9 YEARS IN

Measuring progress and achieving outcomes in Aboriginal health across the Grampians Region

MAY 2019

CONFIDENTIAL: NOT FOR DISTRIBUTION

West Division Aboriginal Engagement Unit
Department of Health and Human Services

BAEAG
BUDJA BUDJA Aboriginal Co-operative Ltd.
GOOLUM GOOLUM ABORIGINAL CO-OPERATIVE
PCP Wimmera Primary Care Partnership 'Partners in Health'

Disclaimer

This report has been prepared from data contained within 46 Koolin Balit progress reports submitted to the Department of Health and Human Services (the department) on a six monthly basis, in line with the department's Koolin Balit Performance Management Framework. Grateful acknowledgement goes to the following organisations for their role in implementing projects to address the needs of each of their communities and in monitoring the progress of these projects:

- Ballarat and District Aboriginal Cooperative (BADAC)
- Budja Budja Aboriginal Cooperative (Budja)
- Goolum Goolum Aboriginal Cooperative (Goolum)
- Wimmera Primary Care Partnership (WPCP)

The above organisations have each reviewed the report and endorse its contents.

The report has been written strictly for the purpose of monitoring, evaluating and improving Aboriginal health outcomes, and is not for distribution.

Contents

Acknowledgements

The Grampians Region Aboriginal Health Governance Committee (GRAHGC) wish to acknowledge the traditional custodians of all the lands across the Grampians Region, and pay respect to Elders past, present and emerging.

A special acknowledgement goes out to the following:

- **Karen Heap** – Chief Executive Officer, Ballarat and District Aboriginal Cooperative
  Tim Chatfield - Chief Executive Officer, Budja Budja Aboriginal Cooperative
  Anthony Craig - Chief Executive Officer, Goolum Goolum Aboriginal Cooperative
  Geoff Witmitz – Executive Officer, Wimmera Primary Care Partnership

  …whom have led and supported the work of the region over many years and have endorsed the writing of this report
- All Koolin Balit project officers and other staff who have invested heavily in strong progress reporting practices, assisted in the development and shaping of specific measures and targets, and provided leadership in their own rights to champion Aboriginal health across the region
- All partners of the regional governance committee and sub committees who have consistently supported this work through participation at meetings and championing Aboriginal health within their own organisations and across the sectors they represent
- The many other workers and colleagues too numerous to name who have played their part in improving the health outcomes of Aboriginal community members over the years in this region.

What this report is and isn't

This report provides a summary of the key outcomes and achievements in Aboriginal health across the Grampians Region, and an insight into some of the primary factors leading to these achievements, as well as challenges encountered along the way.

It is essentially the collation of four years' worth of quantitative (in particular) and qualitative data captured during the Koolin Balit policy period from 2014 to 2018, and in some cases covers data which stretches back to the four years prior during the Closing the Health Gap period, 2009 to 2013.

The data has been drawn from the 46 Koolin Balit progress reports that were submitted to the Department of Health and Human Services on a six-monthly basis, in line with the department's Koolin Balit Performance Management Framework. The data has been derived from six core projects and spans 52 specific targets which were created as a means of measuring progress over time.

One of the primary reasons for the writing of this report was to bring together the information captured over time to be able to view progress, changes and trends all in the one document. The GRAHGC were very interested to see 'how the data looked' across the different measures, and felt there was a story to be told not just in the data itself, but in the approach undertaken to collect it in the first place.

Part A of this report provides the necessary background information including the historical context, governance arrangements, reporting process, and key success factors and challenges.

Part B of this report provides the actual results achieved against the specific targets set across the projects, via a series of graphs and brief narrative reports.

The simplicity in the way the data has been presented in Part B serves to provide a quick and easy account of progress 'at a glance'. One of the dangers of presenting data in this way is the risk of downplaying the extensive effort and broader progress that has been made over time, above and beyond what has been defined in the targets.

Displaying nine years' worth of effort into a single line graph, for example, needs to be appreciated for what it is. It won't capture all of the many intangible outcomes that have occurred along the way, such as the valuable interactions and exchanges, and the many meaningful partnerships that have developed.

The same applies to the use of 'traffic light' colours as a technique to convey progress status, which shouldn't be interpreted as a 'pass or fail', but rather along a continuum from 'Achieved' through to 'Yet to be achieved'.

The use of language and terminology in the report has also been chosen for the purposes of simplicity and ease of understanding. For example, the term 'Outcome' has been used in its most basic sense to mean a 'Result', and not in the context of its use in more formal evaluation methodologies such as process, impact and outcome evaluation.

There is also no attempt to lay claim to any 'statistical significance' of the results contained in the report, which might otherwise occur in more formally commissioned reports or academic research papers.

And finally, the report won't provide an extensive investigation into the factors underpinning the success of each project, nor will it provide a detailed account of project activities as such. A separate report for each project would be warranted to convey the full story.

Assumptions and Limitations

The primary focus of this report is on what the quantitative data collected over time has revealed against the 52 specific targets set for the six projects.

It should be noted that it is very difficult to demonstrate a direct causal effect between the many variables within a program, and the outcomes that have been attained. Factors such as programs receiving funding from multiple sources, and the involvement of staff across various teams all enhance program delivery and reflect the necessary holistic approach required to improve Aboriginal health outcomes, yet make the task of attributing what intervention leads to what outcome, difficult.

The measurement of progress also isn't a perfect science. The setting of specific targets, for example, provided some challenges along the way. Some targets were not easily measurable for a range of reasons including lack of data or lack of systems to collect data, as well as not being culturally appropriate or truly 'self-determined' by the Aboriginal community. Numerous targets were discarded, reworded and/or improved along the way to

be more realistic and meaningful, so that a more accurate picture of progress could be captured, which could then better inform any necessary alterations to service delivery to improve program implementation.

In some cases too, the data collected represented quite low numbers of individuals, as well as variable population levels due to transient movement of individuals and families across catchments. From this perspective, some data needs to be treated with caution.

Also, telling the full story of progress through methods such as case studies, digital stories and other narrative forms of reporting are unfortunately outside the scope of this report, but would have added an extra dimension to the picture.

PART A
Setting the Scene

A brief historical overview

The commitment to enhancing Aboriginal health and wellbeing in the Grampians Region started long before the period covered in this report.

In **1997** the **Koorie Services Improvement Strategy** (KSIS) was introduced to improve service delivery and partnerships between the then Department of Human Services (DHS) and the local Aboriginal community, with reference groups established across the region to identify needs and priorities, and localised action plans developed to address these priorities.

In **2004** the **Grampians Region Aboriginal Services Plan** (GRASP) was developed, which built on the KSIS, and focused on four key priority areas, namely 'Children and Families', 'Youth', 'Lengthening Life' and 'Capacity Building'.

But it wasn't until **2009** when the **Closing the Health Gap** (CtHG) policy was introduced that the work really started to gain momentum, in part due to a significant injection of funding which was provided over a four year period to address some of the critical priorities in the region. This funding supported the introduction of a number of specific projects/programs, the majority of which are still in existence today and continue to be implemented based on their proven value and effectiveness.

Four organisations were funded during this period, namely BADAC, Budja, Goolum and WPCP, to implement projects to address the needs of their communities. These needs were identified and determined by these organisations and the communities they serve. Project proposals were developed by these organisations and submitted to the Grampians Indigenous Reference Group (GIRG) for their endorsement. The GIRG was the overarching governance committee charged with overseeing the development, implementation and evaluation of the regional CtHG plan.

The GIRG comprised a collection of partners including the three Aboriginal Community Controlled Health Organisations (ACCHOs), DHS, health services, community health, primary care partnerships, and other government departments. The regional CtHG plan was closely monitored by the GIRG to determine what activities and initiatives were showing promising results, and some of the targets covered within this report were set during the CtHG period.

Then in **2013**, the **Koolin Balit** (KB) policy was introduced. The region evolved their governance structure into a two-tiered platform (refer Attachment III), with the Grampians Region Aboriginal Health Governance Committee (GRAHGC) fulfilling the role of what was previously undertaken by the GIRG, with the addition of three sub-committees which sat beneath the GRAHGC and were more 'operational' in their function. A similar collection of partners and sectors as represented on the GIRG also formed the membership of the GRAHGC and the three sub-committees.

Five key project proposals, put forward by the same four organisations funded throughout CtHG, were submitted to the GRAHGC for their consideration and endorsement. These projects primarily focused on addressing the same priority areas as the projects implemented during the CtHG period, with the addition of the Regional Aboriginal Eye Health Project as a sixth project in 2016.

Developing the measures and setting the targets

The region recognised the importance of a longitudinal approach to project monitoring, reporting and evaluation many years ago. Fundamental to this was the development of a clear set of specifically defined measures and targets by which to track progress over a mid to longer-term period of time.

BADAC, Budja, Goolum and the WPCP worked in close partnership with the regional office to develop these measures and targets, and much effort was invested into getting the wording right to ensure the targets were S.M.A.R.T.ly written (Specific, Measurable, Achievable, Realistic, and Timely). A crucial element of this was the gathering of baseline data, to not only identify key project priorities in the first place, but to directly inform the creation of the targets.

As each reporting period went by, it was a chance for the project workers and the regional office to check in on the validity of the measures, and how appropriate in practice they actually were to report against. A small number of measures were totally discarded, whilst others were refined to better reflect what were meaningful and culturally appropriate indicators of success for the local Aboriginal communities.

The reporting process explained

The region has taken a serious approach to tracking progress and reporting on the impacts of program implementation for many years now, for a whole range of reasons.

First and foremost is the accountability of the region back to the broader Aboriginal community to ensure the value of the projects is clearly demonstrated, and that the community have a mechanism, via the governance structure, to provide feedback to guide implementation and ensure approaches are culturally informed and appropriate.

In addition to this, the need to contribute to an evidence base about what has and hasn't worked has been a constant theme which has underpinned the reporting philosophy of the region, and has consistently been discussed at governance committee meetings throughout the Koolin Balit period in particular.

Also, the close monitoring of progress against a clear set of targets has been an invaluable tool for guiding project planning and implementation, to maximise resource allocation towards activities which are working, and redirect energy away from those that aren't.

In terms of the actual reporting process itself though, at a very practical level the region has closely followed the Koolin Balit Performance Management Framework, which in essence involves the development and submission of a progress report for each project on a six monthly basis. On paper, this sounds like a simple enough task, but it has been the stringent and methodical approach that has been upheld over time which has been the defining factor behind the strength of reporting.

The process commences many weeks in advance of the final deadline for the submission of the regional report to the Aboriginal Health and Wellbeing Branch of the department. The first draft of each project report is developed by the project officer and/or other support staff within each organisation, with a clear prioritisation of reporting against the targets set, first and foremost, and secondly the completion of the narrative reporting components of the

reporting template (refer Attachment IV to view the reporting template). The regional office has provided consistent support and guidance along the way with this process as required.

This draft is then submitted to the regional office four weeks in advance of the final deadline, where feedback is provided directly onto the report via tracked changes, with suggestions and comments included to further strengthen the content of the report and to ensure consistency of information from one reporting period to the next. Several drafts are commonly required before the organisations and the regional office are satisfied with the final version.

At this point, all final versions are collated into one overall regional report, which is then provided one week in advance of the final deadline to the GRAHGC for their viewing, opportunity for feedback, and ultimate endorsement. At this point, the finalised regional report is submitted to the AHWB branch by the deadline, being 31 March and 30 September each year.

Key Success Factors

The following is a summary of the key success factors behind the outcomes achieved:

- Governance committees which are **led by ACCHOs** and supported by the department, and comprise a collection of key partners who are genuinely invested in advancing Aboriginal health outcomes
- **Strong evaluative practices** centred on a consistent, long term approach to reporting against a set of specific targets. This has provided the evidence by which sound decisions have been made regarding the allocation of funding
- Challenging and overcoming ‘commonly accepted’ practices of short term project funding through the vision of a **mid to longer-term investment** (four to eight years) in programs which have proven positive outcomes
- Sustained, longer-term **focus on specific priority areas and population groups**. The current projects have essentially focused on the same ‘themes’ for the entire nine years
- Prioritisation of funding towards the **employment of project officers and workers** to lead and drive key programs
- **Minimal turnover in project officers and other key staff** has been an asset in terms of retaining corporate knowledge, ensuring business continuity and maintaining strong and consistent relationships
- **Regional office support** throughout the nine years ranging from secretariat responsibilities for the various committees through to policy advice and guidance for project planning, implementation and evaluation
- Utilisation of the **Koolin Balit Performance Management Framework** to guide all planning, monitoring and evaluation activities.

Key Challenges

The following is a summary of the key challenges faced along the way:

- Lowest level of regional Koolin Balit funding in the state, but with significant population disadvantage in terms of socio-economic indicators, isolation, lack of services and distances from major services
- Heavy burden placed on project workers and other staff who complete the six-monthly reports. These workers are already ‘stretched’ in their roles, are under-resourced and have competing demands, including the completion of reports for other government departments. This demonstrates the high level of commitment of these staff and the value they place on strong reporting practices
- Recognising and appreciating that building trust and fostering relationships takes time, commitment and effort, but are the key ingredients for creating meaningful, long term partnerships.

PART B

The Outcomes

Outcomes on a page (thematically aggregated)

6 Projects

52 Targets

38 Achieved

14 Progressing or Yet to be achieved

Smoking Cessation

- Decreased levels of smoking, including around children in the home
- Increased participation in smoking cessation programs
- Increased number of quit attempts

Child and Adolescent Health

- Increased number of child health assessments conducted, including children in out of home care
- Increased referrals to dental, vision, hearing and other health services
- Increased community capacity to improve healthy eating and reduce sugary drink consumption
- Increased number of adolescents accessing welfare and support services

Chronic Disease and Risk Factors

- Increased number of adult health assessments conducted, and care plans written
- Improvements in collective levels of body mass index, blood pressure, blood cholesterol and HbA1c
- Increased number of people with diabetes undertaking regular testing of HbA1c, cholesterol, blood pressure, waist measurements and smoking status

Social and Emotional Wellbeing

- Increased number of people accessing mental health, alcohol and other drug counselling services
- Increased number of mental health care plans being written
- Strengthening of referral pathways between ACCHO and mainstream health providers

Mainstream Cultural Responsiveness and Safety

- Increased number of staff participating in Cultural Awareness training
- Increased number of staff attending/contributing to local Aboriginal events
- Improvements to physical environments to make them more Culturally welcoming
- Improvements in policies and practices to improve Cultural responsiveness and safety
- Anecdotal feedback by local Aboriginal community of improved patient experience

Eye Health

- Increased number of annual retinal examinations for people with diabetes
- Increased number of annual eye checks for adults and children
- Increased number of referrals to optometrists/ophthalmologists
- Increased number of spectacles being provided
- Increased number of ophthalmic separations, including cataract surgery

Project 1: Chronic Disease Prevention and Management program

Organisation: Ballarat and District Aboriginal Cooperative

Commencement Year: 2010

Program duration at 2019: 9 years

Key areas of focus:
Overweight and obesity, high blood pressure, high blood cholesterol, high blood sugar, smoking levels, annual health assessments, individual care plan development and review.

