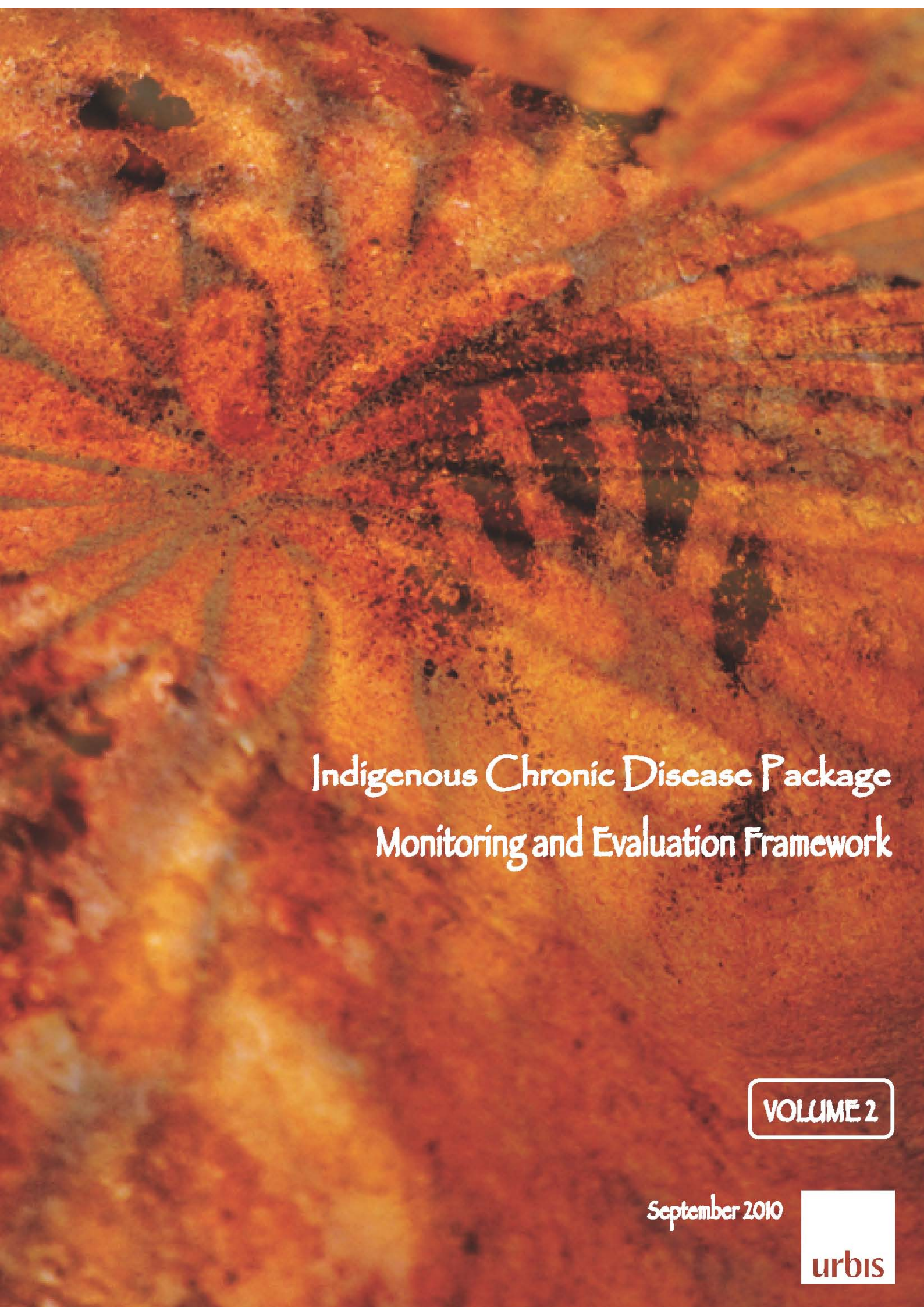

Indigenous Chronic Disease Package Monitoring and Evaluation Framework

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Program Logic A1: National Action to Reduce Indigenous Smoking Rates

Medium term results - Late-medium term (years 5-10)	▪ Key predictors of quitting smoking have increased among Indigenous Australians. ▪ Smoking rates are reduced among key target groups.
Medium term results - Early-medium term (year 4+)	▪ Demand for Indigenous smoking cessation programs and support services is strong. ▪ The health workforce is better informed and resourced to promote smoking cessation among Indigenous Australians.
Early results (years 2-4)	▪ Individuals and communities in contact with A1 activities are: – more aware of the health risks associated with smoking – more aware of the resources available to help them quit or cut back – more inclined to seek assistance as part of quit attempts. ▪ Smoking cessation communication activities, resources and programs are accessed and valued by Indigenous Australians. ▪ Australia has a growing tobacco control workforce (at national, state, regional and local levels) available to assist Indigenous Australians, that is well trained and strengthens overall Indigenous health workforce. ▪ Primary health care services demonstrate increased capacity to: – deliver smoking cessation messages and support to Indigenous Australians – develop partnerships to support cessation attempts by Indigenous Australians. ▪ Health professionals have better access to smoking cessation resources, services and materials to support their own cessation attempts. ▪ Participating services are smoke-free workplaces and/or implementing smoke-free policies. ▪ Evidence that research, monitoring and evaluation is being used to inform future smoking cessation communication activities and program development.
Outputs (year 1 and ongoing)	▪ RTCs and TAWs are recruited and trained. ▪ The training for health workers is well received and well regarded. ▪ Communication activities (including at the local level and by Quitlines) are designed and delivered. ▪ Enhanced or new smoking cessation services and programs (local and Quitline) are designed and delivered. ▪ Measure-specific evaluation activities are planned and implemented.

