginal controlled organisations and other appropriate support agencies which promote a health in all policies approach.
Linkages and Coordination	An Implementation Advisory Committee will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.

	At a jurisdictional level, coordination across government with other Indigenous reforms will be provided through the Indigenous Reform Inter-Departmental Committee (IDC). A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments (i.e. DECS, DFC) as well as with the Australian Government. These mechanisms will be supported by: • Aboriginal Well Health Checks Program - linkages and coordination will occur with Aboriginal communities, who will be engaged through the Aboriginal Health Council during the development, implementation, and monitoring of this program. • Vulnerable Infant Support Service (VISS) - linkages and coordination will occur between this initiative and other CYWHS programs, for example Universal Home Visiting, Family Home Visiting and the new Aboriginal Maternal Infant Care (AMIC) program that will soon commence in the metropolitan region. Linkages and coordination will also occur with other agencies, for example, Families SA and the Aboriginal community controlled sector. • Quality Audits to improve disease management in Aboriginal primary health services - linkages and coordination will occur through the steering group comprising representatives from the Department of Health, regional health services and Aboriginal community controlled health services. • Aboriginal Family Wellness Groups - linkages and coordination in relation to this initiative will occur through the partnership approach with SA Health, regional health services, pilot site communities, GPSA / relevant division of general practice, Aboriginal controlled organisations and other appropriate support agencies which promote a health in all policies approach.
Community/ **Stakeholder Involvement**	The expanded SAAHP will provide advice on key policy issues and community engagement strategies to SA Health and to the Minister for Health. Indigenous Australians will be formally involved in the development, implementation and monitoring of services that can deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and the Commonwealth Government. • Aboriginal Well Health Checks Program - community and stakeholder involvement will occur through the steering group, including membership from Aboriginal communities who will be engaged through the Aboriginal Health Council during the development, implementation, and monitoring of this program. • Vulnerable Infant Support Service (VISS) - community and stakeholder involvement will occur through the Reference Group comprised of relevant health and social care stakeholders and the Aboriginal community controlled health sector and community membership where appropriate. • Quality improvements to improve disease management in Aboriginal primary health services - community and stakeholder involvement will occur through the steering group comprising representatives from the Department of Health, regional health services and Aboriginal community controlled health services. • Aboriginal Family Wellness Groups - community and stakeholder involvement in this initiative will be supported through the partnership approach with SA Health, regional health services, pilot site communities, GPSA / relevant division of general practice, Aboriginal controlled organisations and other appropriate support agencies which promote a health in all policies approach.