Relevant Statewide Koolin Balit Indicators
1.7 Increase in access to services addressing chronic conditions
8.4 Reduction in the proportion of Aboriginal adults who smoke
10 Reduction in the proportion of Aboriginal adults who are obese or overweight
12 Reduction in prevalence of chronic diseases reported in AATSIHS

Brief Overview

Ballarat and District Aboriginal Cooperative (BADAC) is the largest of the three ACCHOs in the Grampians Region, and provides a comprehensive range of health and human services for Aboriginal community members who reside across the Central Highlands Area, who comprise approximately two thirds of the entire region's Aboriginal population.

The Chronic Disease Prevention and Management (CDPM) program commenced in 2010 and involves the collaboration of a team of health professionals who provide a range of services including general practice, nursing, diabetes education, smoking cessation, dietetics and various other health promotion programs.

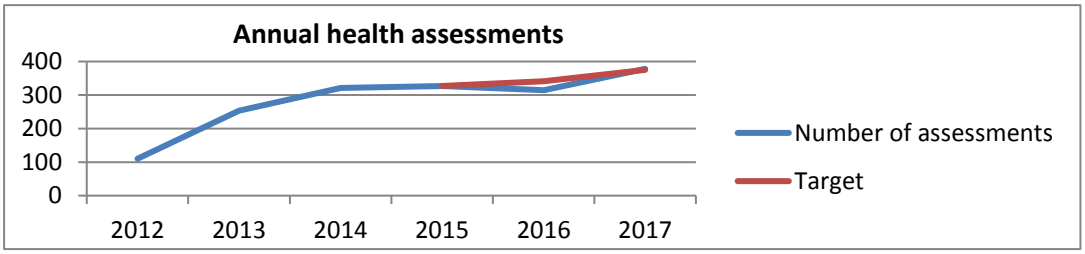
The initial goals of this program for the first few years in particular were to increase the number of Aboriginal community members undertaking annual health assessments, which was overwhelmingly successful, as well as the development and review of individual care plans, and particularly for those with diabetes and multiple risk factors (co-morbidity).

The program focus then expanded to the collection and monitoring of various biometric measures at a collective level over time, to gain a greater insight into the impacts of the program at a 'risk factor' level. Targets were ambitiously set to tackle the challenge of lowering risk factors such as high blood pressure, high blood cholesterol and high body mass index, amongst others.

BADAC are to be commended for their longer term commitment to monitoring such indicators, and the strength of the data too from the perspective of 'sample size' is also very impressive, with the results of over 1000 community members included in their reports.

Target 1: 10% increase in the number of annual individual health assessments conducted per year, commencing at a baseline of 327 assessments conducted at June 2015

Result: Achieved



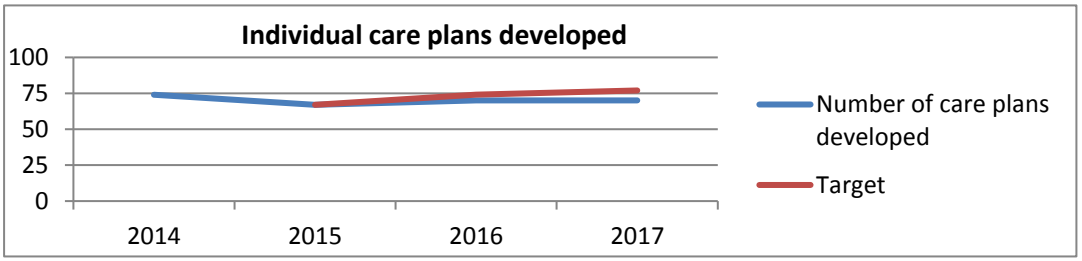
Achieved a **high of 378 assessments** in 2017.

Averaged a **3% increase per year** between 2015 and 2017.

Nearly 3 times increase overall between 2012 and 2017 (110 to 327 assessments).

Target 2: 10% increase in the number of individual care plans developed per year, commencing at a baseline of 67 care plans developed at June 2015

Result: Progressing

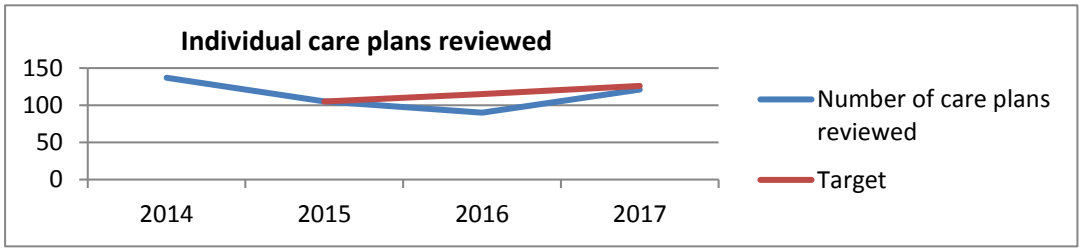


Achieved a **high of 72 care plans developed** in 2017.

Averaged a **0.5% increase per year** between 2015 and 2017.

Target 3: 10% increase in the number of individual care plans reviewed per year, commencing at a baseline of 105 care plans reviewed at June 2014

Result: Progressing

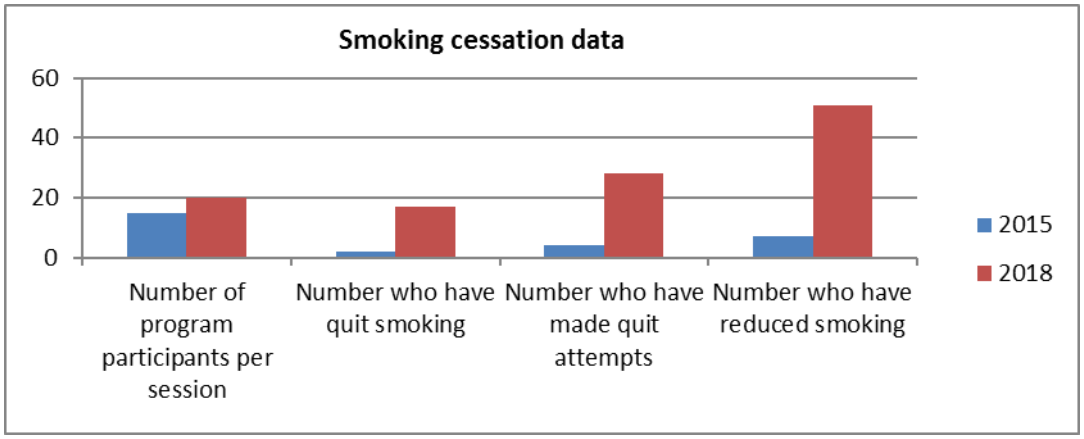


Achieved a **high of 121 care plans reviewed** in 2017.

Averaged a **0.2% increase per year** between 2015 and 2017.

Target 4: An increase in the number of local Aboriginal community members who are participating in quit smoking programs/sessions, as well as an increase in the number of quit attempts and readiness to quit

Result: **Achieved**

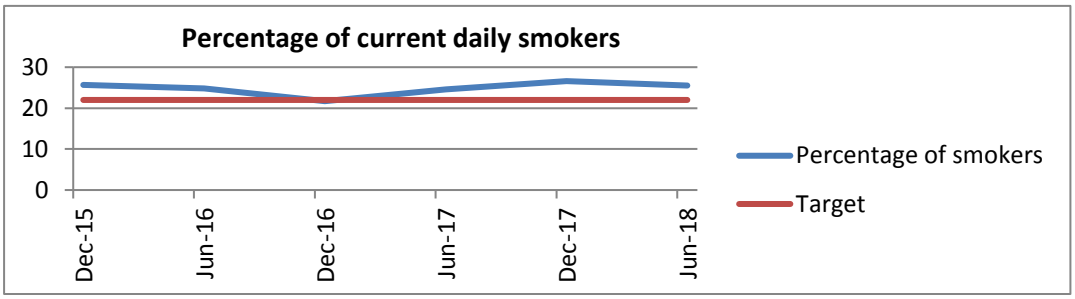


From 2015 to 2018 there has been:

- A **25% increase** in the average number of **participants attending quit programs** (from 15 to 20 people per session, with a high of 25 people in 2018)
- A total of **17 people who have quit smoking**
- A total of **28 people who have made quit attempts**
- A total of **51 people who have reduced their smoking**.

Target 5: A decrease from 25% to 22% in the percentage of community members who are current daily smokers

Result: **Achieved but fluctuating**

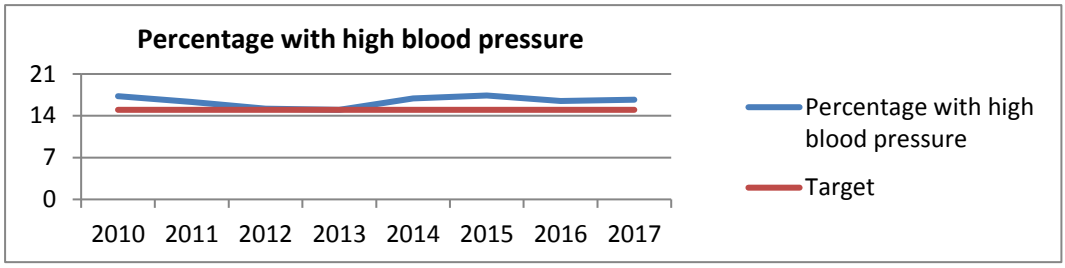


Achieved a **low of 21.7%** in 2016.

Stabilisation of the percentage of **current daily smokers** at an average of 24.6% between 2015 and 2018.

Target 6: A decrease from 17% to 15% in the percentage of community members who register a high blood pressure reading

Result: **Achieved but fluctuating**

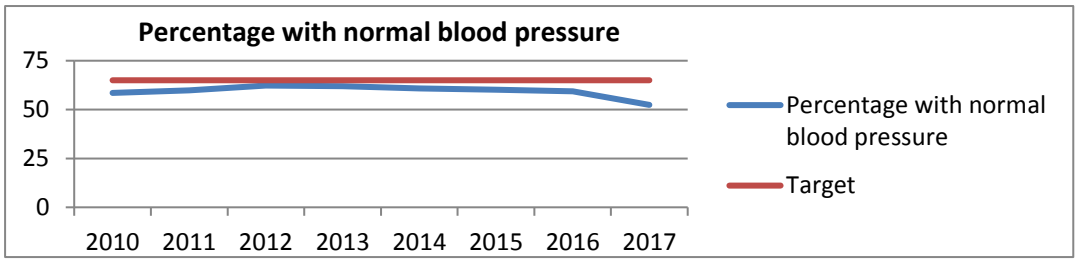


Achieved a **low of 15%** in 2013.

Stabilisation of the percentage of people with **high blood pressure** at an average of 16.4% between 2010 and 2017.

Target 7: An increase from 60% to 65% in the percentage of community members who register a normal blood pressure reading

Result: **Yet to be achieved**

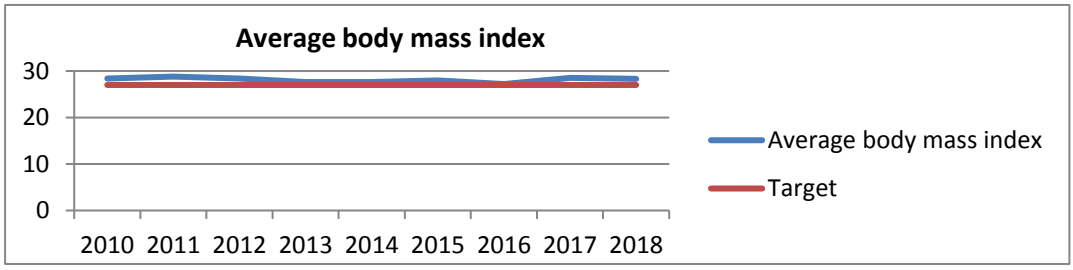


Achieved a **high of 62.3%** in 2012.

The average percentage of people with **normal blood pressure** between 2010 and 2017 was 59.4%.

Target 8: A decrease from 27.6 to 27 in the average collective body mass index of community members

Result: **Yet to be achieved**

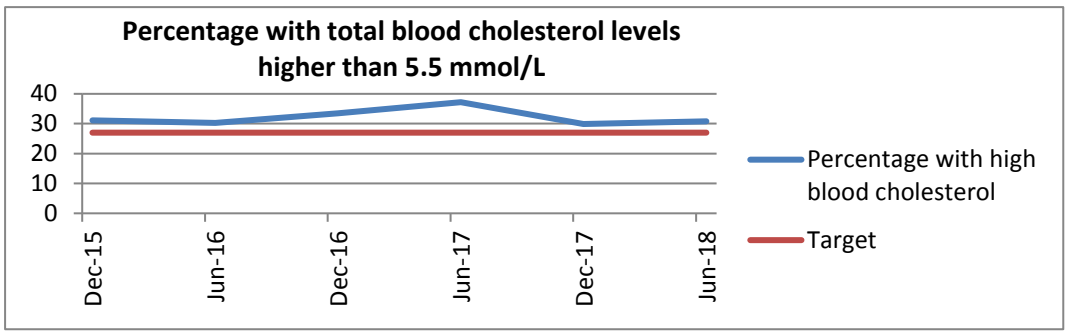


Achieved a **low of 27.2** in 2016.

The average collective **body mass index** between 2010 and 2018 was 28.1.

Target 9: A decrease from 32% to 27% in the percentage of community members with total blood cholesterol levels higher than 5.5 mmol/L

Result: **Yet to be achieved**

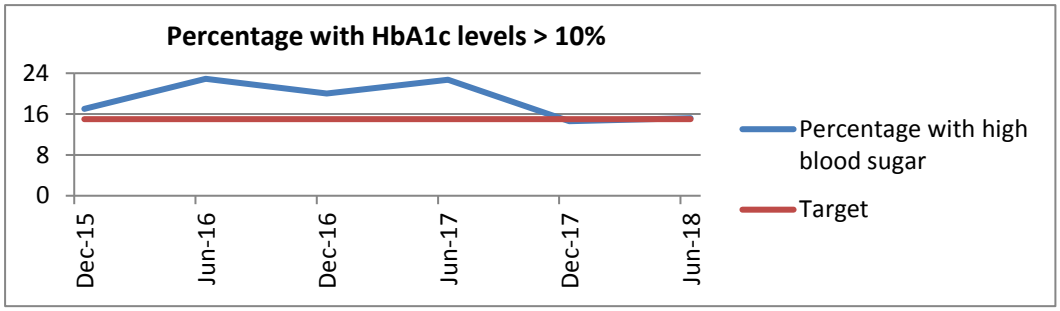


Achieved a **low of 29.9%** in 2017.

The average percentage of people with **total blood cholesterol levels** higher than 5.5 mmol/L between 2015 and 2018 was 32.1%.

Target 10: A decrease from 21% to 15% in the percentage of community members with HbA1c levels > 10%

Result: **Achieved but fluctuating**



Achieved a **low of 14.6%** in 2017.