Activities	**PART A: Tobacco control campaign activities** ▪ Establish a national network of 57 Regional Tobacco Coordinators (RTCs) to work with communities and health services. ▪ RTCs to design and deliver locally-owned tobacco control communication activities based on market research and consultations, with a focus on awareness-raising, education and promoting use of the available support services. ▪ Enhance existing (state/territory) Quitline services to improve the service provided to Indigenous Australians. ▪ Establish networks to share best practice and innovation. ▪ Evaluation of the above. **PART B: Workforce, training, services and programs** ▪ Recruit, train and support approximately 170 Tobacco Action Workers (TAWs) (up to 3 per site x 57 regions, staged introduction over time). These are community awareness and development roles that work in conjunction with smoking cessation practitioners. ▪ Train up to 1,000 other workers (including health workers; youth, drug and alcohol workers; social and emotional wellbeing workers; and community educators specialising in smoking cessation) in brief interventions ▪ Work with local communities to develop quit-smoking services and education programs for children, young parents (including pregnant women and their partners) and families. ▪ Develop and disseminate education kits and training resources. ▪ Evaluation of the above.
Aims	▪ To reduce smoking rates for key groups within Indigenous communities such as young people, health workers and pregnant women. ▪ To develop a national, regional and local tobacco control workforce capable of delivering smoking cessation programs and communication activities in Indigenous communities.

Late-medium term results (years 5-10)				
A1[1] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[2]**	**Data collection**
▪ Key predictors of quitting smoking have increased among Indigenous Australians.	How much impact has been made on smoking behaviours among key target groups?	Population-level or sample incidence rates for various behavioural and attitudinal measures	Community members survey: A1 evaluation	To be determined
▪ Smoking rates are reduced among key target groups.	To what extent have smoking rates reduced?	Smoking rates among adults	HPF #2.18	Year 4 Data collected yearly: Baseline 2008
	What evidence is there of reduction of smoking in pregnancy?	Smoking rates during pregnancy	HPF #2.19	Year 4 Data collected annually: Baseline 2007

Early-medium term results (year 4+)				
A1[3] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[4]**	**Data collection**
▪ Demand for Indigenous smoking cessation programs and support services is strong.	What demand is there for Indigenous smoking cessation programs and support services?	Number of prescriptions for anti-tobacco drugs listed on the PBS (ie Champix) Access to Quitline services	PBS dataQuitline	Annual Year 4
▪ The health workforce is better informed and resourced to promote smoking cessation	To what extent is the health workforce better informed and resourced?	Increased knowledge and self-reported confidence and understanding among relevant health workers	Health workforce survey	Year 4

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2 For reference to data sources, please see Volume 3, Appendix E

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4 For reference to data sources, please see Volume 3, Appendix E

among Indigenous Australians.				

Early results (years 2-4)

A1[5] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[6]**	**Data collection**
▪ Individuals and communities in contact with A1 activities are: - more aware of the health risks associated with smoking - more aware of the resources available to help them quit or cut back - more inclined to seek appropriate assistance as part of quit attempts.	In communities where A1 activities have been more concentrated, to what extent have individuals and communities demonstrated increased awareness and inclination to address smoking-related behavioural risk factors, protective factors and help seeking behaviours?	Demonstrated awareness of health risks and increased inclination to address smoking-related risk factors among Indigenous Australians as a result of A1 activities	Community members survey: A1 evaluation	To be determined
			Community members consultation	Year 4
	What can be learned about why Indigenous Australians may choose not to participate in A1 activities?	Perceptions of Indigenous Australians regarding A1 activities and identification of reasons some may choose not to participate	Community members survey: A1 evaluation	To be determined
			Community members consultation	Year 4
▪ Smoking cessation communication activities, resources and programs are accessed and valued by Indigenous Australians.	To what extent are the A1 smoking cessation communication activities, resources and programs accessed by Indigenous Australians?	Program/service utilisation figures (eg calls to Quitline, inquiries to services)	Program documentation	Year 4
	How satisfied are Indigenous Australians with the smoking cessation programs and supports that they access or have available to them?	Levels of satisfaction with Quitline, other programs and supports	Service/program client feedback surveys	Ongoing
			Community members consultation	Year 4
▪ Australia has a growing tobacco control workforce (at national, state, regional and local levels) available to assist Indigenous Australians, that is well trained and strengthens overall Indigenous health workforce.	How many of the recruited workers stay in the Indigenous health workforce	Number of recruited RTCs and TAWs who are retained through 2013	Program documentation	Year 4
		Experiences and perceptions of health care providers regarding employment patterns of recruited workers	Organisational survey	Year 4

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[6] For reference to data sources, please see Volume 3, Appendix E

Early results (years 2-4)				
A1[5] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[6]**	**Data collection**
	How effective has the broader health worker training been in strengthening Indigenous smoking cessation capacity of those who have been trained?	Self-reported impact of health worker training by participants	Health workforce survey	Year 4
			Training feedback forms	Year 4
	What additional training or support is required, and for whom?	Identification of training gaps and enhancements by RTCs, TAWs and health care providers	Consultation with RTCs, TAWs and providers	Years 2, 4
▪ Primary health care services demonstrate increased capacity to: – deliver smoking cessation messages and support to Indigenous Australians – develop partnerships to support cessation attempts by Indigenous Australians.	How effectively have the RTCs been able to mobilise and support their TAWs? What activities have they undertaken in order to provide this support?	Evidence of RTC activities and perceived impact	Program documentation	Annually
			Consultation with RTCs and TAWs	Years 2, 4
	To what extent do the non-Indigenous health workers who deliver or support Indigenous smoking cessation programs or services demonstrate cultural awareness?	Demonstration of cultural awareness	Community members survey: A1 evaluation	Year 4
	How effective has the state/region-based mentoring approach been in supporting RTCs?	Perceptions of RTCs regarding effectiveness of mentoring approach	Consultation with RTCs	Year 4
	How effective have primary health care services been in developing partnerships to support cessation attempts by Indigenous Australians?	Evidence of partnerships across services, and demonstration of effective activities and collaborations which have resulted	Consultation with RTCs, TAWs, ACCHSs, and other primary health care service providers	Year 4
▪ Health professionals have better access to smoking cessation resources, services and materials to support their own cessation attempts.	What impact has the ICDP had on the smoking rate among Indigenous health care professionals?	Proportion of Indigenous health care professionals intending to quit, attempting to quit, or successfully quitting as a result of ICDP-funded activities	Health workforce survey	Year 4
▪ Participating services are smoke-free workplaces or implementing smoke-free policies.	What impact has the ICDP had on participating health services becoming smoke free workplaces?	Percentage of participating health services that are smoke free, or have plans to become smoke free	Health workforce survey	Year 4
			Organisational survey	Year 4
▪ Evidence that research, monitoring and evaluation is being used to inform future smoking cessation communication activities and program development.	Are the programs and services established under A1 evidence-based?	Demonstration of sound design and genuine use of evidence	Program documentation	Year 2
	To what extent are the learnings from the evaluations adopted in future campaigns?	Design of future campaigns	Program documentation	Post 2013
			Consultation with DoHA	Year 4