4.3 FIXING THE GAPS AND IMPROVING THE PATIENT JOURNEY

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.3.1 Country Metropolitan Liaison Officers Enhance the quality, safety and continuum of care for individual Aboriginal patients referred to metropolitan and country general hospitals. **Contribute to SASP targets** **T 2.5**	▪ Provide resources to increase the number of liaison officers and the linkages between liaison officers. ▪ One liaison position identified for initial six month project role.	▪ Benefits of discharge liaison nurses well documented in several international studies. ▪ Current local evidence indicates that where there are Aboriginal liaison roles, there are improved Aboriginal patient journeys and a reduction in numbers not attending services. ▪ Improved access to acute care and sub acute care services for individuals from Aboriginal and Torres Strait Islander backgrounds. ▪ Improved coordination of care throughout the individual patient journey, including follow up care and supported transitions in place – linking country and metropolitan health services.[26]	▪ Country Health SA will lead the project. ▪ Regional Health Services will be responsible for operational management of liaison positions within their organisation.	**2009-10** ▪ July 2009 – Recruitment of six month project officer to coordinate process strategy ▪ December 2009 – Liaison positions in place within health services ▪ December 2009 – Commence patient pathway development and implementation **2010-11** ▪ July 2010 – Fully implement patient pathways **2011-12** ▪ Monitor and support liaison officers **2012-13** ▪ Monitor and support liaison officers	**Benchmark: F1** *Measurement*: 12 new hospital liaison officers in place prior to June 2010 **Benchmark: F3** *Measurement:* Increased access to culturally sensitive and appropriate information to support patient journey **Benchmark: F5/6** *Measurement*: Reduced length of stay (LOS) for Aboriginal patients in acute facilities **Benchmark:**	**2009-10 $744 000** **2010-11 $1.68 million** **2011-12 $1.716 million** **2012-13 $1.752 million** **Total $5.892 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress ?	What is the cost?
					F6 *Measurement*: Increased number of culturally appropriate transition care procedures **Benchmark: F4** *Measurement:* Reduction in number of non attendees for Aboriginal patients undergoing acute procedures	
4.3.2 Aboriginal Step Down Services ▪ Enhance accommodation options ▪ Improve access to appropriate health services ▪ Support transition of care between parts of the health system for people from	▪ Expansion of Aboriginal Step Down Units in Port Augusta and Ceduna to be staffed and open 24 hours a day, seven days a week. ▪ Linkages will be created between the two rural Step Down units and Adelaide Aboriginal Step Down Service. ▪ Patient pathways to be developed to address social and geographical isolation factors. ▪ Access to transport and	▪ Provision of culturally specific, supportive, affordable accommodation options for Aboriginal people has been demonstrated to result in improved utilisation and access to acute health care services. ▪ Where appropriate, Aboriginal patients able to stay in Step Down Unit rather than in hospital to receive health services.	▪ Local health units for both Ceduna and Port Augusta - under leadership of Country Health SA	**2009-10** ▪ September 2009 – implementation of the Step Down Services and employment of staff completed ▪ December 2009 – Linkages and communication pathways created ▪ March 2010 – Patient pathways developed **2010-11** ▪ July 2010 – Patient pathways fully	**Benchmark: F5** *Measurement:* Reduced LOS for Aboriginal patients in acute facilities **Benchmark: F6** *Measurement:* Increased number of	**2009-10 $437 000** **2010-11 $446 000** **2011-12 $457 000** **2012-13 $466 000** **Total $1.806 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
Aboriginal and Torres Strait Islander backgrounds living in remote communities in north and north-west South Australia **Contribute to SASP targets** **T2.5**	coordination of transition points to be developed for Aboriginal patients.			implemented **2011-12** ▪ Ongoing implementation **2012-13** ▪ Ongoing implementation	culturally appropriate transition care procedures **Benchmark: F4** *Measurement:* Reduction in number of non-attendees for Aboriginal patients undergoing acute procedures **Benchmark: F7** *Measurement:* Occupancy rates for Step Down Services monitored for trends and improvements	
4.3.4 Pilot metropolitan, rural and remote area specialist service support program **Contribute to SASP targets**	▪ Implement liaison services for Aboriginal people accessing a range of clinical specialties (for example, renal, endocrine, neonate, ophthalmology and oncology). ▪ Expand midwifery and	▪ Evidence based research[27] suggests a number of issues where service delivery does not effectively meet client needs. These needs result from the complex health and social experiences of clients, community members and	▪ Southern Adelaide Health Service	**2009-10** ▪ Program Plan ▪ Recruitment of three and a half staff ▪ Service Provision **2010-11** ▪ Recruitment of eight additional staff	**Benchmark: F1** *Measurement*: Four new hospital liaison officers in	**2009-10 $310 000** **2010-11 $1.041 million** **2011-12 $1.051 million** **2012-13 $1.069 million** **Total $3.471 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress ?	What is the cost?
T 2.1, 2.5, T6.1, T6.3	maternal infant care programs and services for Aboriginal women and babies including neonatal services access to people from the APY Lands. ▪ Expand Aboriginal Family Clinics to improve pre-admission checks, clinical and psychological preparation on day of surgery.	families that support their journey into and out of specialist care. ▪ Improving the Journey for Remote Area Aboriginal Patients (2009) indicates that relatively small and inexpensive modifications to systems and practices can lead to significant improvements in health outcomes for Aboriginal patients. ▪ This pilot project will further develop the learning from the cardiology pilot project to streamline and improve processes for Aboriginal people accessing a range of specialty areas.		▪ Service Provision **2011-12** ▪ Service Provision and Monitoring **2012-13** ▪ Service Provision and Monitoring	place by June 2011 **Benchmark: F3** *Measurement:* Increased access to culturally sensitive and appropriate information to support patient journey **Benchmark: F4** *Measurement:* Reduction in number of non-attendees for Aboriginal patients undergoing acute procedures Increased number of care plans in place **Benchmark: F5/6** *Measurement*:	

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress ?	What is the cost?
					Reduced LOS for Aboriginal patients in acute facilities	
Total South Australian investment for Priority Area 4.3 FIXING THE GAPS AND IMPROVING THE PATIENT JOURNEY						**$11 169 000**

Internal Governance and Management	South Australia will coordinate and manage the implementation of its initiatives in this Priority Area through an overarching internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination. This group will be supported by. • Country Metropolitan Liaison Officers will be supported by the Country Patient Liaison Network, Patient Journey Strategy, with specific links to the Aboriginal Health Directorate and the Northern Operations Directorate. Aboriginal liaison officers will form part of a state-wide Aboriginal patient liaison network, which will be aligned with the already implemented country patient liaison network. • Aboriginal Step Down will be supported by the Country Health SA Executive, with specific links to the Aboriginal Health Directorate, and the Northern Operations Directorate. • Pilot metropolitan, rural and remote area specialist service support program will be supported by the Southern Adelaide Health Service Executive, with specific links to the Aboriginal Health Directorate.
Linkages and Coordination	An Implementation Advisory Committee will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives. At a jurisdictional level, coordination across government with other Indigenous reforms will be provided through the Indigenous Reform Inter-Departmental Committee (IDC). A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments (i.e. DECS, DFC) as well as with the Australian Government. These mechanisms will be supported by: • **Country Metropolitan Liaison Officers**, linking in closely with the Country Patient Journey Strategy, the Aboriginal Step Down Strategy, and Aboriginal Community Controlled Health Services, to ensure seamless transition of care for Aboriginal patients. Liaison officers from within health services will provide referral into, coordination, and liaison for Aboriginal clients accessing Step Down services. A Step Down advisory group will be established to ensure linkages between rural and metropolitan Step Down services and the Aboriginal Liaison Officer strategy. The model that has been developed in the Southern Adelaide Health Service for rural and remote Aboriginal cardiac clients provides strong evidence of successfully supporting improved access to culturally appropriate and sensitive services for Aboriginal Australians. The Country Patient Liaison Network will provide the coordination between the groups, in particular, the Aboriginal