Stabilisation of percentage of people with **high blood sugar levels** at an average of 18.7% between 2015 and 2018.

Project 2: Chronic Disease Prevention and Management program

Organisation: Budja Budja Aboriginal Cooperative

Commencement Year: 2010

Duration at 2019: 9 years

Key areas of focus:
Obesity, blood pressure, blood cholesterol, blood sugar, smoking, annual health assessments, individual care plans.

Relevant Statewide Koolin Balit Indicators

1.7 Increase in access to services addressing chronic conditions
8.4 Reduction in the proportion of Aboriginal adults who smoke
10 Reduction in the proportion of Aboriginal adults who are obese or overweight
12 Reduction in prevalence of chronic diseases reported in AATSIHS

Brief Overview

Budja Budja Aboriginal Cooperative (Budja) is situated in the middle of the Grampians Region, in the popular tourist destination of Halls Gap in the Gariwerd National Park. Budja provide a comprehensive range of health services to both the local Aboriginal community in the catchment, which has grown significantly between the 2011 and 2016 census periods, and non-Aboriginal residents and tourists.

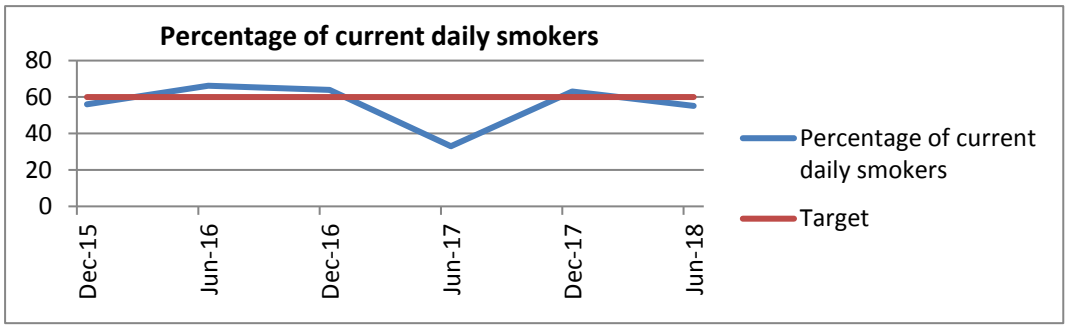
The organisation's key focus, and conversely its key challenge, is its sustainability and capacity to provide the necessary services to its community. This is particularly evident due to the challenge of meeting the needs of a relatively small population who reside across a catchment which is geographically isolated, and lack many of the major services which are prevalent in more densely populated areas. The Koolin Balit funding Budja has received over the past four years has greatly assisted the organisation in ensuring financial sustainability and increasing service delivery to its Community members.

In 2014, the work which Budja had been undertaking to improve the physical and mental health and wellbeing of its community became more formalised under the two programs now known as 'Chronic Disease Prevention and Management (CDPM)' and 'Social and Emotional Wellbeing (SEWB)'. These programs heavily draw upon the delivery of general practice services, alongside a range of allied health services which are delivered in partnership with committed local health services and community health.

Under the CDPM program, and similarly to BADAC, Budja has also committed to the challenge of tackling risk factor change such as decreasing the levels of overweight and obesity, as well as rates of smoking, and to increase the levels of community participation in locally delivered physical activity and healthy eating programs.

Target 11: A decrease from 66% to 60% in the percentage of community members who are regular smokers

Result: Achieved



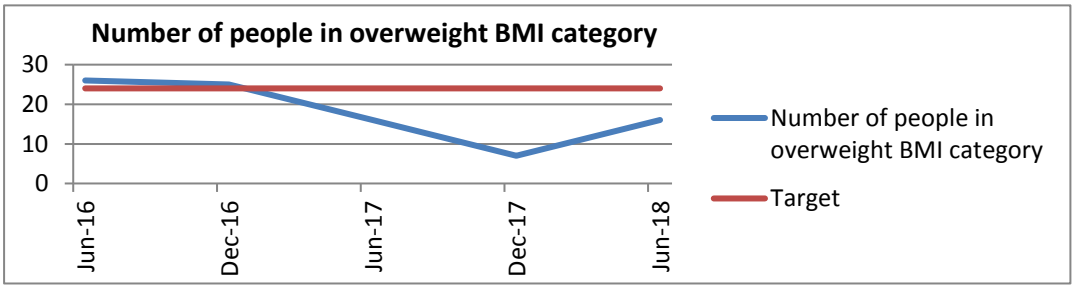
Achieved a **low of 33%** in 2017.

Stabilisation of percentage of **current daily smokers** at an average of 56% between 2015 and 2018.

Target 12: A decrease in the number of Aboriginal community members whose BMI falls within the following categories:

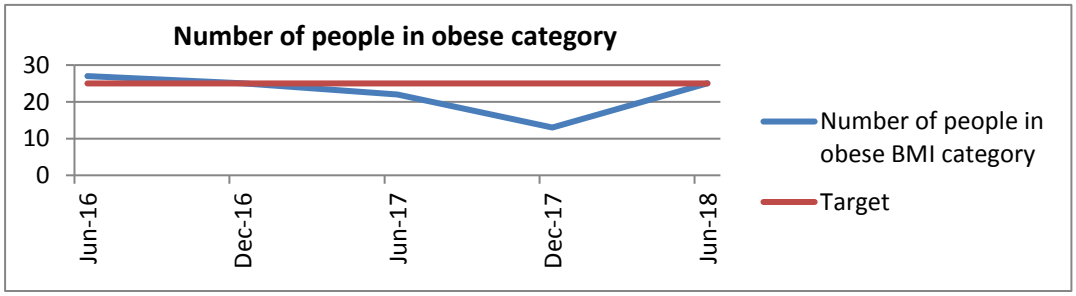
Overweight: ***from 26 to 24 people***
Obese: ***from 27 to 25 people***
Morbidly Obese: ***from * to * people***

Result: Achieved



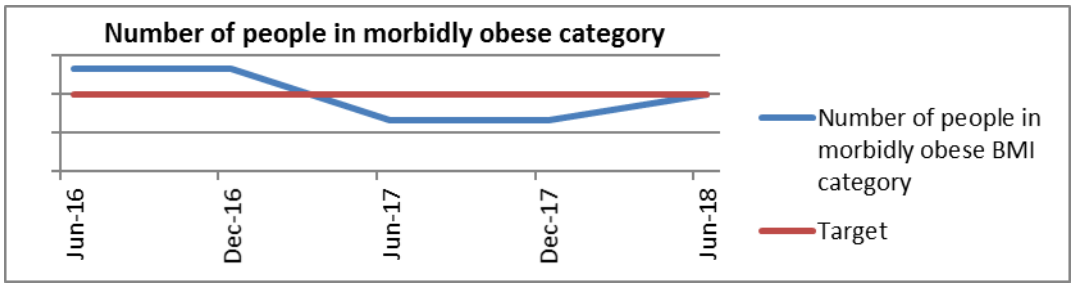
Achieved a **low of 7 people** in the overweight category in 2017.

Achieved an **average of 18 people** in this category between 2016 and 2018.



Achieved a **low of 13 people** in the obese category in 2017.

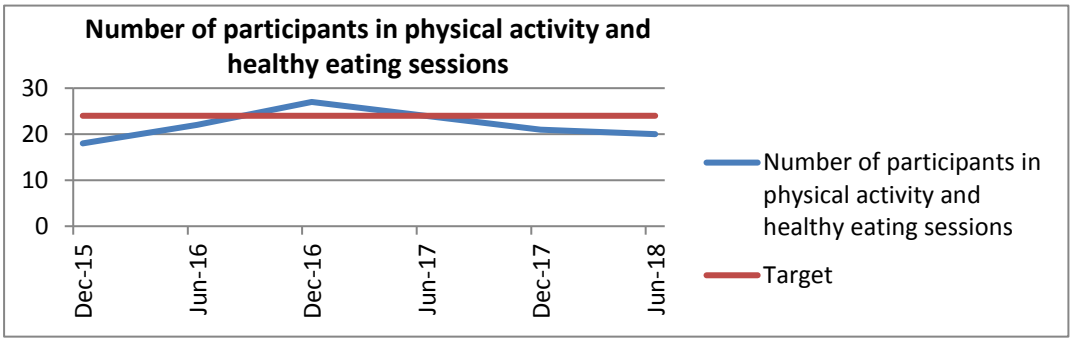
Achieved an **average of 22 people** in this category between 2016 and 2018.



** Value/s not disclosed to protect privacy.*

Target 13: An increase from 12 to 24 community members who regularly participate in fortnightly physical activity and healthy eating sessions

Result: **Achieved but fluctuating**



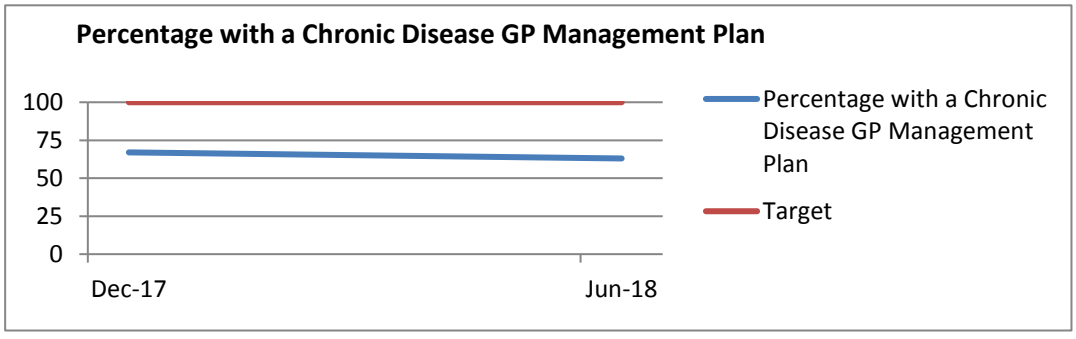
Achieved a **high of 27 people** regularly participating in 2016.

Achieved an **average of 22 participants** per session between 2015 and 2018.

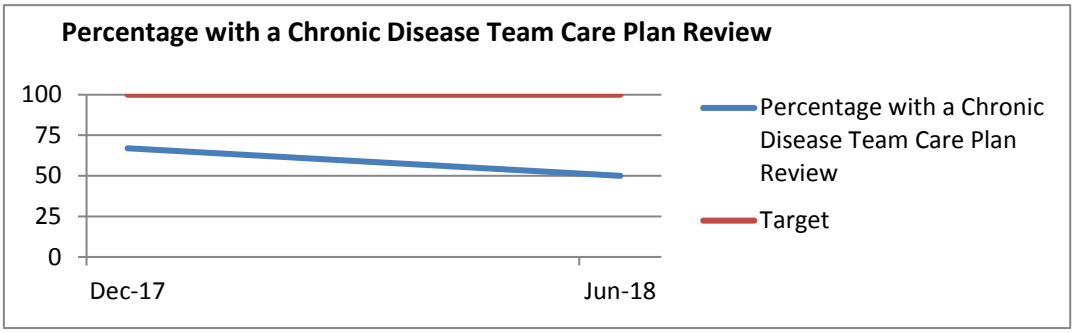
Target 14: 100% of Aboriginal community members who are registered clients at Budja's medical clinic will have the following health plans and reviews in place:

Chronic Disease GP Management Plan
Chronic Disease Team Care Plan
Chronic Disease Team Care Plan Review

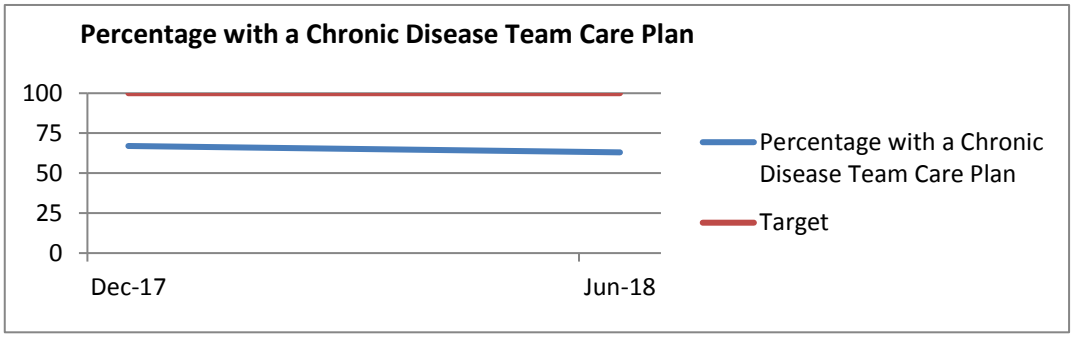
Result: **Yet to be achieved**



Achieved **67% coverage** in 2017 and 63% coverage in 2018.



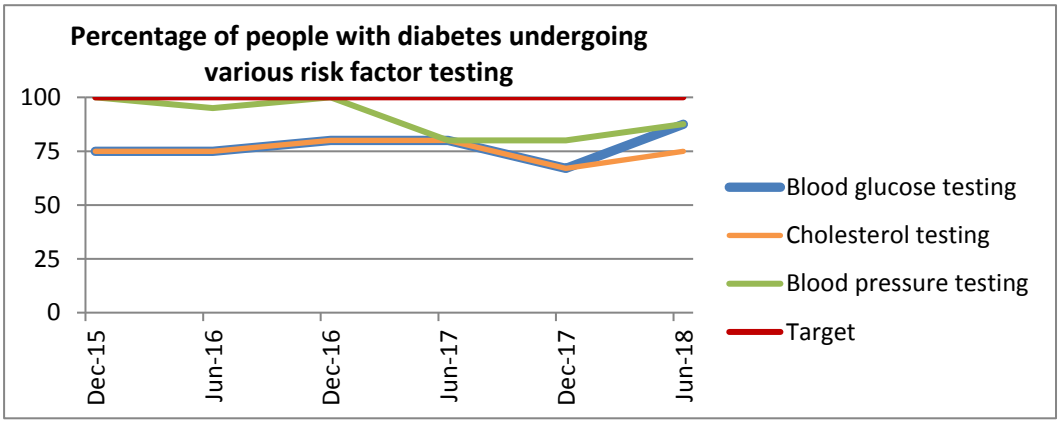
Achieved **67% coverage** in 2017 and 63% coverage in 2018.



Achieved **67% coverage** in 2017 and 50% coverage in 2018.