Outputs (year 1 and ongoing)				
A1[7] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[8]**	**Data collection**
▪ Regional Tobacco Coordinators and Tobacco Action Workers are recruited and trained.	Where have these workers come from? Has there been any negative impact on other programs or workforce groups through movement of workers to the new positions?	Sources of recruitment, and any evidence that workers are moving within and across Indigenous health	Consultation with RTCs, TAWs and primary health care services.	Years 2, 4
			Consultation with RTCs, TAWs and primary health care services	Six monthly/ annually
	What training and support has been made available to workers?	Availability and usage of training and support options for RTCs and TAWs	Program documentation	Year 4
	How satisfied are the workers with the training and support available to them?	Level of RTC and TAW satisfaction with training and support provided	Post-training feedback surveys/RTO reporting/Health workforce survey	Year 4
			Consultation with RTCs and TAWs	Six monthly/ annually
▪ The training for health workers is well received and well regarded.	How many health workers have participated in the training (target 1,000)?	***Number of health workers and community educators trained in smoking cessation***	Program documentation	Annually
	How effective and appropriate do the participants believe the training to have been?	Level of health worker satisfaction with training provider	Post-training feedback surveys / RTO reporting	Year 4
▪ Communication activities (including at the local level and by Quitlines) are designed and delivered.	How effective have the social marketing activities been in communicating the key messages?	Extent of recall, understanding of key messages	CCommunity members survey: A1 evaluation	TTo be determined
	Are key target groups aware of the new/enhanced services and programs available?	Level of service awareness	Community members survey: A1 evaluation	To be determined
▪ Enhanced or new smoking cessation services and programs (local and Quitline) are designed and delivered.	What is the evidence base for enhancements made in the Quitlines and new programs developed?	Clarity of rationale for enhancements and use of evidence available	Funding submissions and program documentation; expert review of these	Year 4
	How easy or difficult have the new local programs been to deliver?	Evidence of difficulties faced and overcome	Program documentation	Year 4
	Do Indigenous Australians believe these services/programs are effective, appropriate? What impact have they had on the local	Awareness and perceptions of local communities regarding new smoking cessation services and programs	Community members survey: A1 evaluation	To be determined

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Early results (years 2-4)				
A1[5] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[6]**	**Data collection**
	community?			
	How well utilised are the new/enhanced services and programs?	Number of sessions conducted, ***Number of Indigenous participants***	Program documentation	Annually
▪ Measure-specific evaluation activities are planned and implemented.	What is the scope and extent of the evaluation of this measure?	Documentation of scope, methodology, rigour, timing	Program documentation	Annually
	How well have the campaign activities funded under A1 been able to respond to the lessons identified in the evaluation?	Acknowledgement of lessons learned; identification of next steps/responses	Program documentation	Year 4

PART A: Culturally appropriate tobacco control campaign activities

Activities				
A1[9] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[10]**	**Data collection**
▪ Establish a national network of 57 Regional Tobacco Coordinators to work with communities and health services.	Has the workforce been established?	***Number of RTCs recruited***	Program documentation	Annually
▪ Regional Tobacco Coordinators to design and deliver locally-owned tobacco control communication activities based on market research and consultations, with a focus on awareness-raising, education and promoting use of the available support services.	What local smoking cessation communication activities have been designed and delivered?	Creation of campaign materials, expenditure of funds	Program documentation	Year 4
▪ Enhance existing (state/territory) Quitline services to improve the service provided to Indigenous Australians	In what ways have the Quitline services been enhanced for Indigenous Australians?	Evidence of changed/improved practices at Quitline services	Program documentation Consultation with Quitline and other stakeholders	Year 4
▪ Establish networks to share best practice and innovation.	Have mentor RTCs been identified at state/regional level?	Development of mentor leadership role at regional level	Consultation with RTCs and other stakeholders	Year 4
	Are regional networks in place?	Evidence of regional network communication and	Consultations with RTCs	Year 4

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[10] For reference to data sources, please see Volume 3, Appendix E

Activities				
A1[9] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[10]**	**Data collection**
		activity	and other stakeholders	Six monthly/ Annually
▪ Evaluation of the above.	Has this measure been evaluated?	Advertising and awarding of campaign evaluation	Program documentation	To be determined
		Receipt and acceptance of evaluation report	Program documentation	To be determined

PART B: Workforce, training, services and programs

Activities				
A1[11] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[12]**	**Data collection**
▪ Recruit, train and support approximately 170 Tobacco Action Workers (up to 3 per site x 57 regions, staged introduction over time).. These are community awareness and development roles that work in conjunction with existing smoking cessation practitioners.	Has the workforce been established?	***Number of TAWs (target 170) recruited***	Program documentation.	Annually
▪ Train up to 1,000 other workers (including health workers; youth, drug and alcohol workers; social and emotional wellbeing workers; and community educators specialising in smoking cessation).	Have training program/s been established to provide Indigenous smoking cessation training for health workers?	Submission and approval of training programs/materials	PProgram documentation	▪ yYear 4
		Numbers attending training	Program documentation	Annually
▪ Develop and disseminate education kits and training resources.	What kind of training resources are developed?	Number and type of training resources created	Program documentation	Year 4
	How are they disseminated, and to whom?	Documentation of distribution	Program documentation	Year 4
▪ Work with local communities to develop quit-smoking services and education programs for children, young parents (including	What local smoking cessation services and programs have been designed and delivered?	Number of ACCHSs providing tobacco use treatment and prevention groups	OSR items 15(39), 16(2), 17(19), 18b(11), 27b(11), 31(2),	Annually

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[12] For reference to data sources, please see Volume 3, Appendix E

Activities				
A1[11] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[12]**	**Data collection**
pregnant women and their partners) and families.			32(19), 45b(11)	
	What have been the facilitations/barriers to developing these services and programs?	Establishment of new services/programs	Program documentation	Annually
		Identification of facilitators and barriers	Consultations with TAWs and other stakeholders	Years 2, 4
				Six monthly/ annually
		Expansion of existing services/programs	Program documentation	Year 4
▪ Evaluation of the above.	Has this measure been evaluated?	Advertising and awarding of campaign evaluation	Program documentation	Year 4
		Receipt and acceptance of evaluation report		

Aims
▪ To reduce smoking rates for key groups within Indigenous communities such as young people, health workers and pregnant women.
▪ To develop a national, regional and local tobacco control workforce capable of promoting smoking cessation programs and communication activities in Indigenous communities.