	Patient Liaison Network. Linkages will occur from the commencement of each of the strategies. It will be important to link with the proposed Commonwealth initiative of Resource Officers to create linkages between public health services, Aboriginal Community Controlled services and other relevant health services. Mutual support will be an important part of this partnership. • **Aboriginal Step Down**, linking in closely with the Country Metropolitan Liaison Officers Strategy, and Aboriginal Controlled Health Services, to ensure a seamless transition of care for Aboriginal patients. Liaison officers will provide referral into and liaison for, Aboriginal clients accessing Step Down services, in partnership with relevant health services. There will also be participation as members of the Patient Liaison Network, and coordination between Step Down services through the use of complimentary forms, and consistent processes. Established links and partnerships with rural and metropolitan liaison nurses / officers will also be utilised. An identified project officer within the liaison strategy will lead the development of patient pathways, including the Step Down services, with the view that research and data indicate high Did Not Attend rates and poor transition between points of care for people from Aboriginal backgrounds. Linkages will occur from the commencement of the Step Down services. • **Pilot metropolitan, rural and remote area specialist service support program,** linking in closely with the Country Metropolitan Liaison Officers Strategy, Aboriginal Controlled Health Services and Southern Adelaide Health Service (SAHS) to ensure a seamless transition of care for Aboriginal patients accessing specialist care services. Key stakeholders in the pilot region will include Flinders Medical Centre, Noarlunga Hospital, Southern Primary Health Care sites; Noarlunga Health Village including Southern Women's Community Health Service, Clovelly Park (Inner Southern), Woodcroft, Seaford, Marion Youth Centre and Drug & Alcohol Services South Australia and the States first GP Plus Health Care Centre at Aldinga.
Community/ Stakeholder Involvement	The Implementation Advisory Committee will provide advice on key policy issues and community engagement strategies to SA Health and to the Minister for Health. People from Aboriginal backgrounds will be formally involved in the development, implementation and monitoring of services that can deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and the Commonwealth Government. • Country Metropolitan Liaison Officers - Aboriginal community members and key representative groups are involved in the planning, establishment, and ongoing decision making processes in regards to the Aboriginal Liaison Officers, in particular the Country Aboriginal Forum, which includes membership from across mainstream Aboriginal community controlled health services. There is strong evidence to support good project outcomes with transparent community and stakeholder involvement. The responsibility for this area will lie with CHSA Aboriginal Health Division. This is ongoing through existing forums. • Aboriginal Step Down - there is a need to ensure that Aboriginal community members and key representative groups are involved in the planning, establishment, and ongoing decision making processes in regards to the delivery of the Step Down services. The Aboriginal Health Forum will be consulted in regards to an implementation plan and appropriate protocol development. The Aboriginal Health Directorate, in conjunction with the Northern Operations Directorate, will lead the consultation and development phase. • Pilot metropolitan, rural and remote area specialist service support program **-** An Aboriginal advisory group working in collaboration with the project management team will inform the services planning that reflect community and tertiary care need.