Target 15: An increase to 100% in the percentage of Aboriginal clients with diabetes who undertake regular testing of their HbA1c levels, along with cholesterol, blood pressure, waist measurements and smoking status

Result: **Progressing**

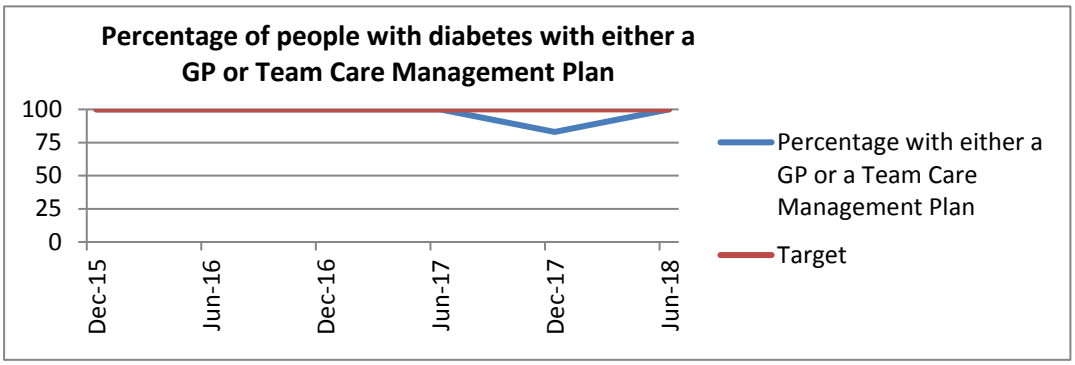


HbA1c - achieved a **high of 100%** in 2016 and 2017, and **averaged 77%** between 2015 and 2018.

Blood cholesterol - achieved a **high of 100%** in 2016 and 2017, and **averaged 75%** between 2015 and 2018.

Blood pressure - achieved a **high of 100%** in 2015 and 2016, and **averaged 90%** between 2015 and 2018.

Target 16: Maintenance of current 100% coverage of all community members with diabetes having either a GP Management Plan or a Team Care Management Plan.
Result: Achieved



Achieved an **average of 97% coverage** between 2015 and 2018, with a momentary dip down to 83% in 2017.

Project 3: Social and Emotional Wellbeing program

Organisation: Budja Budja Aboriginal Cooperative

Commencement Year: 2010

Duration at 2019: 9 years

Key areas of focus:
Provision of counselling services, access to counselling services, development of mental health care plans, addressing alcohol and substance misuse

Relevant Statewide Koolin Balit Indicators

1.4 Increase in access to mental health services earlier for young Aboriginal people

6.2 Reduction in the proportion of Aboriginal adults reporting 'high or very high' levels of psychological distress

9.1 Reduction in the use of illicit drugs and risky drinking among young Aboriginal people (ages 15-24)

9.2 Reduction in the rate of Aboriginal emergency department presentations and hospital separations due to alcohol consumption

Brief Overview

The importance of providing holistic care, based on the social and cultural determinants of health, has been a philosophy that has underpinned the work of Budja for many years now. The organisation has focused heavily on addressing the underlying factors contributing to poor Social and Emotional Wellbeing (SEWB) outcomes, with a particular focus on reducing levels of smoking, alcohol and substance use.

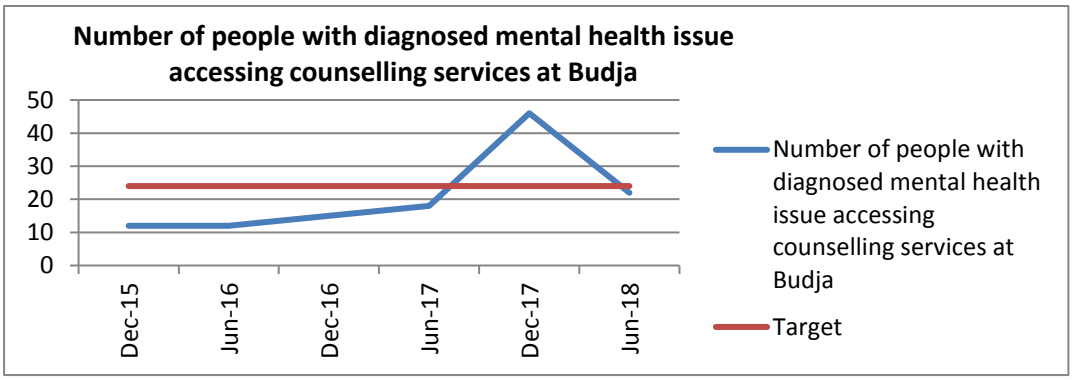
The activities at the heart of the SEWB program include the development of mental health care plans and reviews and the provision of counselling services, a shortage of which is a major issue for the broader population at large across this middle part of the Grampians Region.

Attracting and securing general practitioner services for the mid to long term has been another key challenge for Budja over the years, and the organisation has worked tirelessly to recruit locum GPs to fill this gap, some of whom have specialist expertise in 'mental health care' and provide an invaluable contribution to this program.

Despite such challenges, Budja has significantly strengthened the delivery of SEWB services over the past couple of years with a marked increase in the number of community members accessing culturally appropriate and safe counselling and other related services, both within the Budja clinic and via outreach service delivery within the home.

Target 17: An increase from 12 to 24 community members with a diagnosed mental health issue who are accessing counselling services provided at Budja (Baseline- 12 community members at June 2015)

Result: Achieved

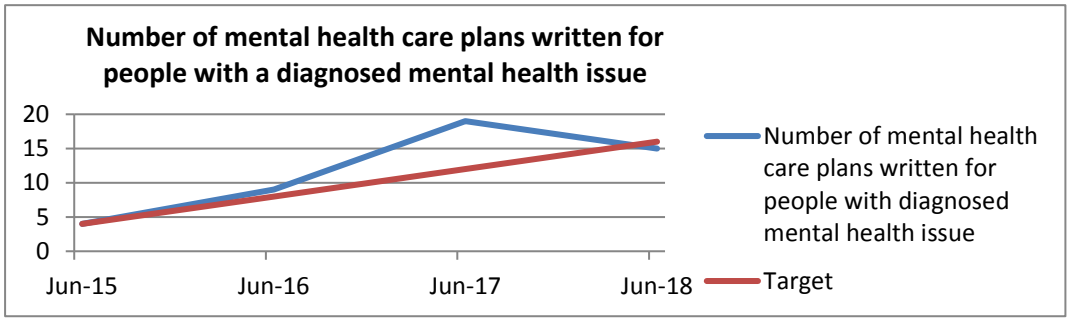


Achieved a **high of 46 people accessing counselling services** in 2017.

Achieved an **average of 21 people** accessing counselling services between 2015 and 2018.

Target 18: An increase of 4 mental health care plans written per financial year for community members with a diagnosed mental health issue (Baseline- 4 mental health care plans at June 2015)

Result: Achieved

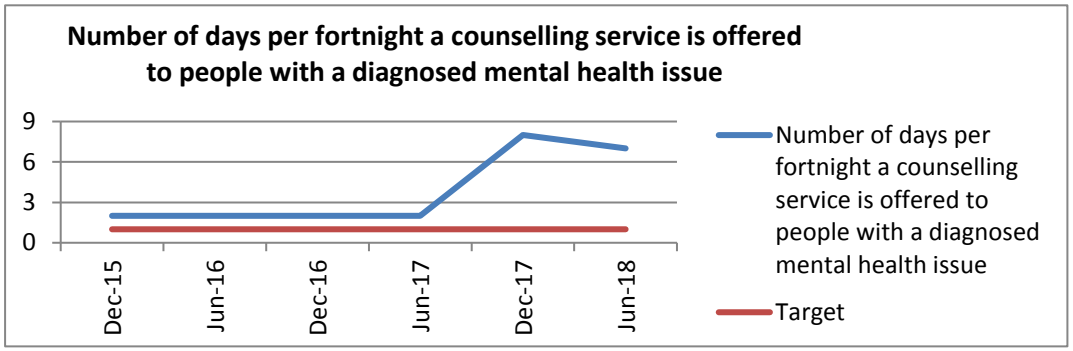


Achieved a **high of 19 people with a mental health care plan** in 2017.

Achieved an **average of 14 people** with a mental health care plan between 2015 and 2018.

Target 19: An increase from a half day to a full day per fortnight counselling service provided at Budja for community members with a diagnosed mental health issue

Result: Achieved



Achieved a **high of 8 days per fortnight** in 2017.

Achieved an **average of 4 days per fortnight counselling services offered**.

Target 20: Clear referral pathways between Budja and mainstream health partners (particularly Grampians Community Health) continue to be strengthened, particularly for issues associated with excessive alcohol consumption, smoking, illicit and prescription substance abuse and domestic violence (narrative report)

Result: Achieved

Narrative Report only

Significant strengthening of referrals between Budja and Grampians Community Health including drug and alcohol counselling, family violence counselling and child and family services financial counselling.

Data reveals a range of **clients have either abstained from, or have better controlled their level of drug/substance use.**

Target 21: Increased provision of outreach mainstream health services at Budja in areas including alcohol and substance misuse and domestic violence (currently only half a day per fortnight)

Result: Achieved

Narrative Report only

Levels of service delivery have increased, particularly in the area of counselling, in part due to the implementation of a highly successful 'home visits' program.

Project 4: *Wirrin-ditch-murrun-dalk* (Children Living Healthy) project

Organisation: Goolum Goolum Aboriginal Cooperative

Commencement Year: 2014

Duration at 2019: 5 years (extends on previous 4 year focus on children and adolescents)

Key areas of focus:
Smoking cessation around children in the home, smoking cessation/reduction general, child health checks (including Out of Home Care), access to dental and other services, adolescent health, self-esteem and identity

Relevant Statewide Koolin Balit Indicators

1.4 Increase in access to mental health services earlier for young Aboriginal people

6.3 Reduction in the rate of presentations of young Aboriginal people to emergency departments for injury

8.2 Reduction in the proportion of Aboriginal children and young people living in households with a current daily smoker

8.3 Reduction in the proportion of Aboriginal young people who smoke

8.4 Reduction in the proportion of Aboriginal adults who smoke

9.1 Reduction in the use of illicit drugs and risky drinking among young Aboriginal people (ages 15-24)

9.2 Reduction in the rate of Aboriginal emergency department presentations and hospital separations due to alcohol consumption

Brief Overview

Goolum Goolum Aboriginal Cooperative (Goolum) is located in Horsham, the heart of the Wimmera, and provide a comprehensive range of health and human services for the local Aboriginal community across the catchment.

From the very beginning of the CtHG period in 2010, Goolum quickly identified the value of investing in their local Aboriginal children and youth to maximise the opportunities for a successful 'life trajectory', and have consistently focused on these two population groups over the past nine years.

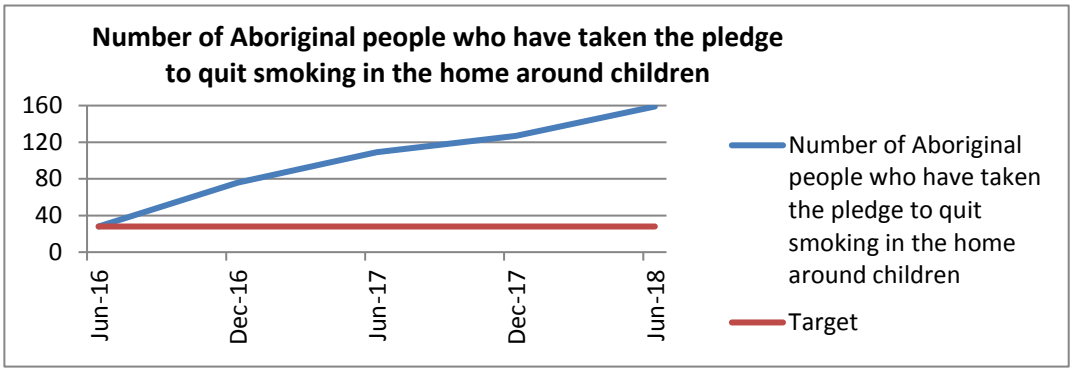
In many ways, Goolum provide a wonderful case study for how best practice, across government program alignment and leverage can occur. This is evident through the close links which the Aboriginal health programs have with other programs such as the Aboriginal Delkaia Best Start program (funded through Department of Education and Training), as well as several programs funded through the Department of Justice and Community Safety which focus on empowering local youth through a range of strength-based activities and programs.

Goolum has led a very successful smoking cessation program focusing on reducing the levels of smoking in the home around children, which has also been an exemplar in terms of the Aboriginal community leading the way for the broader community to make significant improvements in this area.

Amongst many other significant achievements is the work the organisation has undertaken in ensuring all Aboriginal children in Out of Home Care receive a health check.

Target 22: An increase in the number of Aboriginal people who have taken the pledge to quit smoking in the home around children (from 28 people at June 2016)

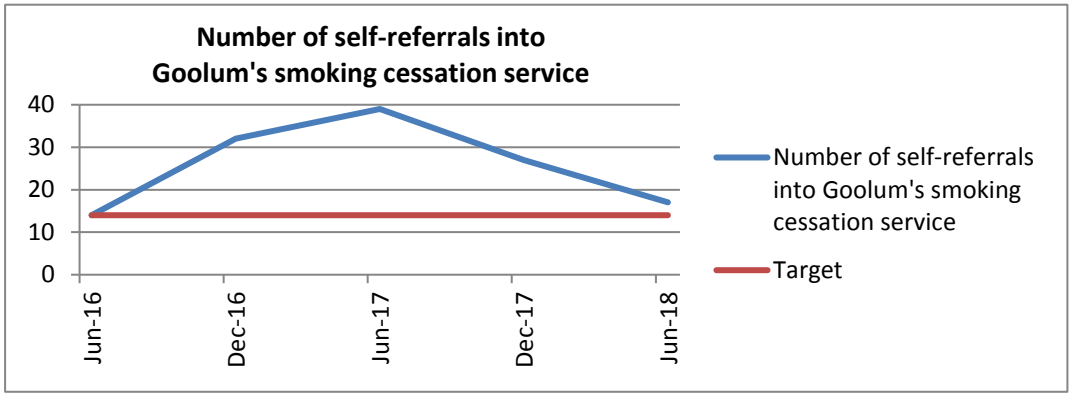
Result: **Achieved**



Over 5 times increase between 2016 and 2018 (28 to 159 people).

Target 23: An increase in the number of self-referrals into Goolum's smoking cessation service as a result of the online 'Take the Pledge' campaign (from 14 self-referrals at June 2016)

Result: **Achieved**



Achieved a **high of 39 self-referrals** in 2017.

Achieved an **average of 26 self-referrals** every six months between 2016 and 2018.

Target 24: An increase in the knowledge, confidence and capacities of current smokers to address their smoking in the home around children (narrative report)

Result: **Achieved**

Narrative Report only

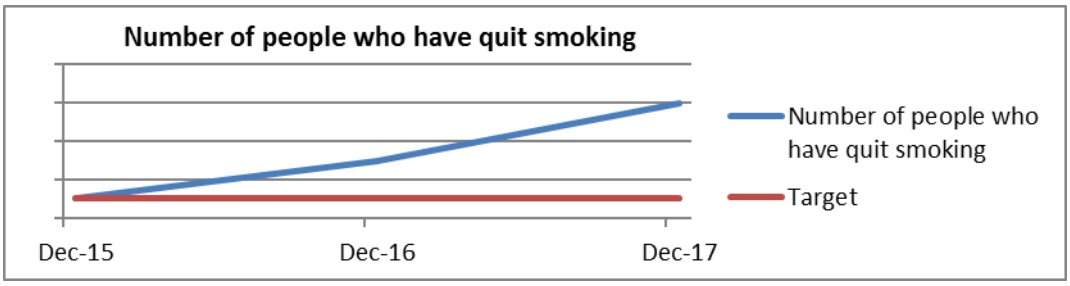
Anecdotal feedback indicates a **dramatic decrease in the levels of smoking in the home around children.**

Nicotine Replacement Therapy kits have been reported as a **very effective method** of reducing the levels of smoking amongst community members.