Program Logic A2: Helping Indigenous Australians Reduce their Risk of Chronic Disease

Medium term results - Late-medium term (years 5-10)	▪ Preventable chronic disease lifestyle risk factors are reduced in the lives of those individuals and communities that have had contact with A2 activities. ▪ Increased number of Indigenous Australians participate in healthy lifestyle activities and make more healthy lifestyle choices (improved nutritional choices, appropriate physical activity).
Medium term results - Early medium term (year 4+)	▪ Health services participating in A2 are able to provide increased options and tailored support for Indigenous Australians with or at risk of chronic disease seeking to improve or manage their health condition.
Early results (years 2-4)	▪ Participants in A2 activities: have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean. ▪ Primary health care services involved in A2 are able to offer more support for Indigenous Australians with or at risk of chronic disease. ▪ The workforce implementing A2 is adequately trained and resourced to deliver the measure.
Outputs (year 1 and ongoing)	▪ There are strong participation rates for A2 activities. ▪ The occupancy rate for healthy lifestyle worker positions is high. ▪ Training provides the necessary skills and information to deliver A2.
Activities	▪ Employ 105 healthy lifestyle workers in Indigenous health services (includes ACCHSs, state and territory health services) and Divisions of GP over 3 years. ▪ Provide on the job training through employers and accredited training through RTOs for the healthy lifestyle workers. ▪ Deliver lifestyle modification sessions or activities to Indigenous Australians at risk of, or with a chronic disease.
Aims	▪ To prevent the development of chronic disease for those at risk of chronic disease and to slow the progression of disease for those who already have chronic disease ▪ To increase the capacity of the health workforce and system to support Indigenous Australians to make healthy lifestyle choices.

Late-medium-term results (years 5-10)				
A2[13] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[14]**	**Data collection**
▪ Preventable chronic disease lifestyle risk factors are reduced in the lives of those individuals and communities that have had contact with A2 activities.	Has there been a change in the prevalence of chronic disease risk factors among Indigenous Australians in contact with A2 activities?	Reduction in chronic disease risk factors or slowed progression of disease among healthy lifestyle program participants participating in the pre and post health participant survey	Aboriginal and Torres Strait Islander Health Assessments	Year 4
▪ Increased number of Indigenous Australians participate in healthy lifestyle activities and make more healthy lifestyle choices (improved nutritional choices, appropriate physical activity).	Have participants made healthy lifestyle behaviour changes as a result of participation in A2 activities?	Self reported changes to lifestyle behaviours	Pre and post survey of healthy lifestyle program participant	Years 3, 4
			Community members consultation	Year 4

Early-medium-term results (year 4+)				
A2[15] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[16]**	**Data collection**
▪ Health services participating in A2 are able to provide increased options and tailored support for Indigenous Australians with or at risk of chronic disease who are seeking to improve or manage their health condition.	What evidence is there of an increase in available services and an increase in demand for services?	Number of participating health services that report an increased number of Indigenous Australians participating in healthy lifestyle activities	Organisational survey	Year 4
	What evidence is there of contribution to long-term health promotion capacity of the Indigenous workforce and health system?	Perceptions regarding the capacity of A2 workers to support Indigenous Australians in making healthy lifestyle choices	Health workforce survey	Year 4
			Community members consultation	Year 4

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Early results (years 2-4)				
A2[17] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[18]**	**Data collection**
▪ Participants in A2 activities have an improved understanding of their risk of developing chronic disease and what having a chronic disease would mean.	How has participants' understanding of and behaviour in relation to their health conditions changed?	Perceptions regarding the impact on knowledge, planning and behaviour re their health condition	Community members consultation	Year 4
▪ Primary health care services involved in A2 are able to offer more support for Indigenous Australians with or at risk of chronic disease.	What evidence is there of increased supports within participating organisations to healthy lifestyle workers to assist individuals and communities adopt healthy lifestyles?	Level of organisational support reported by A2 workforce for the work that they do	Health workforce survey	Year 4
			Organisational survey	Year 4
▪ The workforce implementing A2 is adequately trained and resourced to deliver the measure.	How effective is the training which is provided?	Perceptions of A2 workers regarding the impact of training on their capacity to support Indigenous Australians to make healthy lifestyle choices	Health workforce survey	Year 4
			Consultation with healthy lifestyle workers and service providers	Year 4
				Six monthly/ annually

Outputs (year 1 and ongoing)				
A2[19] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[20]**	**Data collection**
▪ There are strong participation rates for A2 activities.	How many people have participated in healthy lifestyle activities?	***Number of participants in healthy lifestyle sessions and activities***	Program documentation	Annually
	How many health lifestyle sessions and activities have been conducted?	***Number of healthy lifestyle sessions and activities conducted***	Program documentation	Annually
▪ The occupancy rate for healthy lifestyle worker positions is high.	What are the recruitment rates for these positions?	Number of positions filled, and length of time positions remain filled	Program documentation	Year 4

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▪ Training provides the necessary skills and information to deliver A2.	To what extent do A2 providers feel adequately trained to deliver the measure?	Level of healthy lifestyle workers' satisfaction with training provided	Health workforce survey	Year 4
			Consultation with healthy lifestyles workers	Six monthly/ annually