4.4 HEALTHY TRANSITION TO ADULTHOOD

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.4.1 CAMHS in APY Lands Ensuring that there is a clinically appropriate Mental Health Service provided to children, adolescents and their families that sits within a sound clinical and corporate governance framework. Improve community capacity Improve community resilience Address mental health issues of children and young people in APY Lands communities Reduce the impact of trauma and abuse on Aboriginal children and young people. **Contribute to SASP targets** **T1.26,2.5, 2.7, 2.8, 6.1**	• Clinical assessments. • Mental Health promotion. • Skill development through education and training. • Creating community networks. • Ensure that the APY Lands workers are provided with the appropriate support, supervision, training and development to undertake their role.	▪ Disadvantage on the APY Lands is well documented, in particular the focus is to build community capacity, develop early intervention strategies, decrease the burden of disease and improve community resilience. ▪ The Mulligan review has well documented the needs of children and young people on the APY Lands.[28,29]	Child and Adolescent Mental Health Services (CAMHS), Children, Youth and Women's Health Service	**2009-10** ▪ July – December– Program planned ▪ Housing/ office infrastructure planned ▪ July 2009 one Full Time Equivalent (FTE) Admin recruited ▪ September 2009 one FTE Coordinator recruited ▪ December 2009 two FTE Clinicians recruited ▪ March 2010 Anangu workers recruited or negotiations with relevant agencies for contract for services ▪ February 2010 Clinical service begins **2010-11** ▪ Ongoing Clinical Service provided **2011-12** ▪ Ongoing Clinical Service provided **2012-13** ▪ Ongoing Clinical Service provided ▪ Number of staff recruited. ▪ Number of contacts with Aboriginal children and young people.	**Benchmark: S1** *Measurement*: FTE **2009-10;** Clinical / Anangu staff = four Admin = one **2010-11;** Clinical / Anangu staff = six Admin = one **2011-12;** Clinical / Anangu staff = six Admin = one **Benchmark: S2** *Measurement*: ▪ Number of Aboriginal children and young people receiving a timely mental health service **Benchmark: S3** *Measurement*: ▪ Number of consultation and liaison services provided to other agencies **Benchmark: S4**	**2009-10 $400 000** **2010-11 $800 000** **2011-12 $800 000** **2012-13 $800 000** **Total $2.8 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
					Measurement: ▪ Number of training and development sessions provided to staff other agencies **Note** As this is the development of a new service it is unclear the numbers of young people who will be provided with a service. Baseline data will be collected in the first year and a method to monitor will be developed for subsequent years.	
4.4.2 The Journey Home Increase the mental health and wellbeing of Aboriginal young offenders and their families Strengthen connections with community and culture as a means of developing protective factors Operate from an early intervention focus	Establish service to provide comprehensive support to young people and their families from initial assessment within secure care facilities. Family work will focus on understanding issues of grief/loss, attachment to family and culture and anger management. Families and the young person will be supported and connected to the Journey Programs in the community. Participation in camps will be an integral part of the program as a means of developing greater links for young people with their culture and with the land. Participation is subject to pre-	Aboriginal young people are over represented in the juvenile justice system and are incarcerated at much higher rates than non- Aboriginal young people.[30,31]	Child and Adolescent Mental Health Services (CAMHS), Children, Youth and Women's Health Service	**2009-10** ▪ Voluntary elements provided in Phase 1 consolidated into permanent elements ▪ Recruit one FTE Project officer and develop detailed proposal options program ▪ Recruit initial workforce ▪ Service provision begins **2010-11** ▪ Recruitment additional workforce ▪ Program provided to young people **2011-12** ▪ Program provided to young people	**Benchmark: S1** *Measurement*: FTE Clinical / Anangu staff = four Admin = one **Benchmark: S2** *Measurement*: ▪ Number of Aboriginal young offenders **Benchmark: S3** *Measurement*: ▪ 50% young people attending program not sentenced to detention	**2009-10 $300 000** **2010-11 $691 000** **2011-12 $700 000** **2012-13 $700 000** **Total $2.391 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
Contribute to SASP targets **T1.26,2.5, 2.7, 2.8, 6.1**	release eligibility and as part of post release reintegration. The involvement of Aboriginal community elders is a vital part of connecting these young people and their families with their culture. Training in the Journey Program will be conducted each year for the agency and identified partner agencies. Aboriginal and non Aboriginal staff will be targeted to attend the training. Country sites will be prioritised for the training to increase the capacity for ongoing work to occur in regional and remote areas.			**2012-13** ▪ Program provided to young people	**Benchmark: S4** *Measurement*: ▪ Agreements endorsed with Youth Justice re sentencing options & pre release ▪ Range agencies engaged in providing services **Note:** negotiations are currently occurring with Aboriginal Controlled Organisations regarding the development of this service. Details of numbers of young people to be serviced will not be available until service model is developed. Baseline data will be collected in the first year and a method to monitor will be developed for subsequent years	