Active health promotion by Goolum Aboriginal health workers with Aboriginal children attending local primary schools has been reported as **another effective means of reducing the levels of smoking in the home environment.**

Target 25: An increase of one person per calendar year who has quit smoking (from * people at December 2015)

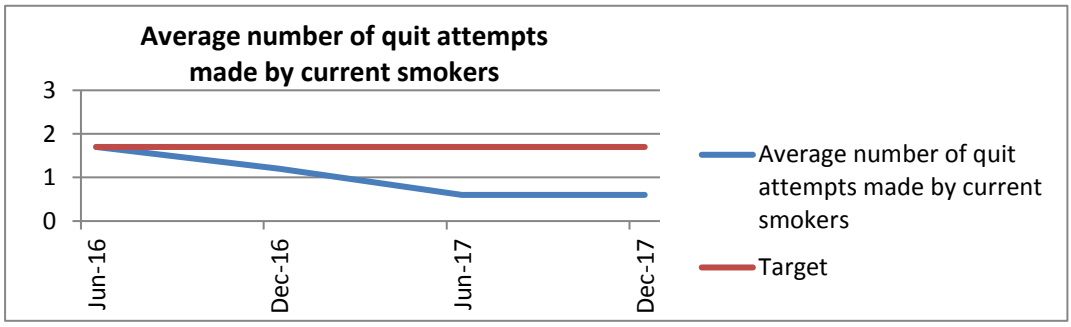
Result: **Achieved**



** Value/s not disclosed to protect privacy.*

Target 26: An increase in the average number of quit attempts made by current smokers per financial year (from 1.7 quit attempts made over the six month period to June 2016)

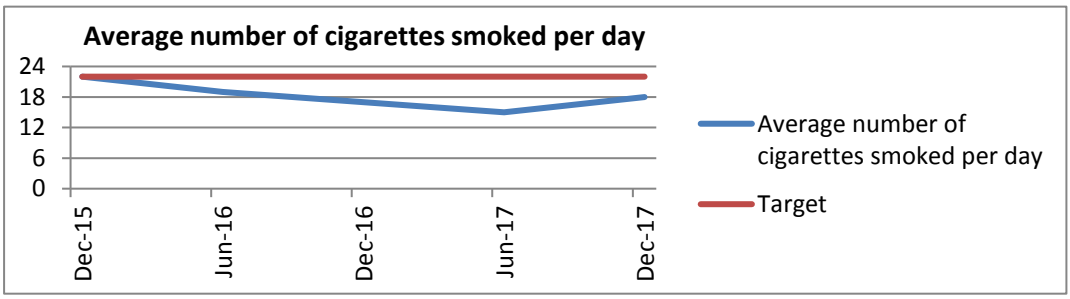
Result: **Yet to be achieved**



The **average number of quit attempts** made per current smoker has **progressively fallen** from 1.7 attempts to 0.6 attempts between 2016 and 2017.

Target 27: A reduction in the average number of cigarettes smoked per day (from 22 cigarettes smoked per day at December 2015)

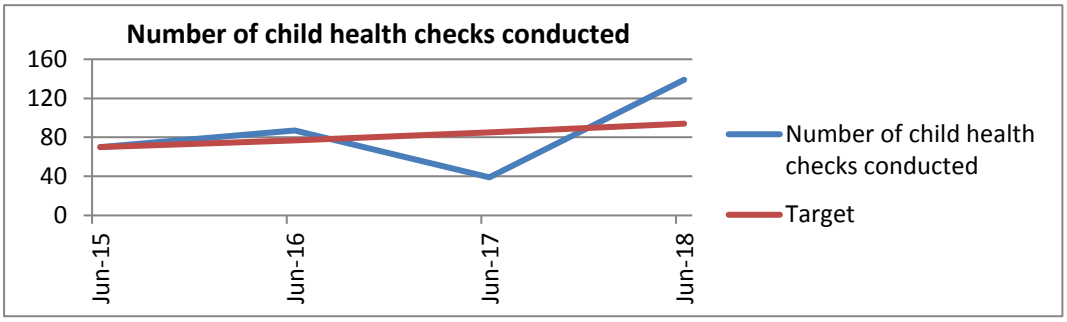
Result: **Achieved**



The **average number of cigarettes smoked per day has progressively fallen** from 22 cigarettes to 18 cigarettes between 2015 and 2017, with a **low of 15 cigarettes smoked per day** at June 2017.

Target 28: A 10% increase in the number of child health checks conducted per financial year (from 70 child health checks at June 2015)

Result: **Achieved but fluctuating**

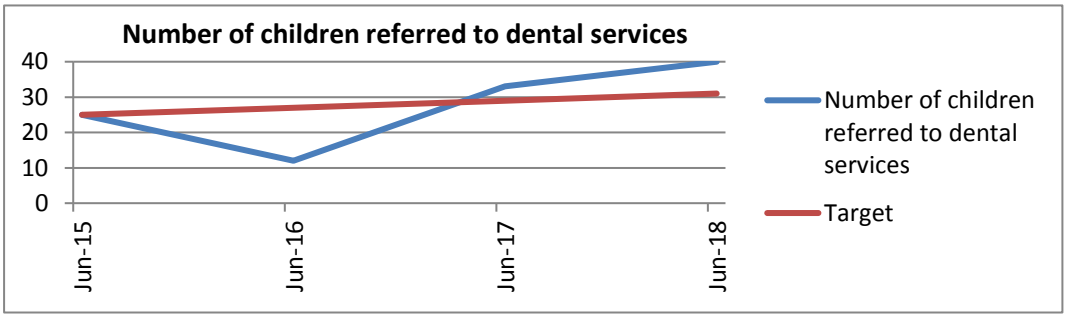


Achieved a **high of 139 child health checks** conducted during the 2017/18 financial year.

Achieved an **average 20% increase** in the number of child health checks conducted per financial year between 2015 and 2018.

Target 29: An increase of 2 Aboriginal children per financial year who are referred to dental services (from 25 children at June 2015)

Result: **Achieved but fluctuating**



Achieved a **high of 40 children referred to dental services** during the 2017/18 financial year.

Achieved an **average increase of 3 Aboriginal children referred to dental services** per financial year between 2015 and 2018.

Target 30: An increase in the knowledge, confidence and capacities of Aboriginal children and their families to address unhealthy eating choices and consumption of sugary drinks (narrative report)

Result: **Achieved**

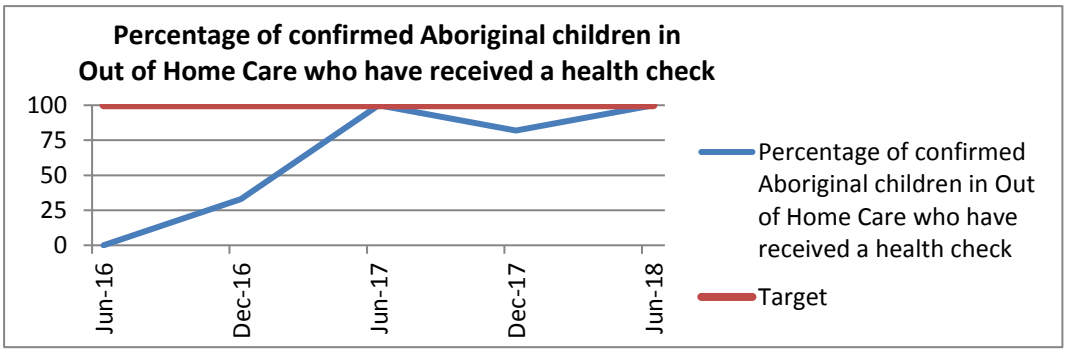
Narrative Report only

Anecdotal feedback indicates **improvements in community knowledge and behaviour patterns** regarding the importance of **healthy eating and decreasing the consumption of sugary drinks.**

An **average of 45 Aboriginal children per week attended 'Healthy Food preparation sessions'** as a part of the Koorie Kids After School (KOOKAS) program at Goolum, which has played a key role in **improving community knowledge and behaviours in relation to healthy eating.**

Target 31: 100% of confirmed Aboriginal children in Out of Home Care (OoHC) within Goolum's service area will receive a child health check by June 2018

Result: **Achieved but fluctuating**



A **steady increase** in the percentage of **Aboriginal children in OoHC receiving child health checks**, from a baseline of 0% at June 2016 to the **achievement of the 100% target** one year later at June 2017.

Target 32: 100% of confirmed Aboriginal children in OoHC within Goolum's service area will receive a dental check by June 2018

Result: **Progressing**

Data unavailable for this target as further consolidation of the processes regarding OoHC support services is required.

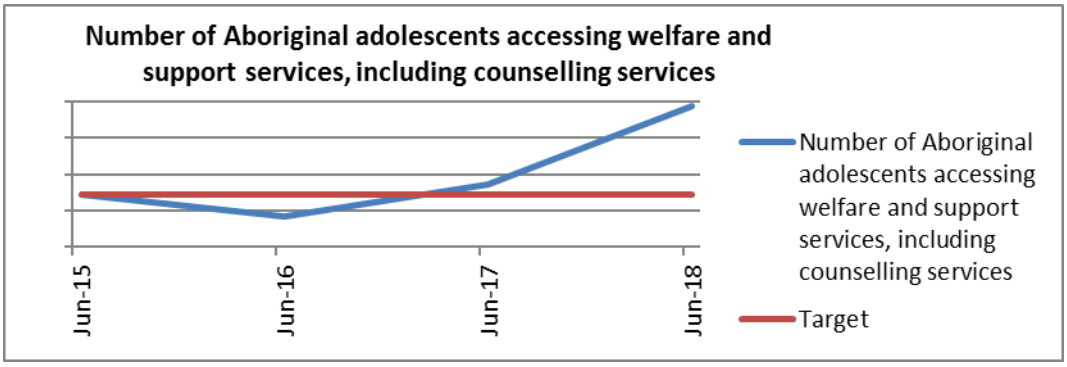
Target 33: 100% of confirmed Aboriginal children in OoHC within Goolum's service area will be referred to other essential health services as required by June 2018

Result: **Progressing**

Data unavailable for this target as further consolidation of the processes regarding OoHC support services is required.

Target 34: An increase in the number of Aboriginal adolescents per financial year who access welfare and support services, including counselling sessions at Goolum (from * adolescents at June 2015)

Result: **Achieved**



** Value/s not disclosed due to data sensitivity.*

Target 35: An increase in the number of Aboriginal adolescents participating in activities to improve their sense of identity, self-esteem, physical health and social/emotional well-being (narrative report)

Result: **Progressing**

Narrative Report only

Anecdotal feedback reveals **increasing numbers of Aboriginal adolescents involved in a range of activities and programs aimed at building self-esteem, confidence and skills**. Examples of the types of skills developed within such programs include bicycle repair, small engine maintenance, metal fabrication, woodwork, design and graphics, art and craft, life skills and cooking sessions. Many of these programs are able to be delivered as a result of funding from multiple sources, in order to address health and wellbeing outcomes holistically.

Project 5: Towards Cultural Security project

Organisation: Wimmera Primary Care Partnership

Commencement Year: 2010

Duration at 2019: 7 years (2 year gap across 2012 to 2013)

Key areas of focus:
Workforce participation in Cultural Awareness training, workforce attendance/participation at cultural events, cultural audits and improvements to physical environments of local organisations, improved policies and practices, increased community cultural safety.

Relevant Statewide Koolin Balit Indicators

1.5 Increase in Aboriginal people accessing mainstream community health services, aged care assessment services and HACC services

2 Improvement in Aboriginal people's experience of healthcare

5.1 Improve links between mainstream and Aboriginal community organisations

5.2 Improve identification rates of Aboriginal health service users

5.3 Improve cultural responsiveness of, and cultural safety experienced in, Victorian hospitals

Brief Overview

At a Wimmera Primary Care Partnership (WPCP) strategic planning forum in 2009, the Chief Executive Officers of 20 member organisations unanimously agreed that they needed to improve the level of Cultural responsiveness and safety offered by the services within their organisations, and so the Towards Cultural Security (TCS) project was born.

In 2010, Phase One of the project involved the establishment of organisation baseline measures, through the completion of a very comprehensive online survey undertaken by nearly 700 staff across 20 organisations. An individual report was then developed for each organisation, outlining a range of ways in which service delivery could be strengthened to improve access by the local Aboriginal community.

Phases Two and Three of the project from 2014 onwards, were the periods where very real and tangible outcomes were generated, leveraging off the foundation period of Phase One. A locally developed and delivered Cultural Awareness Training program has been a driving force, with nearly 700 staff from a range of health and human services organisations who have now participated. The success of this training package has been recognised nationally, the model of which was presented at the National Rural Health Conference in Cairns in 2017.

Significant improvements to the physical environments of health services, community health, councils and other organisations has been another highlight, including the extensive display of Aboriginal and Torres Strait Islander flags, Acknowledgement plaques, locally produced artwork and the engagement of the local men's shed in the creation of flag stands.

A very significant 'Bus Trip to Echuca' is another example of a unique opportunity where a range of local partners participated in a Cultural Awareness experience, the effects of which have been far reaching.

Target 36: Work with WPCP member organisations to review policies to improve culturally appropriate service delivery, and to implement the recommendations of these policies

Result: **Progressing**

Narrative Report only

Aboriginal advisory committees now established for Wimmera Health Care Group and Horsham Rural City Council, who are providing advice to executive members on **policies and practices relating to improved Cultural responsiveness**.

Indirect influence of project leaders on staff within organisations to champion actions including provision of **acknowledgements at meetings**, exploring **Aboriginal employment opportunities**, conducting **activities during Reconciliation and NAIDOC Weeks**, among others.

Target 37: Improvements to the physical environments of participating agencies to make them more culturally welcoming

Result: **Achieved**

Narrative Report

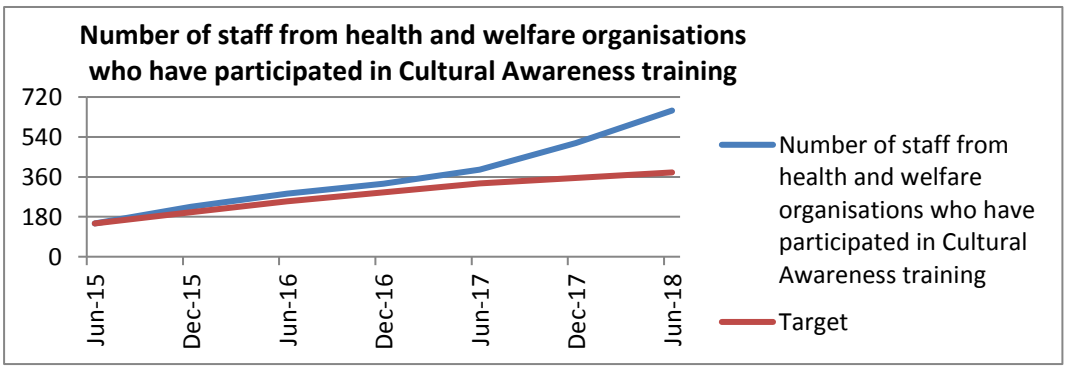
13 organisations have participated in two rounds of cultural audits of the physical environments within their buildings, led by local Aboriginal community members. These organisations have each received a **comprehensive report** which provides a **set of recommendations** to improve these environments so that they are **more culturally welcoming and inclusive.**

Key improvements made include **installation of Acknowledgement plaques** (8 organisations), **display of locally commissioned artwork** (4 organisations), and **installation of flag sets** (20 organisations) **with flag stands** created by the Horsham Men's Shed.