Activities

A2[21] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[22]	Data collection
▪ Employ 105 healthy lifestyle workers in ACCHSs, state and territory health services and Divisions of GP.	How many healthy lifestyle workers have been employed?	***Number of healthy lifestyle workers funded and trained***	Program documentation	Annually
▪ Provide on-the-job training through employers and accredited training through Registered Training Organisations for the healthy lifestyle workers.	Did the training occur? What kind of training was provided?	Description and key results of training provided to healthy lifestyle workers	Program documentation	Year 4
▪ Deliver lifestyle modification sessions or activities to Indigenous Australians who have a chronic disease or are at risk of developing a chronic disease.	How have these lifestyle modification sessions been delivered? What has been the uptake and demand?	Perceptions of A2 providers regarding activities and responses	Consultation with service providers	Year 4
	What is the evidence base for these activities?	Demonstration of evidence base used in development and delivery of healthy lifestyle modification sessions	Program documentation	Year 4

Aims

- To prevent the development of chronic disease for Indigenous Australians with, or at risk of, chronic disease and to slow the progression of the disease for those who already have chronic disease.
- To increase the capacity of the health workforce and system to support Indigenous Australians to make healthy lifestyle choices.

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Program Logic A3: Local Indigenous Community Campaigns to Promote Better Health

Medium-term results - Late-medium term (years 5-10)	▪ In communities in which A3 activities have taken place, more Indigenous Australians are adopting healthy lifestyle choices.
Medium-term results - Early-medium term (year 4+)	▪ The evaluation of the local/regional campaigns provides a clear evidence base for the development and implementation of future local community campaigns.
Early results (years 2-4)	▪ The central coordinating function and support structures are used by and useful to the people developing and running the local/regional campaigns. ▪ Individuals in contact with A3 activities are more aware of risk factors for chronic disease and the role of healthy lifestyle behaviours in preventing and managing chronic disease, including accessing primary care. ▪ Campaign activities achieve their immediate outcomes (such as recall and understanding of key messages) and campaign funds are spent efficiently.
Outputs (year 1 and ongoing)	▪ The measure is implemented in accordance with agreed timelines: – the research is completed and presented in a usable form in Year 1 – a national coordination structure is established by the end of Year 1 – local and regional campaigns are initiated and implemented in Year 2 – the campaigns are evaluated in Years 3/4. ▪ Partnerships and cohesive relationships are established between the central coordinating function and local/regional media and health organisations.
Activities	▪ Undertake a comprehensive national research project (literature review, consumer research and consultation) to develop understanding of barriers and motivators to lifestyle change, levels of knowledge and awareness, communications gaps, key messages and appropriate channels. ▪ Use this research to develop a coordinated national communications strategy that includes local and regional campaigns. These campaigns will target people at risk of chronic disease either through lifestyle or lack of engagement with the health sector. ▪ Fund and oversee local or regional health promotion campaigns across Australia, using the evidence base from the research and involving local Indigenous media organisations and community groups. ▪ Evaluate the effectiveness of these campaigns and the resources developed to support them.
Aim	▪ To deliver locally generated and relevant health promotion initiatives that target Indigenous Australians at risk of chronic disease, including groups who have low engagement with health services.

Late-medium term results (years 5-10)				
A3[23] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[24]**	**Data collection**
▪ In communities in which A3 activities have taken place, more Indigenous Australians are adopting healthy lifestyle choices.	In places where the A3-funded campaign activities have run, have behavioural risk factors declined (incidence, severity)?	Risk factor statistics, fresh fruit and vegetables sales/demand	HPF#2.23	Year 4 Data collected 6 yearly: Baseline 2004-05
			A3 evaluation	To be determined
	Has broader help-seeking for chronic disease prevention increased?	Service access statistics, eg attendance at / demand for exercise groups	HPF#2.22, #2.26	Year 4 Data collected 6 yearly: Baseline 2004-05
			A3 evaluation	To be determined
	Have broad norms and expectations re healthy living become more positive? Who for? Why? Why not?	Perceptions of Indigenous community members where A3 activities have taken place	Community members consultation	Year 4
			A3 evaluation	To be determined

Early-medium term results (year 4+)				
A3[25] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[26]**	**Data collection**
The evaluation of the local/regional campaigns provides a clear evidence base for the development and implementation of future local	How adequate was the meta evaluation of the local campaign activities?	Extent of evidence base which can be used to inform future community campaign	Program documentation	Year 4

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Early-medium term results (year 4+)				
A3[25] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[26]**	**Data collection**
community campaigns.	How well have the campaign activities funded under A3 been able to respond to the lessons identified in the evaluation?	Acknowledgement of lessons learned; identification of next steps/responses	Consultation with local campaign managers, central campaign coordinators and other stakeholders	Year 4
	To what extent are the lessons from these evaluations adopted in future campaigns?	Design of future campaigns	Program documentation	Year 4

Early results (years 2-4)				
A3[27] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[28]**	**Data collection**
▪ The central coordinating function and support structures are used by and useful to the people developing and running the local/regional campaigns.	How evidence-based were the local campaigns?	Use of evidence in program design	A3 evaluation	To be determined
	How well supported and coordinated were the local campaigns?	Completion of campaign activity on time	Program documentation	Years 2, 4
	How and to what extent were the central resources and support structures used in designing the local campaigns?	Level of participating organisations' and DoHA's satisfaction with the management of the campaign activities.	Consultation with participating organisations and DoHA	Years 2, 4
			A3 evaluation	To be determined
	How effective and appropriate was the national/local structure?	Perceptions of participating organisations regarding effectiveness and appropriateness	Consultation with participating organisations	Years 2, 4
	How helpful have the resources and supports been at the local level? Any limitations or disappointments?	Level of participating organisation satisfaction with resources and supports	Consultation with participating organisations	Year 4
				Six monthly/ annually
▪ Individuals in contact with A3 activities are more aware of risk factors for chronic	How effective were the individual campaigns in bringing about the intended specific attitudinal and	Self-reported behaviour changes as a result of A3 activities	Community members consultation	Year 4