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.4.3 Aboriginal focus schools and investing in Aboriginal youth Significantly improve the sexual and reproductive health, wellbeing and safety of young Aboriginal people in targeted rural, remote and metropolitan South Australian communities through school (Aboriginal Focus Schools) and out-of-school (Investing in Aboriginal Youth) strategies; raise levels of sexual health literacy of parents and carers; develop the capacity of the Aboriginal and the non-Aboriginal workforce in health, education and community services in sexual health, community development, youth participation and peer education to improve health literacy and improve personal	• An integrated model based on the SHine Focus schools program and Investing in Aboriginal Youth Program and using a targeted and community development approach to reach the whole State through the life of the project. • Project Manager, administrative support officer and 2 Coordinators recruited, oriented, networked. • State-wide Project Reference committee established. • Project plan finalised. • Communication Strategy developed. • Research evaluation plan developed and literature review with university research partner. • Review of current education resources in youth participation and peer education, sexual health promotion developed by Investing in Aboriginal Youth and Focus schools programs reviewed for cultural and age appropriateness with Aboriginal health literacy expert. • Finalisation of community training program.	Sexual health is determined by social, economic and environmental factors including poverty, racism, geographic isolation, lack of access to information, education and other resources, and opportunities to learn and maintain health and wellbeing. Lack of information and education at an early age have been linked to unhealthy and unsafe relationships and a range of negative health, education and social outcomes including pregnancy at an early age, sexual violence, child abuse, psychological distress and the transmission of STIs/HIV. Aboriginal South Australians have the poorest sexual and reproductive health outcomes including early teen pregnancy and low birth weight infants.[32] Relationships which are healthy, safe and equitable are fundamental to many issues including: reproductive health; mental health; child protection; prevention of domestic violence, sexual violence, homophobia and homophobic violence; and building community safety and capacity. One-third of Aboriginal children leave school before 15 years of age, which means they do not receive comprehensive relationships and sexual health education and, consequently, are at risk of a reduced capacity to	SA Health, Aboriginal Health Division SHine SA	**2009-10** Aboriginal stakeholders are engaged in Project. Reference Committee established and functioning. Project Plans completed Aboriginal Focus Schools and Investing in Aboriginal Youth communities identified and Aboriginal schools signed on all 10 sentinel communities (Metropolitan, APY Lands, West Coast/Eyre Peninsula, Southern Fleurieu, lower North/Yorke Peninsula, Riverland, Murray Mallee, upper and lower south-east, Whyalla/Port Pirie/Port Augusta, mid-north/Flinders Ranges.) Research and evaluation plan completed. Resources reviewed and redeveloped to ensure cultural and age appropriateness. Final program and schedule of training developed for 2010-11. **2010-11** All sentinel communities have completed training at all levels (Focus School and Investing in Aboriginal Youth). Aboriginal Focus Schools are implementing curriculum in years five to 10, sentinel communities have commenced youth participation and peer education programs and have planned local health promotion implementation strategy by end this year.	**Benchmark: H1** *Measurement:* ▪ Number of additional health professionals recruited and operational in each 6 month period *Measurement*: ▪ Sentinel communities consulted and signed on. ▪ Program implementation plan completed. ▪ Program research and evaluation plan completed. ▪ Curriculum and resource development plan with Aboriginal health literacy expertise input ▪ Number of participants in training programs by type and by sentinel community.	**2009-10 $400 000** **2010-11 $800 000** **2011-12 $800 000** **2012-13 $800 000** **Total $2.8 milion**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
health choices. **Contribute to SASP targets** **T2.5, T6.1, T6.3**	• Rest of project team six FTE recruited. Training of Aboriginal health, youth and education workers, and parents in sexual health, health promotion, youth participation and peer education. Youth participation, peer education and health promotion programs supported in communities.	make informed 'healthy choices' and have extremely poor levels of health literacy.[33]		**2011-12** All sentinel communities continue the repeat implementation of activities in year two (2010-11). **2012-13** All sentinel communities continue the repeat implementation of activities in year two (2011-12).		
Total SA investment for Priority Area 4.4 HEALTHY TRANSITION TO ADULTHOOD						**$7,991,000**

Internal Governance and Management	South Australia will coordinate and manage the implementation of its initiatives in this Priority Area through an overarching internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination. This group will be supported by the Indigenous Early Childhood and Young People Working Group. **CAMHS Service to the APY Lands** governance structures will sit within CAMHS with reference to country Health SA and Community Controlled organisation i.e. Nganampa Health Service. **The Journey Program** Develop a multi stakeholder Advisory Group to oversight the development of the program **The Focus Schools Program** Closing the Gap Reference Committee for Aboriginal Focus Schools and Investing in Aboriginal Youth Projects. The Committee will have representation from Health, DECS including the Aboriginal Education Unit, AHCSA. An internal operational group consisting of all project staff will report to the Reference Committee on planning, implementation and evaluation outcomes and process.
Linkages and Coordination	An Implementation Advisory Committee will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives. At a jurisdictional level, coordination across government with other Indigenous reforms will be provided through the Indigenous Reform Inter-Departmental Committee (IDC). A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments (i.e. DECS, DFC) as well as with the Australian Government. These mechanisms will be supported by ▪ **CAMHS Service to the APY Lands** by collaborations with Aboriginal community controlled services, Families SA, DECS, NPY Women's Council ▪ **The Journey Program** will include collaborations with Aboriginal Sobriety Group, Metropolitan Aboriginal Youth Family Service, Families SA, Youth Court, Life Without Barriers

	▪ **The Focus Schools Program** SHine SA will continue to be involved in the Early Childhood and Young People Working Group to ensure that there is an understanding of the overall implementation of the various Close the Gap initiatives, to prevent duplication, avoid overwhelming small communities with projects and to get better value for the funds invested.
Community/ Stakeholder Involvement	The Implementation Advisory Committee will provide advice on key policy issues and community engagement strategies to SA Health and to the Minister for Health. Indigenous Australians will be formally involved in the development, implementation and monitoring of services that can deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and the Commonwealth Government. ▪ **CAMHS Service to the APY Lands** by collaborations with Aboriginal community controlled services, Families SA, DECS, NPY Women's Council ▪ **The Journey Program** will include collaborations with Aboriginal Sobriety Group, Metropolitan Aboriginal Youth Family Service, Families SA, Youth Court, Life Without Barriers ▪ **The Focus Schools Program** The first year of the SHine SA project will involve a thorough community consultation on the proposal in all of the 10 proposed sentinel sites. This will include consultation on the project plan, evaluation, resources, curriculum, health promotion initiatives, community education programs and the workforce development of Aboriginal and non-Aboriginal workers. A communications strategy will be developed to inform progress at a state and local level.