Target 38: An increase in the total number of staff from health and welfare organisations who have participated in Cultural Awareness training (from 150 staff at June 2015) to:

- 250 at June 2016
- 330 at June 2017
- 380 at June 2018

Result: **Achieved**



From 2015 to 2018 there has been:

Over 4 times increase in the number of staff from health and welfare organisations who have participated in Cultural Awareness training (150 to 659 staff).

Over 6 times increase in the total number of participants who have undertaken Cultural Awareness training (150 to 948 participants), including other organisations such as the Department of Education and Training, local schools, and Victoria Police.

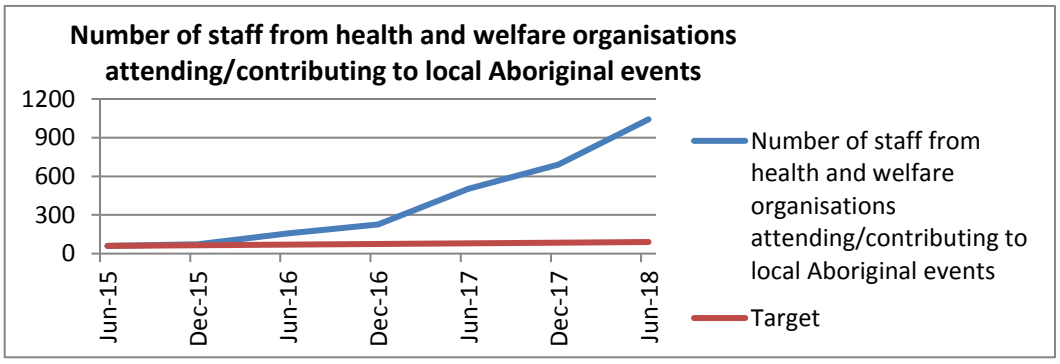
Nearly 8 times increase in the number of health and human services organisations participating in Cultural Awareness training (3 to 23 organisations).

98% of participants (326 out of 331 participants) either 'strongly agreed' or 'agreed' that the training increased their knowledge, insights and confidence to deliver more culturally appropriate and responsive services.

Target 39: An increase in the total number of staff from health and welfare organisations attending and/or contributing to local Aboriginal events (from 60 staff at June 2015) to:

- 70 at June 2016
- 80 at June 2017
- 90 at June 2018

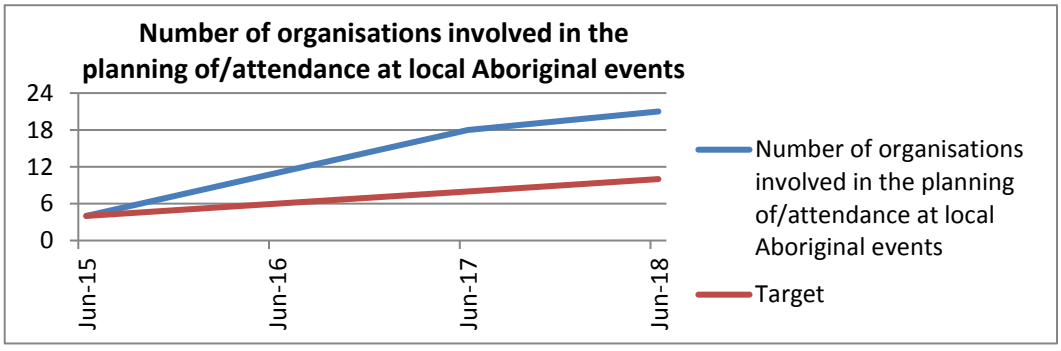
Result: **Achieved**



Over 17 times increase in total staff attendance between 2015 and 2018 (60 to 1042 people).

Target 40: An additional 2 organisations per financial year will be involved in the planning of, and attendance at, local Aboriginal events (from 4 organisations at June 2015)

Result: **Achieved**



Over 5 times increase in the number of organisations involved in the planning of/attendance at local Aboriginal events between 2015 and 2018 (4 to 21 organisations).

Target 41: An additional two collaborative service planning and delivery initiatives to be undertaken per financial year

Result: Achieved

Narrative Report

Examples of key collaborative initiatives that have taken place between 2015 and 2018 include:

Cultural Dinner for CEOs and board members of health services and councils across the Wimmera, with a total of **50 attendees**.

Bus Trip to Echuca to visit Echuca Regional Health and Njernda Aboriginal Corporation to learn about culturally responsive health service delivery. Attended by **30 staff** from Wimmera Health Care Group, Goolum Goolum Aboriginal Cooperative, Wimmera PCP, Grampians Community Health and DHHS.

Development of **'Wotjobaluk Bumper Stickers'** for multi-purpose use such as displayed in cars, shops, workplaces, etc.

Engagement of local Men's Shed in the creation of Flag Stands which house the Aboriginal, Torres Strait Island, and Australian Flags within **20 organisations across the Wimmera.**

Display of community created banners on the light posts along the main street of Horsham during **NAIDOC Week 2018**.

Target 42: Increased satisfaction and experience of health services by local Aboriginal community members (narrative report)

Result: Progressing

Narrative Report only

Anecdotal feedback from local Aboriginal patients and clients reveals some **positive improvements in service delivery**, resulting from **greater collaboration between health and human services organisations and local Aboriginal organisations and community members**, particularly in terms of **seeking advice and guidance in the creation and implementation of policies and practices**.

Project 6: Regional Aboriginal Eye Health project

Organisation: Auspiced through Budja Budja Aboriginal Cooperative

Commencement Year: 2014

Duration at 2019: 3 years (ceased in 2016)

Key areas of focus:
Access to eye examinations (including retinal examinations for people with diabetes), access to spectacles, access to cataract surgery, improvements in knowledge and awareness of poor eye health as an issue.

Relevant Statewide Koolin Balit Indicators
1.7 Increase in Aboriginal people accessing eye health services

Brief Overview

The Regional Aboriginal Eye Health project came to fruition in May 2014 when a co-funded opportunity arose between the regional and central offices of the then Department of Health.

Although the area of 'eye health' had not been identified as a priority of focus within the region at the commencement of the Koolin Balit period, the project presented an opportunity to respond to evidence presented in the Roadmap to Close the Gap for Vision ('The Roadmap').

Implementation of this project took place from July 2014 to December 2016, with the underlying purpose to improve eye health outcomes for Aboriginal people across the region.

The project was overseen by the Grampians Region Aboriginal Eye Health Advisory Group (GRAEHAG), which comprised a group of partners (refer Attachment III for full partner list) who met quarterly across the project's duration to guide the implementation, monitoring and reporting of progress against the project plan.

The project achieved many impressive outcomes including significant increases in the numbers of Aboriginal community members receiving eye examinations, spectacles, ophthalmology consultations and cataract surgeries, to name a few.

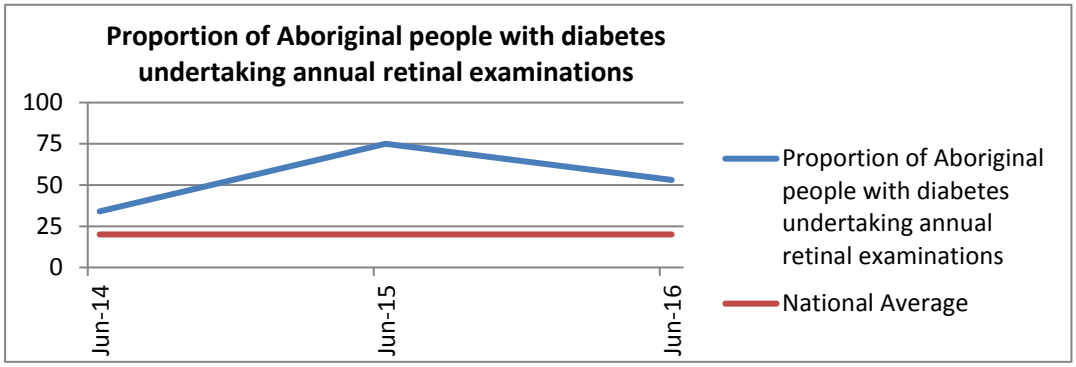
It was regarded as a leading project amongst twelve like projects across the country at the time, with an article about the model adopted for the project published in the Medical Journal of Australia in February 2017.

Other positive outcomes included local, state wide and national level media opportunities, including project presentations provided at various state and national conferences.

A full report for this project was published in 2017.

Target 43: An increase in the proportion of Aboriginal people with diabetes (either type 1 or 2) undertaking annual retinal examinations

Result: Achieved

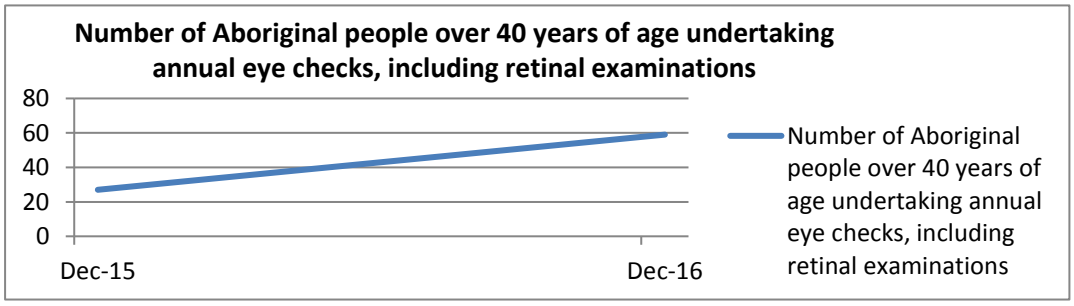


An **increase from 34% to 53%** (31 to 54 people) between 2014 and 2016 (National rate during this period was 20%).

Achievement of a **regional rate of 75%** (71 people) during 2015, largely due to a 95% rate for Goolum's catchment resulting from a targeted diabetes prevention and management campaign.

Target 44: An increase in the number of Aboriginal people over 40 years of age, undertaking annual eye checks, including retinal examinations

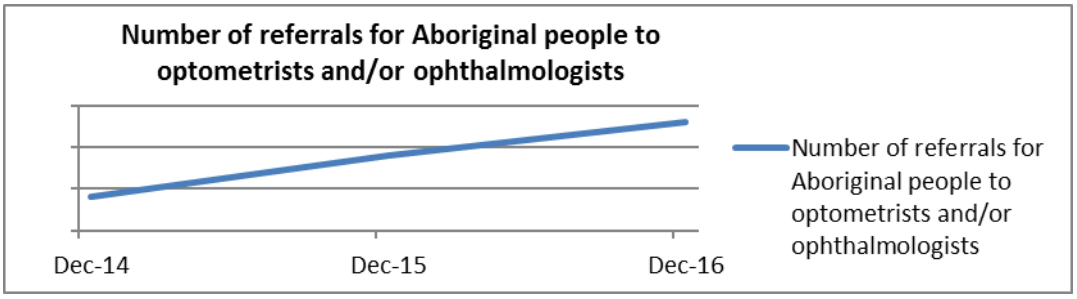
Result: Achieved



A **doubling** (27 to 59 people) between 2015 and 2016.

Target 45: An increase in the number of referrals for Aboriginal people to optometrists and/or ophthalmologists *

Result: Achieved

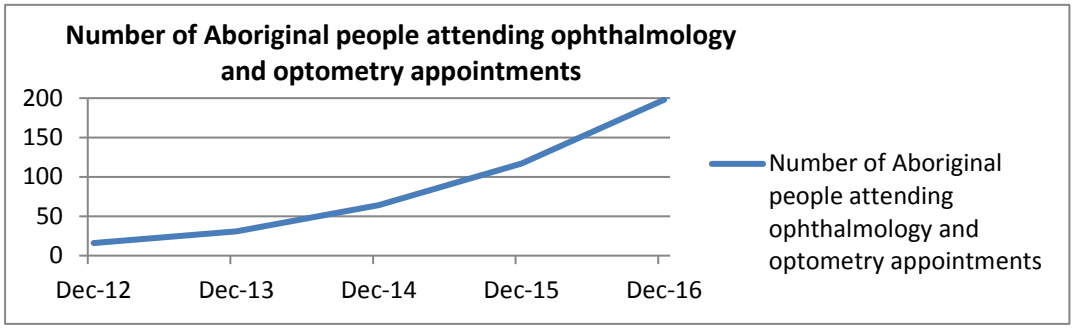


Over 3 times increase in referrals between 2014 and 2016.

** Value/s not disclosed to protect privacy.*

Target 46: An increase in the number of Aboriginal people attending ophthalmology and optometry appointments

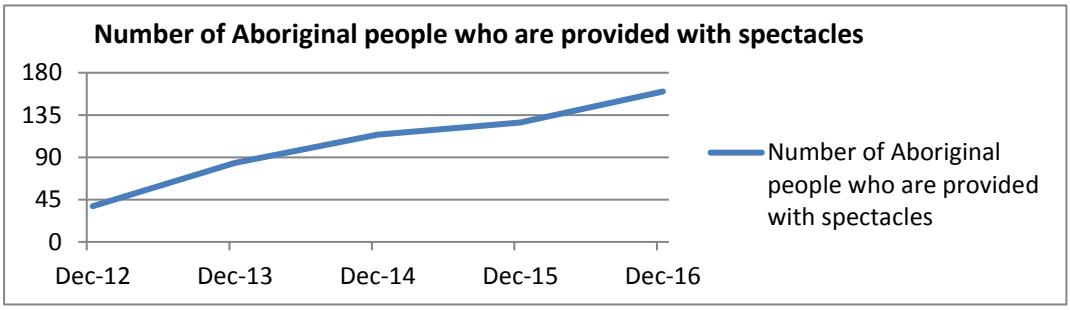
Result: Achieved



Over 12 times increase between 2012 and 2016 (16 to 198 people).