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[28] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
A3[27] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[28]**	**Data collection**
disease and the role of healthy lifestyle behaviours in preventing and managing chronic disease, including accessing primary care.	behavioural change? Have targeted help-seeking behaviours increased?	Perceptions of A3 workforce and services		Six monthly/ annually
Early results (years 2-4) (continued)				
	Have specific targeted norms and beliefs re healthy living changed? Who for? Why? Why not?	Specific attitudinal and behavioural measures, eg perceived importance of diet and exercise, perceived capacity to influence own health outcomes, self reported increases in exercise	Consultation with community members	Year 4
			A3 evaluation	To be determined

Outputs (year 1 and ongoing)				
A3[29] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[30]**	**Data collection**
▪ The measure is implemented in accordance with agreed timelines: – the research is completed and presented in a usable form in Year 1 – a national coordination structure is established by the end of Year 1 – local and regional campaigns are initiated and implemented in Year 2 – the campaigns are evaluated in Years 3/4.	Have any unexpected barriers been faced in implementing the measure? How (and how effectively) have they been overcome?	Evidence of barriers, and ways in which these were overcome	Consultation with program managers and other stakeholders	Years 2, 4
▪ Partnerships and cohesive relationships are established between the central coordinating	How effective were the partnerships?	Evidence provided by participating organisations	Consultation with participating organisation	Year 4

[29] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[30] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
A3[29] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[30]**	**Data collection**
function and local/regional media and health organisations.			A3 evaluation	To be determined
	How well is the management model working?	Evidence provided by participating organisations	Consultation with participating organisation	Year 4
			A3 evaluation	To be determined
▪ Campaign activities achieve their immediate outcomes (such as recall and understanding of key messages) and campaign funds are spent efficiently.	How effective have the campaigns been in communicating the key messages?	Extent of consumer recall, understanding of key messages	A3 evaluation	To be determined
		Number and types of targeted activities undertaken	Program documentation	Annually
		Description of dissemination of information undertaken	Program documentation	Annually
		What level of reach is attained with target audience?	Program documentation	Year 4
	How appropriate has the resource allocation been to local projects?	***Number and types of culturally appropriate information resources developed***	Program documentation	Annually

Activities				
A3[31] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[32]**	**Data collection**
▪ Undertake a comprehensive national research project (literature review, consumer research and consultation) to develop understanding of barriers and motivators to lifestyle change, levels of knowledge and awareness, confirm communications gaps, key messages and appropriate channels. (Year 1 – due May Year 1 ; this research will also inform ICDP Measure A1 and the Australian Better Health Initiative (ABHI))	Was the research completed and presented in a usable form?	Receipt and acceptance of reports	Program documentation	Year 2
			Consultation with program managers	Year 2
	Did the research provide a credible basis for the development of the campaign activities?	Documentation of the evidence base on which the measure is developed	Program documentation	Year 2
			Consultation with program managers	Year 2

[31] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[32] For reference to data sources, see Volume 3, Appendix E

Activities				
A3[31] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[32]**	**Data collection**
▪ Use this research to develop a coordinated national communications strategy that includes local and regional campaigns. These campaigns will target people at risk of chronic disease either through lifestyle or lack of engagement with the health sector.	Is an appropriate national coordination structure established?	Establishment of national coordination structure, including staff recruitment	Program documentation	Years 2, 4
			Consultation with program managers and other stakeholders	Years 2, 4
		Extent of stakeholder consultation and agreement regarding suitability of the support to be provided	Program documentation	Years 2, 4
			Consultation with program managers and other stakeholders	Years 2, 4
▪ Fund and oversee local or regional health promotion campaigns across Australia, using the evidence base from the research and involving local Indigenous media organisations and community groups.	Are the local and regional campaigns initiated and implemented?	Campaign activity evidence (eg materials developed, descriptions of information dissemination)	Program documentation	Years 2, 4
				Six monthly/ annually
▪ Evaluate the effectiveness of these campaigns and the resources developed to support them.	Are the campaigns evaluated?	Advertising and awarding of campaign evaluation. Receipt and acceptance of evaluation report	Program documentation	Year 4

Aim
▪ To deliver locally generated and relevant health promotion initiatives that target Indigenous Australians at risk of chronic disease, including groups who have low engagement with health services.

Program Logic B1: Subsidising PBS Medicine Co-payments

Medium-term results (year 4+)	▪ The utilisation of Pharmaceutical Benefits Scheme (PBS) medicines by Indigenous Australians with or at risk of chronic disease is increased.
Early results (years 2-4)	▪ The financial barrier to using PBS medicines is reduced or removed for eligible Indigenous Australians with or at risk of chronic disease who participate in the program.
Outputs (year 1 and ongoing)	▪ Indigenous health services participate in the program. ▪ General practices participate in the program (after first satisfying the requirements of the Practice Incentives Program Indigenous Health Incentive Program). ▪ Eligible Indigenous Australians with or at risk of chronic disease participate in the program. ▪ Updated prescriber and pharmacy software products are used by prescribers and dispensers.
Activities	▪ Reduce or eliminate co-payments for eligible patients when purchasing PBS medicines at community pharmacies and other PBS access points (reflected in legislation). ▪ Consult with stakeholders and provide information on the measure to Indigenous health services, general practices, community pharmacies and other PBS access points. ▪ Provide incentive payments to providers of pharmacy and prescriber software to update software products to accommodate the measure .
Aim	▪ To improve access to PBS medicines for eligible Indigenous Australians with or at risk of chronic disease.

Medium-term results (year 4+)				
B1[33] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[34]**	**Data collection**
▪ The utilisation of PBS medicines by Indigenous Australians with or at risk of chronic disease is increased.	How many medicines are dispensed under the measure?	Number of Closing the Gap medicines dispensed	PBS	Annually
	Is utilisation of PBS medicines by participants increased?	***Numbers and locations of people accessing medicines through the program***		
	Is utilisation of PBS medicines by Indigenous Australians increased?	PBS utilisation of participants (before and after measure, vs s100, vs all Australians)		
	What types of medicines are dispensed under the measure?	PBS utilisation for participants by Anatomical Therapeutic Classification (ATC) (eg A10, C10, C01-109, R03, J01)		
	Has utilisation of medicines for management of different chronic diseases increased?	PBS utilisation of Indigenous Australians (by ATC) before and after measure (using all VII PBS dispense records)		
	What is the cost to the PBS?	Costs associated with net changes to PBS utilisation		
	Does medication adherence improve for participants?	Proportion of repeat prescriptions dispensed, timeliness of repeat dispensing[35]		

[33] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[34] For reference to data sources, see Volume 3, Appendix E.