4.5 MAKING INDIGENOUS HEALTH EVERYONE'S BUSINESS

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.5.1 Children's Services Increase access for Indigenous children and families to health promotion and intensive intervention services and environments through children's services. **Contribute SASP to targets T2.5, T2.1,T2.2, T2.4,T2.7, T6.3, T6.1**	▪ Adapt the existing Health and Wellbeing Framework to explicitly include the Aboriginal Health Cultural Respect Framework. ▪ Develop a phased implementation plan based on the location of Aboriginal Populations and access the children's services. ▪ Systematic implementation will initially prioritise Children's Centres.[34] This will be collaboration between education , health and families and communities and seeks to potentially expand to include agencies such as non-government organisations and the Aboriginal community controlled sector. ▪ Ensure intensive intervention for those families with more complex problems as part of the Strengthening Families Action Team initiative. ▪ Train staff in Health Promotion and Culturally appropriate practice. ▪ Support ATSI children and families to access health and related services.	The early years of life are critical in achieving improved health outcomes, effective learning, safety and a positive trajectory. A combination of universal and targeted strategies avoids stigmatisation. Targeting occurs through intensive intervention support. Promoting health through settings is an evidence based approach.[35] Children's Services are an important setting through which to reach Aboriginal children and families including those most at risk.	SA Health, Statewide Strategic Services Division	**2009-10** ▪ State-wide Coordinator employed by October 2009 ▪ Wellbeing Project Management Group established July 2009 ▪ Governance arrangements for staffing finalised ▪ Health and Wellbeing Framework adapted ▪ Evaluation process and plan finalised December 2009 ▪ Location for each phase of the various components roll out finalised ▪ Up to three positions funded and trained ▪ Phase 1 roll out **2010-11** ▪ Phase 2 roll out ▪ Up to an additional 3 positions funded and trained ▪ Interim evaluation completed **2011-12** ▪ Phase 3 roll out ▪ Up to an additional three positions funded and trained ▪ Interim evaluation completed **2012-13** ▪ Phase 3 roll out	**Benchmark: P7** *Measurement*: ▪ Number of services implementing Health and Wellbeing Framework including cultural competency frameworks ▪ Number of staff trained in culturally appropriate practice ▪ Number of families successfully assisted	**2009-10 $300 000** **2010-11 $600 000** **2011-12 $1.0 million** **2012-13 $1.5 million** **Total $3.4 million**

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
				▪ Up to an additional three positions funded and trained. Final evaluation completed		
4.5.2 Indigenous Environmental Health Worker Program Establish an effective and sustainable Indigenous Environmental Health Worker (IEHW) Program in South Australia **Contribute to SASP targets T1.26 T2.4, T2.5,T2.6,T2.7, T6.1**	By establishing • 12 FTE IEHW positions in aboriginal communities across South Australia • A local training program of formal vocational and on the job supervision/mentoring. • Ongoing management through relevant community organisations (e.g. Nganampa Health).	• IEHW programs have been demonstrated in other states to be successful by building a flexible, culturally competent and mutually supportive local workforce to deliver targeted and effective local environmental health programs. • The activities of IEHW target the living conditions (particularly housing and the community environment identified in the 1987 Uwankara Palyanku Kanyintjaku Report[36]) that give rise to communicable (shigella and streptococcal infections) and long term chronic sequelae (kidney and heart disease)[37]. • To provide a universal service to both rural and remote communities, it is considered that 12 positions would be required to establish culturally sensitive training capacity within South Australia and to locate at least one IEHW position in all major communities in South Australia.[38]	SA Health, Public Health and Clinical Coordination Division Community organisations	**2009-10** ▪ Communities engaged in further development of implementation plan ▪ Acceptance of proposal by community organisations **2010-11** ▪ Recruitment of IEHW ▪ Establishment of local training capacity delivered by VET sector (e.g. Batchelor Institute) **2011-12** ▪ IEHW complete training and begin full time operation **2012-13** ▪ Full time operation ▪ Program evaluation	**Benchmark:** *Measurement*: ▪ Implementation Plan developed ▪ Number of community organisations accepting IEHW positions. ▪ 12 IEHW recruited ▪ Training capacity established in South Australia. ▪ Number of IEHW obtaining qualifications. ▪ Outcomes evaluated through activities reported through *Public and Environmental Health Act 1987* ▪ Independent process evaluation of program	**2009-10 $200 000** **2010-11 $400 000** **2011-12 $800 000** **2012-13 $1.2 million** **Total $2.6 million**

Total South Australian investment for Priority Area 4.5 MAKING INDIGENOUS HEALTH EVERYONE'S BUSINESS	$6 000 000

Internal Governance and Management	South Australia will coordinate and manage the implementation of its initiatives in this Priority Area through an overarching internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination. This group will be supported by the Indigenous Early Childhood and Young People Working Group for the Children's Services initiative
Linkages and Coordination	An Implementation Advisory Committee will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives. At a jurisdictional level, coordination across government with other Indigenous reforms will be provided through the Indigenous Reform Inter-Departmental Committee (IDC). A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments (i.e. DECS, DFC) as well as with the Australian Government. These mechanisms will be supported by • An IEHW or community organisation representative will be a joint member with SA Health on the EnHealth Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH) to link with the broader national network of IEHW. • The Public and Environmental Health Council (the peak environmental health ministerial advisory body in South Australia) will provide an avenue for advocacy on issues and coordination with the broader environmental health activities of State and Local Government. • Children's Centres Operations Group and, the Senior Officers Group (Early Childhood) that will provide high level links across each of the relevant government sectors. Further the program and will receive advice from whole of government projects such as the Strengthening Families Action Team. • Project Management for this initiative will include specific representation through Aboriginal Health Council SA
Community/ Stakeholder Involvement	The expanded SAAHP will provide advice on key policy issues and community engagement strategies to SA Health and to the Minister for Health. Indigenous Australians will be formally involved in the development, implementation and monitoring of services that can deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and the Commonwealth Government.