Target 47: An increase in the number of Aboriginal people who are provided with spectacles

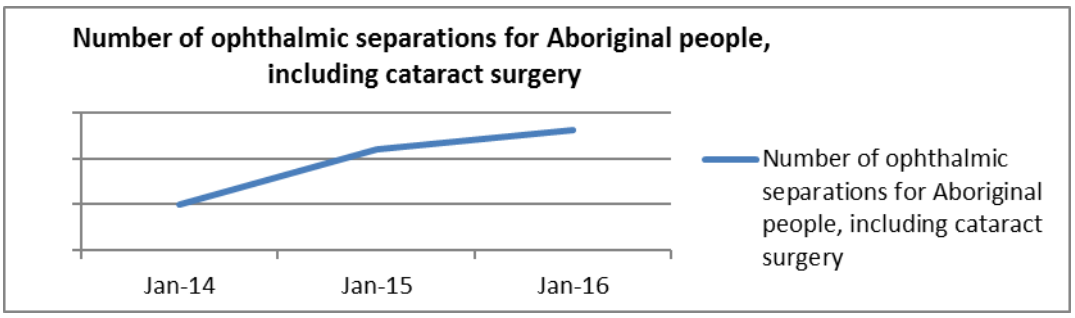
Status: Achieved



Over 4 times increase between 2012 and 2016 (38 to 160 people).

Target 48: An increase in the number of ophthalmic separations for Aboriginal people, including cataract surgery *

Result: Achieved



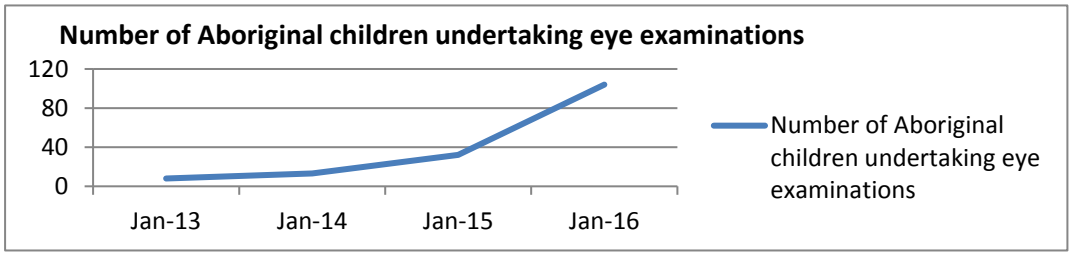
Nearly 3 times increase between 2014 and 2016.

Full clearance of waiting list in 2016.

** Value/s not disclosed to protect privacy.*

Target 49: An increase in the number of Aboriginal children undertaking eye examinations

Result: **Achieved**



A **13 times increase** between 2013 and 2016 (8 to 104 children).

Local evidence revealed **9% (8 out of 86 children) required glasses** and a **further 23% (20 out of 86 children) required follow up for an eye issue**.

A total of 67% (58 out of 86 children) were tested within school settings.

Target 50: An increase in the awareness and knowledge of poor eye health as a significant health issue

Result: **Achieved**

Narrative Report only

Anecdotal feedback of **improvements in the awareness and knowledge of poor eye health as a significant health issue**.

'Check Today, See Tomorrow' National health promotion campaign aimed at increasing the number of Aboriginal people with diabetes undertaking annual retinal examinations. Involved the creation of a suite of **locally created resources** including a **promotional you tube clip and related stories, polo tops, and hard copy resources** circulated to ACCHOs, general practices and community health centres.

Aboriginal Eye Health Seminar held in Ballarat in 2016, with **60 participants** from a range of organisations including local optometry practices, general practices, community health, health services, ACCHOs, University of Melbourne, Australian College of Optometry, VACCHO and DHHS.

Target 51: An increase in the number of Aboriginal prisoners undertaking eye examinations

Result: **Achieved but further work required**

Narrative Report

Strong existing partnership between local optometrist and correctional facilities in the region to ensure regular delivery of services within the prison system.

Identification of **need for better systems and processes to ensure health checks and referrals are undertaken by Aboriginal prisoners upon entry into prison**.

Target 52: An increase in the number of vulnerable Aboriginal children undertaking eye examinations

Result: Progressing

Narrative Report

Aboriginal children in Out of Home Care have been identified and prioritised to undertake eye examinations.

Closing Comments and Reflections

The value of strong evaluative practices in the region over the past nine years has been crucial to informing program development and making sound decisions regarding funding allocation. It has also provided a mechanism for building an evidence base about what programs and activities have and haven't worked from a Culturally appropriate perspective.

However, none of this has occurred without the hard work and consistent effort of a committed group of partners and workers, where relationships and levels of trust have continued to foster over time. Relationships based on mutual respect and a clear and united vision about the path being taken.

This has not come without the expected challenges and minor setbacks associated with any collaborative endeavour, to which the partnership has always managed in an open and respectful way. The old adage "the whole is greater than the sum of its parts" has certainly been an underlying philosophy that has been shared by the partnership.

As we transition into the new policy period that is Korin Korin Balit-Djak, the region feels well equipped to enact the principles that underpin the policy, by continuing those very practices which have served them well in the periods gone before.

Appendix I. Full list of Project Measures

Project 1: Chronic Disease Prevention and Management program (BADAC)

- Number of annual individual health assessments conducted per financial year
- Number of individual care plans developed per financial year
- Number of individual care plans reviewed per financial year
- Number of local Aboriginal community members who are participating in quit smoking programs/sessions, as well as an increase in the number of quit attempts and readiness to quit
- Percentage of community members who are current daily smokers
- Percentage of community members who register a high blood pressure reading
- Percentage of community members who register a normal blood pressure reading
- Average collective body mass index of community members
- Percentage of community members with total blood cholesterol levels higher than 5.5 mmol/L
- Percentage of community members with HbA1c levels > 10 %

Project 2: Chronic Disease Prevention and Management program (Budja)

- Percentage of community members who are regular smokers
- Number of Aboriginal community members whose BMI falls within the following categories:
    - Overweight
    - Obese
    - Morbidly Obese
- Number of community members who regularly participate in fortnightly physical activity and healthy eating sessions
- Percentage of Aboriginal community members who are registered clients at Budja's medical clinic who have the following health plans and reviews in place:
    - Chronic Disease GP Management Plan
    - Chronic Disease Team Care Plan and Plan Review
- Percentage of Aboriginal clients with diabetes who undertake regular testing of their HbA1c levels, along with cholesterol, blood pressure, waist measurements and smoking status
- Percentage of community members with diabetes who have a GP Management Plan or a Team Care Management Plan.

Project 3: Social and Emotional Wellbeing program (Budja)

- Number of community members with a diagnosed mental health issue who are accessing counselling services provided at Budja
- Number of mental health care plans written per financial year for community members with a diagnosed mental health issue
- Number of days a counselling service is provided at Budja for community members with a diagnosed mental health issue
- Clear referral pathways between Budja and mainstream health partners (particularly Grampians Community Health) continue to be strengthened, particularly for issues associated with excessive alcohol consumption, smoking, illicit and prescription substance abuse and domestic violence (narrative report)
- Provision of outreach mainstream health services at Budja in areas including alcohol and substance misuse and domestic violence (currently only half a day per fortnight)

Project 4: *Wirrin-ditch-murrun-dalk* (Children Living Healthy) program (Goolum)

- Number of Aboriginal people who have taken the pledge to quit smoking in the home around children
- Number of self-referrals into Goolum's smoking cessation service, as a result of the online 'Take the Pledge' campaign
- Levels of knowledge, confidence and capacities of current smokers to address their smoking in the home around children
- Number of people who have quit smoking
- Average number of quit attempts made by current smokers
- Average number of cigarettes smoked per day
- Number of child health checks conducted
- Number of Aboriginal children who are referred to dental services
- Levels of knowledge, confidence and capacities of Aboriginal children and their families to address unhealthy eating choices and consumption of sugary drinks (narrative report)
- Percentage of confirmed Aboriginal children in Out of Home Care (OoHC) within GGAC's service area who have received a child health check
- Percentage of confirmed Aboriginal children in OoHC within Goolum's service area who have received a dental check
- Percentage of confirmed Aboriginal children in OoHC within Goolum's service area who have been referred to other essential health services as required
- Number of Aboriginal adolescents who access welfare and support services, including counselling sessions at Goolum per calendar year
- Number of Aboriginal adolescents participating in activities to improve their sense of identity, self-esteem, physical health and social/emotional well-being (narrative report)

Project 5: Towards Cultural Security project (WPCP)

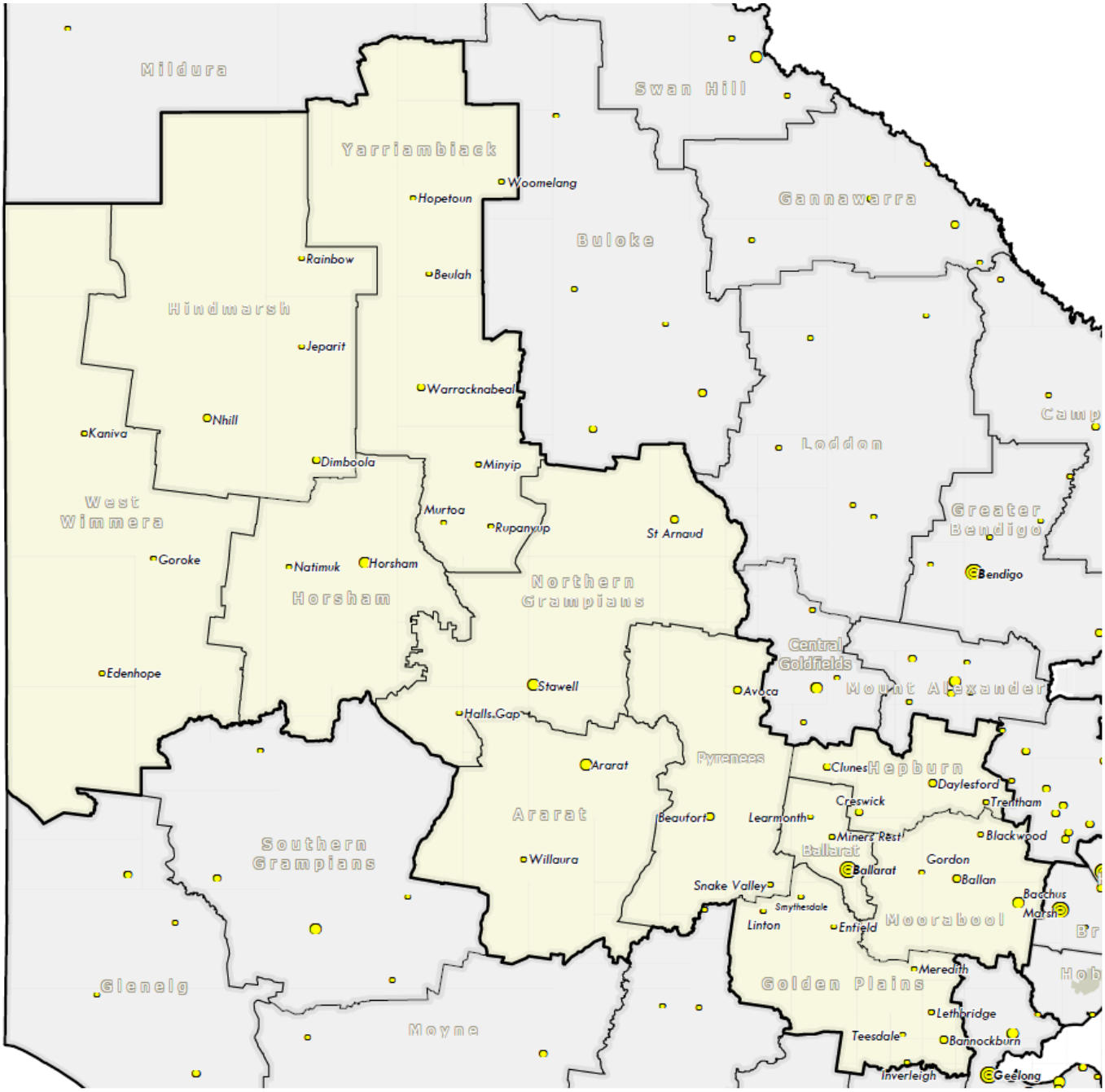
- Number of WPCP member organisations who have reviewed policies to improve culturally appropriate service delivery, and to implement the recommendations of these policies
- Improvements to the physical environments of participating agencies to make them more culturally welcoming
- Number of staff from health and welfare organisations who have participated in Cultural Awareness training
- Number of staff from health and welfare organisations attending and/or contributing to local Aboriginal events
- Number of organisations involved in the planning of, and attendance at, local Aboriginal events per financial year
- Number of collaborative service planning and delivery initiatives undertaken per financial year
- Level of satisfaction and experience of health services by local Aboriginal community members (narrative report)

Project 6: Regional Aboriginal Eye Health project

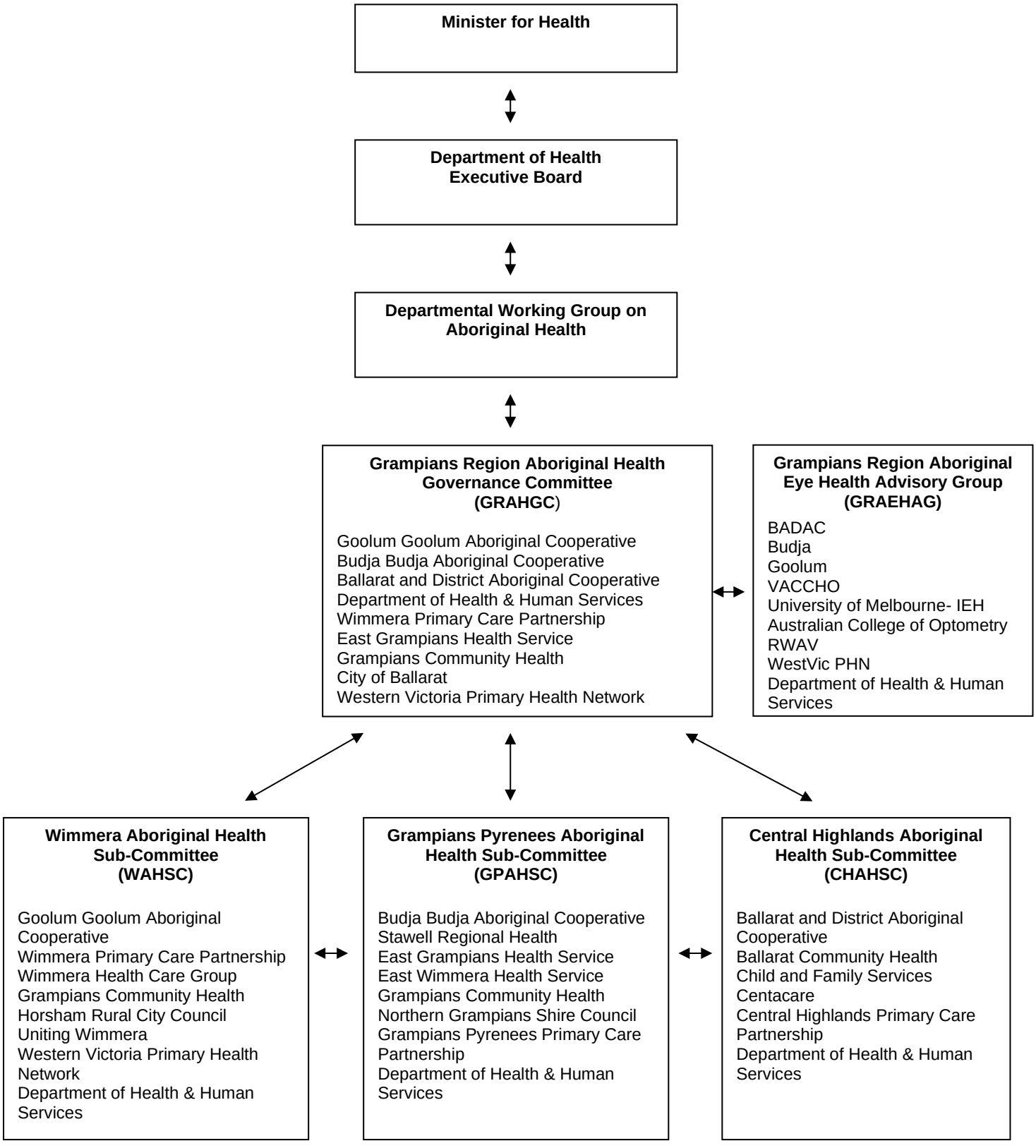
- Proportion of Aboriginal people with diabetes (either type 1 or 2) undertaking annual retinal examinations
- Number of Aboriginal people over 40 years of age, undertaking annual eye checks, including retinal examinations
- Number of referrals for Aboriginal people to optometrists and/or ophthalmologists
- Number of Aboriginal people attending ophthalmology and optometry appointments
- Number of Aboriginal people who are provided with spectacles