[35] Note that the PBS data set does generally support an analysis of dispensing of repeat prescriptions, but this could be developed.

Early results (years 2-4)				
B1[36] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[37]**	**Data collection**
▪ The financial barrier to using PBS medicines is reduced or removed for eligible Indigenous Australians with or at risk of chronic disease who participate in the program.	How many Indigenous Australians with or at risk of a chronic disease access to co-payment relief?	Number of consenting participants by service type Proportion of PIP IHI (B3) registered participants to access PBS under new arrangements Number of individual patients to have co-payments reduced/removed (as a proportion of all consenting patients)	PIP IHI PBS	Annually
	What, if any, barriers exist which impede access to the program, and how are they being addressed?	Evidence of access barriers, and evidence of response	Consultation with Indigenous health services, general practices and community pharmacies	Years 2, 4
		Barriers identified by community members	Community members consultation	Six monthly/ annually
	How much access is there by concession card holders/non-concession patients?	Volume of Closing the Gap concession prescriptions and non-concession prescriptions	PBS	Annually
	Is co-payment relief valued by patients?	Self reported impact and behaviour change	Community members consultation	Year 4
				Six monthly/ annually
	Do Indigenous health services and general practices prescribe under the new arrangements?	Approximate volume of Closing the Gap prescriptions produced by service type	Consultation with Indigenous health services and general practices	Year 4
	Are the eligibility criteria understood and appropriately and consistently applied?	Prescriber understanding of eligibility criteria Perceived workability of eligibility criteria Evidence of inappropriate application of the criteria	Consultation with Indigenous health services and general practices	Year 4

[36] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[37] For reference to data sources, see Volume 3, Appendix E.

Outputs (year 1 and ongoing)				
B1[38] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[39]**	**Data collection**
▪ Indigenous health services participate in the program.	Do all Indigenous health services participate? What is the rate of take-up? Where is participation strong/weak?	***Number of Indigenous health services participating in the program*** Practice participation (registration and commence obtaining patient consent) Urban vs rural vs remote participation	PIP IHI	Annually
	Do all doctors within services prescribe under CtG arrangements?	Uniformity in prescriber 'participation'	Consultation with Indigenous health services	Year 4
	What are the barriers to take-up?	Reasons for non-participation	Consultation with Indigenous health services	Years 2, 4 Six monthly/ annually
	Is participation for Indigenous health services straightforward? What new systems have to be put in place?	Nature and extent of additional administrative tasks	Consultation with Indigenous health services	Year 4 Six monthly/ annually
▪ General practices participate in the program (after first satisfying the requirements of the Practice Incentives Program Indigenous Health Incentive Program) (PIP IHI).	How many general practices participate in the program? What is the rate of take-up?	***Number of practices participating in the program***	PIP IHI	Annually
	Do all doctors within service prescribe under CtG arrangements?	Uniformity in prescriber 'participation'	Consultation with general practices	Year 4
	What types of general practices participate and what types do not? Do all general practices that participate in B3 participate in B1?	Profile of participating general practices (size, geographic coverage etc) Proportion of B3 participants who participate in B1	PIP IHI	Annually
	What are the barriers to participation?	Reasons for non-participation	Consultation with general practices	Years 2, 4 Six monthly/ annually
	What new systems have to be put in place? What is the administrative burden on services?	Nature and extent of administrative burden	Consultation with general practices	Year 4

[38] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[39] For reference to data sources, see Volume 3, Appendix E.

Outputs (year 1 and ongoing)				
B1[38] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[39]**	**Data collection**
▪ Eligible Indigenous Australians with or at risk of chronic disease participate in the program.	Do individuals provide their consent?	Number of patient registrations received	PIP IHI	Annually
		Patient registration coverage (service type, state/territory, age)	PIP IHI	Annually
	What are the reasons for not participating?	Perceptions regarding why individuals may choose not to participate	Community members consultation	Year 4
				Six monthly/ annually
	At what rate is consent obtained from patients of Indigenous health services and general practices?	Extent of increase over time of recipients of co-payment relief registered with Medicare Australia	PIP IHI	Annually
▪ Updated prescriber and pharmacy software products are used by prescribers and dispensers.	How many community pharmacies participate in the program?	***Number of community pharmacies participating in the program***	Program documentation	Annually
	Do health services and pharmacies update prescribing/dispensing software in a timely way?	Proportion of providers/prescribers using latest versions of software	Software vendors	Years 2, 4
		Proportion of electronic vs manual annotation of prescriptions	PBS	Annually

Activities				
B1[40] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[41]**	**Data collection**
▪ Reduce or eliminate co-payments for eligible patients when purchasing PBS medicines at community pharmacies and other PBS access points (reflected in legislation).	What are the eligibility criteria? Are they appropriate? How were they developed?	Rationale/evidence base for development of eligibility criteria	Program documentation	Year 4
▪ Consult with stakeholders and provide information on the measure to Indigenous health services, general practices, community pharmacies and other PBS access points.	To what extent were stakeholders informed about the new arrangements for Indigenous people with or at risk of a chronic disease?	Key results of consultation process	Consultation with NACCHO and affiliates, general practice peak organisations, community pharmacy representatives	Years 2,4

[40] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[41] For reference to data sources, see Volume 3, Appendix E.

Activities				
B1[40] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[41]**	**Data collection**
▪ Provide incentive payments to providers of pharmacy and prescriber software to update software products to accommodate the measure.	What was required of software vendors? What incentives were provided?	Documentation of software specifications and incentives	Program documentation	Year 4
	Did all vendors respond in the same way? Were timelines met?	Extent of vendor participation, and timing of software delivery	Program documentation	Year 4

Aim

- To improve access to PBS medicines for eligible Indigenous Australians with, or at risk of, chronic disease.