4.6 DATA COLLECTION AND EVALUATION

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
4.6.1 Monitor and evaluate the Closing the Gap Implementation Plan **Contribute SASP target T2.5**	Funding to improve Indigenous identification and collection of KPI data ▪ This involves several system enhancements (the Client Management Engine, CommuniCare and Medical Director and Ferrett systems , training for Indigenous identification and data collection for KPI's in hospitals, mainstream primary care services and Aboriginal Medical Service, and population surveys using the Health Omnibus Survey which will be based on an increased sample size of Indigenous people ▪ Employment of staff for a time limited period and contracting services for some activities Funding for evaluation of the total Implementation Plan ▪ Program evaluation is critical for building knowledge about evidence based practice. Evaluation frameworks need to be developed up front so that systems are established at commencement for the collection of data.	Good quality data is vital for monitoring progress on closing the gap in Indigenous health	SA Health	**2009-10** ▪ Monitoring and Evaluation Framework Developed **2010-11** ▪ Ongoing Implementation **2011-12** ▪ Ongoing Implementation **2012-13** ▪ Ongoing Implementation	*Measurement*: ▪ Monitoring and Evaluation Framework developed **Benchmark: F7** ▪ Monitor progress in improving Indigenous health data	**2009-10 $515 000** **2010-11 $472 000** **2011-12 $485 000** **2012-13 $498 000** **Total $1.97 million**
Total SA investment for Priority Area 4.6 DATA COLLECTION AND EVALUATION						**$1 970 000**

5. RISK MANAGEMENT

A detailed risk management plan will be developed and incorporated into project plans for each initiative.

The support of the Indigenous health sector, mainstream health services, communities and State and Commonwealth Government Departments will be critical for the effective coordination of the Implementation Plan.

Links to state and national workforce and training initiatives will also be critical to the achievement of the staffing resources indicated in the Implementation Plan.

Coordination mechanisms have been developed both at the jurisdictional level and at the individual project level to facilitate the involvement of key stakeholders and the coordination of critical enablers throughout the implementation of the plan.

6. REVIEW AND EVALUATION

SA Health will put in place a rigorous evaluation framework for the suite of program initiatives detailed in this implementation plan. The evaluation framework will need to examine both the impacts (immediate and longer term) of initiatives on health service demand and provide programmatic evaluation of sub-programs. Decisions on the detail of the evaluation framework will require further refinement following the finalisation of the implementation plans.

The preceding pages identify the performance benchmarks within program evaluation/performance monitoring that will be completed. The overarching evaluation framework will utilise this information and provide a consolidated review of the full Implementation Plan against the broad indicators identified in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

In addition to the evaluation framework it is critical for SA Health to improve data collection to ensure the performance information required can be collected.

To deliver these improvements there will be some increase in staff for time limited periods and some activities/services may be contracted.

Expenditure allocation for this component is identified in section 4.6.

Appendix A

NATIONAL INDIGENOUS REFORM AGREEMENT'S SERVICE DELIVERY PRINCIPLES FOR INDIGENOUS AUSTRALIANS:

Service Delivery Principles for Indigenous Australians are detailed within the Council of Australian Governments (COAG) National Indigenous Reform Agreement. Implementation of this plan will advance these Service Delivery Principles as described below:

Priority

Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs.

Closing the 17 year life expectancy gap is the fundamental aim of the programs and services identified in this Implementation Plan. The initiatives will be tailored to meet local needs through consultation and collaboration with the Indigenous health sector, mainstream health services, communities and State and Commonwealth Government Departments.

The suite of early childhood initiatives will be coordinated with initiatives identified in the Indigenous Early Childhood Development National Partnership Agreement to provide a coordinated response to addressing the targets relating to Aboriginal children and youth. Supporting children and families to be healthy and intervening early in adverse pathways is an effective way to improve health and wellbeing outcomes, and close the gap through better health, development and learning.

Initiatives will increase employment opportunities for Aboriginal people and will specifically address the issues of social inclusion and responding to Indigenous disadvantage

Indigenous engagement

Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.

Engagement with Indigenous men, women, children and communities will be central to the design and delivery of programs and services identified within the Implementation Plan.

An Implementation Advisory Committee will be developed to provide advice on the implementation of priorities within the Implementation Plan, including advice on effective community engagement strategies. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.

Regional and local level planning about the implementation of initiatives will be informed by ongoing engagement with Aboriginal people and Aboriginal health services, including through existing regional Aboriginal Health forums.

Sustainability

Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.