- Number of ophthalmic separations for Aboriginal people, including cataract surgery
- Number of Aboriginal children undertaking eye examinations
- Level of awareness and knowledge of poor eye health as a significant health issue
- Number of Aboriginal prisoners undertaking eye examinations
- Number of vulnerable Aboriginal children undertaking eye examinations

Appendix II. Map of Grampians Region



Appendix III. Koolin Balit Governance Structure for Grampians Region



Appendix IV. Koolin Balit Reporting Template

This report is due for submission to the Aboriginal Health and Wellbeing Branch by 31 March each year for the July to December period and 30 September for the January to June period by email to aboriginalhealthandwellbeing@dhhs.vic.gov.au.

All text in square brackets is for guidance only and should be removed prior to submission.

[Program Area/Region/Agency] **[Reporting Period]**

[Project / Program title]

Prepared by:	Individual] (Contact Details, including organisation)
Endorsed by:	[Regional Aboriginal Health Advisory Committee (if applicable]
Approved by:	[Regional Director of Health and Aged Care / Program Area Director/Executive Director]

Traffic Light Status report

■ (1)	Significant issues are impacting on achieving objectives or delaying implementation	[Insert appropriate symbol here for each project]
▲(2)	Emerging or anticipated issues may impact on the achievement of objectives	
● (3)	No current issues and implementation progressing as planned	

Progress against Key Performance Indicators from your plan

Performance Indicators	Report
[add rows as necessary]	**[add rows as necessary]**
[add rows as necessary]	**[add rows as necessary]**

Please describe any key successes or good news stories and what factors contributed to these.

Please describe any barriers or challenges to implementation and strategies for addressing these.

Please describe any aspects of the project where additional support from the department (including both central and the regional office) would be beneficial.

Have any resources been developed as part of the project? If so, have a copy of these been provided to DHHS and would you be supportive of these to be provided to other projects to support sharing of learnings and information?

Are you, or will you be doing an evaluation of this project (separate from the statewide evaluations currently underway?
☐ **Yes, planned** ☐ **Yes, underway** ☐ **No, we have decided a project level evaluation is not necessary/appropriate**

Appendix V. Koolin Balit Statewide Indicators

Objective		Indicator	Measure	Data source	Frequency	Regional
Outcome 1: Aboriginal Victorians are confident they will be provided with the highest quality health services regardless of who provides them						
1. Increase the number of Aboriginal Victorians accessing health services	1.1	Increase in proportion of Aboriginal children and families who participate in maternal and child health key age and stage visits	Proportion of Aboriginal children who participate in Maternal and Child Health (MCH) key age and stage visits, particularly first home visit and 3.5 years visit.	DET MCH	Annual	No
	1.2	Increase in proportion of Aboriginal children immunised at key age milestones	Proportion of Aboriginal children fully vaccinated at 12, 24, 60 months. Australian Childhood Immunisation Database (ACIR), percentage of children enrolled in Medicare who are fully immunised for age, by Aboriginal status.	ACIR	Annual	Yes
	1.3	Increase in uptake of programs that aim to improve positive lifestyle behaviour during pregnancy to help provide an optimum environment for the baby to grow	i. Proportion of mothers who attended at least one antenatal care session ii. Proportion of mothers whose first antenatal care session occurred in the first trimester	VPDC	Annual	To be determined
	1.4	Increase in access to mental health services earlier for young Aboriginal people	i. Hospital separation rates of young Aboriginal people (15-24 years) for mental health-related conditions. ii. Emergency Department presentations of young Aboriginal people (15-24 years) for mental health-related conditions. iii. Mental health care service contact rates for young Aboriginal people related to selected mental health-related conditions	i. VAED ii. VEMD	Annual	Yes
	1.5	Increase in Aboriginal people accessing mainstream community health services, aged care assessment services and HACC services	i. Number/proportion of Aboriginal people receiving mainstream community health services (nursing and allied health), ii. Number/proportion of Aboriginal people receiving aged care assessment services iii. Number/proportion of Aboriginal people aged less than 50 receiving HACC nursing and allied health services iv. Number/proportion of Aboriginal people aged 50-plus receiving HACC (CHSP from July 2015) nursing and allied health and assessment services	i. CHMDS ii. ACAP MDS ii. HACC MDS v. HACC MDS	Annual	Yes

Objective		Indicator	Measure	Data source	Frequency	Regional
	1.6	Increase in Aboriginal people accessing eye health services	i. Number of Aboriginal people attending eye health consultations (Victorian Eyecare Scheme) ii. Rate of cataract surgery per 1000 population aged 50-59 years and over 60 years. iii. Number of Aboriginal people receiving diabetic retinopathy screening (when available). iv. Difference between rates of diabetic retinopathy screening for Aboriginal and non-Aboriginal people.	i Aboriginal Spectacle Scheme plus VES ii VAED iii & iv MBS	Annual	Yes
	1.7	Increase in access to services addressing chronic conditions	i. Rate of ambulatory care sensitive conditions (ACSC) hospital separations **(BP3 measure)** ii. Rate of hospital separations for selected chronic conditions (asthma, cardiovascular, diabetes - COPD) Appropriate age ranges vary depending on the condition. Asthma 35-64 years Diabetes 15-74 years. Access to data to be confirmed. CVD 45-59 years COPD 40-49 years iii. Number of MBS Item 715 Aboriginal health assessments iv. Number of GP Management Plans and Term Care Arrangements claimed through Medicare	i,ii VAED iii, iv MBS	i Annual ii Annual iii Annual iv Annual	Yes
2. Improve the cultural responsiveness of the health system	2	Improvement in Aboriginal people's experience of healthcare	i. Proportion of Aboriginal hospital inpatients rating their care whilst in hospital as good or very good, and the difference between Aboriginal and non-Aboriginal respondents ii. Proportion of Aboriginal people who rate the discharge process from hospital as good or very good (and the difference between Aboriginal and non-Aboriginal respondents) iii. Aboriginal people's response rate to the Victorian Healthcare Experience Survey (adult inpatient survey)	i - iii Victorian Healthcare Experience Survey – adult inpatient survey	Quarterly	No
3. Improve early detection rates for preventable and treatable conditions	3	Increase in uptake of screening and early detection services and improved system response (across a range of preventable conditions)	i. Selected cancer screening rates ii. Selected health assessment rates iii. Selected early intervention hospital separations for selected conditions	i,ii Breast Screen and other screening program registry data iii VAED	Annual	No

Objective		Indicator	Measure	Data source	Frequency	Regional
4. Increase the skilled Aboriginal health workforce	4.1	Increase in the number of upskilled Aboriginal workers in ACCHOs, community health services and mainstream public health services	Number of workers completing DHHS ATSI training grants in ACCHOs, community health services and mainstream public health services	Training Grant data submitted to DHHS (Health Workforce Planning Initiatives)	6 monthly	Yes
	4.2	Increase in the number of Aboriginal people employed in the mainstream health workforce	i. Number/proportion of Aboriginal people employed in the mainstream public health workforce ii. Number of public health services with an Aboriginal Employment plan iii. Number of cadetships (nursing and allied health) iv. Number of nursing and midwifery graduates	i VPSCAWS ii-iv Health Workforce Planning Initiatives	Annual	Yes
	4.3	Increase in the impact/s of grants and traineeships provided to Aboriginal people	Measures to be determined through the forthcoming evaluation 'Evaluating Aboriginal Health Workforce Development in Victoria' which is due to report, including recommendations on monitoring the impacts of grants and traineeships, in September 2015.	To be determined in Sep 2015	To be determined in Sep 2015	To be determined
5. Improve patient pathways for Aboriginal people	5.1	Improve links between mainstream and Aboriginal community organisations	i. Number of Koori Maternity Services (KMS) sites ii. Number of ACCOs who are members of their local PCP (annually) iii. Number of ACCOs that are members of their PCP's governance group (annually)	i. Maternity and Newborn Program ii. DHHS Service Coordination Survey iii. DHHS Service Coordination Survey	i. To be determined ii. Annual iii. Annual	To be determined
	5.2	Improve identification rates of Aboriginal health service users	i. Proportion of Aboriginal inpatients correctly identified as Aboriginal. ii. Level of identification of Aboriginal CHS clients iii. Level of identification of Aboriginal clients in HACC services	i. AIHW 2011 ii. CHS iii. HACC	To be determined	Yes
	5.3	Improve cultural responsiveness of, and cultural safety experienced in, Victorian hospitals	To be determined through the forthcoming evaluation 'Improving Cultural responsiveness of Victorian hospitals' which is due to report, including recommendations on measuring CR & CS, in August 2016.	To be determined in Aug 2016	To be determined in August 2016	To be determined
Outcome 2: Improved quality of life for Aboriginal Victorians						
6. Improve the overall wellbeing of Aboriginal people	6.1	Increase in the proportion of Aboriginal adults reporting excellent or very good health **(VAAF measure)**	Proportion of Aboriginal and non-Aboriginal adults reporting excellent or very good health	AATSIHS 2012/13	Approximately every 3 years	No

Objective		Indicator	Measure	Data source	Frequency	Regional
	6.2	Reduction in the proportion of Aboriginal adults reporting 'high or very high' levels of psychological distress **(VAAF measure)**	Proportion of Aboriginal and non-Aboriginal adults reporting 'high or very high' levels of psychological distress	AATSIHS 2012/13	Approximately every 3 years	No
	6.3	Reduction in the rate of presentations of young Aboriginal people (15-24) to emergency departments for injury.	i. Rate of presentations of young Aboriginal people to emergency departments for injury ii. Rate of inpatient separations of young Aboriginal people for injury iii. Mental health care service contact rates related to injury and self-harm	i. VEMD ii. VAED	Annual	Yes
7. Improve the health outcomes of Aboriginal mothers and babies	7.1	Reduction in the Aboriginal perinatal mortality rate **(VAAF measure)**	Aboriginal perinatal (stillbirths and neonatal deaths <28 days) mortality rate per 1000	VPDC	Annual	No
	7.2	Decrease in the percentage of Aboriginal babies with low birth weight below 2500 grams **(VAAF measure)**	Proportion of Aboriginal babies with low birth weight (< 2500 grams)	VPDC	Annual	No
	7.3	Increase in breastfeeding rates for mothers of Aboriginal babies	i Proportion of Aboriginal children ever breastfed ii Proportion of Aboriginal children exclusively breastfed to 6 months of age or greater	i. AATSIHS ii. National Infant Feeding Survey	Dependent on survey frequency	No
8. Reduce the rate of smoking in the Aboriginal population	8.1	Reduction in smoking in pregnancy by mothers of Aboriginal babies	i. Proportion of mothers of Aboriginal babies who smoked in the first half of pregnancy ii. Proportion of mothers of Aboriginal babies who smoked in the first half of pregnancy and quit iii. Proportion of mothers of Aboriginal babies who smoked in the first half of pregnancy and continued to smoke	VPDC	Annual	No
	8.2	Reduction in the proportion of Aboriginal children and young people living in households with a current daily smoker	Proportion of Aboriginal children and young people living in households with a current daily smoker.	NATSISS & NATSIHS	Approximately every 3 years	No
	8.3	Reduction in the proportion of Aboriginal young people who smoke	Proportion of Aboriginal young people who smoke	NATSISS and NATSIHS/ AATSIHS	Approximately every 3 years	No
	8.4	Reduction in the proportion of Aboriginal adults who are current smokers **(VAAF measure)**	Proportion of Aboriginal people who smoke	AATSIHS	Approximately every 3 years	No

Objective		Indicator	Measure	Data source	Frequency	Regional
9. Reduce alcohol related harm experienced by Aboriginal people	9.1	Reduction in the use of illicit drugs and risky drinking among young Aboriginal people (ages 15-24)	i. Hospital separation rates of young Aboriginal people for mental disorders due to alcohol and drugs use ii. Selected AOD health care service contact rates for young Aboriginal people iii. ED presentations of young Aboriginal people for mental disorders due to alcohol and drug use	i. VEMD ii. VAED ii. ADIS	Annual	Yes
	9.2	Reduction in the rate of Aboriginal emergency department presentations and hospital separations due to alcohol consumption	i. Rate of Aboriginal emergency department presentations for mental disorders due to alcohol consumption (ICD -10, F10), ii. Rate of Aboriginal hospital separations for mental disorders due to alcohol consumption (ICD-10, F10) iii. Rate of hospital separations for alcoholic liver disease and cirrhosis (K70,74)	i VEMD i,ii VAED	Annual	Yes
Outcome 3: Reduced burden of disease						
10. Reduce the proportion of Aboriginal adults who are obese or overweight	10	Reduction in the proportion of Aboriginal adults who are obese or overweight	Proportion of Aboriginal adults who are obese or overweight	AATSIHS	Approximately every 3 years	No
11. Improve the oral health of Aboriginal people	11	Reduction in the prevalence of oral diseases among Aboriginal children and adults	i. Decayed, filled, missing teeth in children 0-5 years (dfmt) ii. Rate of hospital separations for dental caries, Aboriginal children 0-9 years. iii. Rate of hospital separations for embedded/ impacted teeth, Aboriginal patients 10-29 years.	i DHSV ii, iii VAED	Annual	Yes
12. Reduce the prevalence of chronic diseases in Aboriginal people	12	Reduction in prevalence of chronic diseases reported in AATSIHS	Percentage of Aboriginal people with chronic health conditions reported in AATSIHS	AATSIHS	3 years	No