The initiatives detailed in the Implementation Plan represent a significant investment to build the capacity of health services to better meet the needs of Aboriginal South Australians. Services have been designed to allow a phased implementation to build on existing strengths of the current service system while using the available evidence to develop additional services.

The Iga Warta Principles (**Appendix C**) have been used as a guide in the development of these programs and services. The Iga Warta Principles are essential to achieving a range of responses and targets that are sustainable over the short, medium and long-term.

Training and support has been built into the Implementation Plan and will link to other state and national workforce and training initiatives that are critical to the development of a skilled, knowledgeable and competent workforce.

South Australia's initiatives are based on a range of research evidence. The initiatives will also be informed by SA Health funded research in collaboration with Aboriginal Health Services across South Australia.

Access

Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.

The initiatives detailed in the Implementation Plan have been developed with the recognition that there is diversity between urban, regional and remote locations requiring differing service responses. Geographic access to services as well as physical and cultural accessibility has been considered in the development of the individual proposals within the Implementation Plan.

A number of initiatives include the development of service infrastructure in remote locations increasing access to remote communities that is currently hindered by resourcing and the visiting nature of services.

The provision of administrative infrastructure, such as office space, cars, computers and administrative support has been considered within the project proposals and linkages have been made through the Aboriginal Affairs and Reconciliation Division of the Department of the Premier and Cabinet to infrastructure reforms at a jurisdictional level.

Information and communication campaigns will target a range of locations covering urban, regional and remote communities and will use content and images locally relevant to South Australians.

Integration

There should be collaborations between and within Governments at all levels and their agencies to effectively coordinate programs and services.

South Australia's initiatives will operate between all levels of government, through a joint collaboration between government and non-government services, be integrated with Australian Government funded programs, and be responsive to the needs of Aboriginal communities and service providers. A joined-up approach will be undertaken to ensure that reform within South Australia provides a cohesive response to the needs of Aboriginal people. Linkages will be made to other State Government Departments as well as with the Australian Government.

A number of key mechanisms will facilitate this integration at the jurisdictional level:

- SA Health internal coordination committee. This group will be chaired by SA Health and involve appropriate stakeholders who will meet as required to ensure effective internal coordination.
- Implementation Advisory Committee. Membership of this committee will be drawn from the membership of the SA Aboriginal Health Partnership Forum (SAAHP) currently including representation from the Commonwealth government, State government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.
- Indigenous Reform Inter-Departmental Committee (IDC).

These groups will be supported by individual project implementation mechanisms to ensure that services and programs are well integrated, sensitive to local needs and foster positive outcomes.

Accountability

Programs and services should have regular and transparent performance monitoring, review and evaluation.

SA Health will put in place a rigorous evaluation framework that will provide transparent and culturally appropriate performance monitoring for the suite of program initiatives detailed in this implementation plan. The evaluation framework will examine both the impacts (immediate and longer term) of initiatives on health service demand and evaluate sub-programs.

Evaluation will account for process and outcome targets identified in the Implementation Plan, and will employ on both quantitative and qualitative methods. Advice, guidance and input will be sought from agencies with experience in evaluating Aboriginal programs and building capacity in health services and communities to undertake evaluation at the local level.

Progress against the Implementation Plan will be reported annually through to the Australian Health Ministers Conference through the Australian Health Ministers Advisory Council.

Appendix B

NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS

In addition the following principles should also be considered in any investment in remote locations, as detailed in the COAG National Indigenous Reform Agreement.

National principles for investments in remote locations include:

a) remote Indigenous communities and remote communities with significant Indigenous populations are entitled to standards of services and infrastructure broadly comparable with that in non-Indigenous communities of similar size, location and need elsewhere in Australia;

b) investment decisions should aim to: improve participation in education/training and the market economy on a sustainable basis; and reduce dependence on welfare where possible; and promote personal responsibility, engagement and behaviours consistent with positive social norms;

c) priority for enhanced infrastructure support and service provision should be to larger and more economically sustainable communities where secure land tenure exists, allowing for services outreach to smaller surrounding communities, while ensuring:

    i. recognition of Indigenous peoples' cultural connections to homelands (whether on a visiting or permanent basis) but avoiding expectations of major investment in service provision where there are a few economic or educational opportunities; and

    ii. facilitation of voluntary mobility by individuals and families to areas where better education and job opportunities exist, with higher standards of service.

Appendix C

The South Australian Department of Health has developed its service delivery to the Aboriginal community of South Australia based an agreed set of principles called the Iga Warta principles.

Iga Warta principles

1. The project must be sustainable for example, in funding, leadership, coordination and continuously evaluated.
2. It must have a proactive, preventative approach for example, address the need to 'get in early'.
3. It must address the environmental determinants of health for example, food, water, housing and unemployment.
4. It must have an Aboriginal community and family approach, for example, it must address the need to empower Aboriginal Communities and families, and enhance their traditional guiding principles.
5. It must respect Aboriginal time and space - it should be culturally sensitive.
6. It must address the need for coordination and continuity between regions and Adelaide for example, strategies must be coordinated with other activities in other sectors.

The Iga Warta principles are guides for each of the Department's units to design service delivery, using the principles as the basis of conscience decision-making that is inclusive of Aboriginal communities..

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