Program Logic B3 (part A): Supporting Primary Care Providers to Coordinate Chronic Disease Management

Medium-term results (year 4+)	▪ Registered practices (general practices and Indigenous health services) are better equipped to provide an enhanced standard of care for Indigenous Australians with chronic disease. ▪ Participating patients are more satisfied with their care.
Early results (years 2-4)	▪ Participating patients receive the target level of care. ▪ Practices offer care management plans and team care coordination as per the requirements of the measure. ▪ General practice staff demonstrate increased knowledge and cultural awareness. ▪ Participating patients receive additional and complementary health services. ▪ Participating patients value the enhanced services.
Outputs (year 1 and ongoing) **Activities**	▪ Eligible practices (general practices and Indigenous health services) are aware of the Practice Incentives Payment (PIP) Indigenous Health Incentive (IHI) and the level of care they are to provide. ▪ Eligible practices (general practices and Indigenous health services) register for the measure (i.e. access one-off payment). ▪ Registered practices have measures in place to encourage the registration of eligible Indigenous Australians. ▪ Eligible Indigenous Australians consent to participate. ▪ Registered general practices attend cultural awareness training within 12 months. ▪ Introduce an Indigenous Health Incentive (IHI) under the Practice Incentives Program (PIP): – A one-off payment to eligible practices (general practices and Indigenous health services) that agree to undertake specified activities to improve provision of care for Indigenous Australians with a chronic disease, including establishing and using a mechanism to follow up their Indigenous patients, and undertaking cultural awareness training (Sign-on payment) – Practice payments for every eligible Indigenous Australian aged 15 years and over registered with the practice for chronic disease management each calendar year (Patient registration payment) – Practice payment for each registered patient for whom a target level of care is provided by the practice in a calendar year (Tier 1 outcome payment) – Payment to practices for providing the majority of care for a registered patient in a calendar year (Tier 2 outcome payment). ▪ Communicate the intent of the measure and the availability of practice payments.
Aim	▪ To support general practices and Indigenous health services to provide better health care for Indigenous Australians, including best practice management of chronic disease.

Medium-term results (year 4+)				
B3, Part A [42] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[43]**	**Data collection**
▪ Registered practices (general practices and Indigenous health services) are better equipped to provide an enhanced standard of care for Indigenous Australians with chronic disease.	To what extent have registered practices improved the standard of care for Indigenous Australians with chronic disease with an identified need?	Proportion of Indigenous Australians with chronic disease to have had relevant tests (eg HbA1c, cholesterol, spirometry/peak flow, blood pressure)	HPF# 3.03, 3.04	Year 4 Data collected monthly/six monthly Baseline 2010
		Proportion of Indigenous Australians receiving Aboriginal Health Assessments for early detection of chronic disease	HPF# 3.05	Year 4 Data collected annually: Baseline 2008-09
		Proportion of primary health care services to provide management of chronic disease, use PIRS, use clinical practice guidelines, maintain Chronic Disease Registers etc	APCC, H4L, NT AHKPI, QAIHC Core Indicators	Year 4 onwards
		Proportion of Indigenous Australians with Type 2 diabetes to receive recommended care	Clinical information and/or quality improvement systems	To be determined (Sentinel sites)
▪ Participating patients are more satisfied with their care	To what extent are eligible Indigenous Australians more satisfied with their care?	Level of satisfaction with enhanced standard of care	Community members consultation	Year 4

[42] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[43] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
B3, Part A [44] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[45]**	**Data collection**
▪ Participating patients receive the target level of care.	Are registered patients provided with the target level of care?	Proportion of registered patients receiving target level of care (# of Tier 1 and Tier 2 outcome) by service type	PIP IHI	Annually
	How is care of registered patients shared between different practices/services?	Number of Tier 1 and Tier 2 outcomes payments made to non-registering services by service type	PIP IHI	Annually
Early results (years 2-4) (continued)				
▪ Practices offer care management plans and team care coordination as per the requirements of the measure.	Are registered patients offered care management plans and team care coordination?	Proportion of registered patients receiving target level of care (# of Tier 1 outcome) by service type	PIP IHI	Annually
▪ General practice staff demonstrate increased knowledge and cultural awareness.	Do general practice staff members value the training? What do they learn from it? How do they apply what they learn?	Level of training participants' satisfaction with training	Feedback from training participants	Year 4
		Level of staff and general practice satisfaction with training	Consultation with staff and general practices	Year 4
		Evidence of changed knowledge, cultural awareness and practice as a result of training	Health workforce survey	Year 4
▪ Participating patients receive additional and complementary health services.	What additional and complementary services are offered? How does this differ from what has been previously available?	Extent of additional and complementary health services, and evidence of uptake	Consultation with health services	Year 4
		Number of Aboriginal and Torres Strait Islander Health Assessments (pre and post)[46] by service type	MBS	Annually
▪ Participating patients value the enhanced service.	Are these additional services valued by participating patients?	Perceptions and impact of additional services, including cultural awareness	Community members consultation	Year 4

[44] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[45] For reference to data sources, see Volume 3, Appendix E

[46] Note that as of 1 May 2010, the Aboriginal and Torres Strait Islander Health Assessment MBS items (704-710) have been combined into one new MBS item number (715).

Outputs (year 1 and ongoing)				
B3, Part A [47] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[48]**	**Data collection**
▪ Eligible practices (general practices and Indigenous health services) are aware of the PIP Indigenous Health Incentive and the level of care they are to provide.	Do general practices and Indigenous health services know about the incentive? Do they understand its purpose? Do they understand their obligations/what is required to claim the various payments?	Level of awareness of the measure (general practices and Indigenous health services)	Consultation with GPs and Indigenous health services	Year 4 Six monthly/ annually
	Was the communications strategy effective?	Perceptions of GPs and practice/service staff	Consultation with GPs and Indigenous health services	Year 4 Six monthly/ annually
▪ Eligible practices (general practices and Indigenous health services) register for the measure (i.e. access one-off payment).	How many Indigenous health services register for the incentive? How many general practices register for the measure?	***Number of PIP practices signed on to the incentive***	PIP IHI	Annually
	What is the pattern of uptake over time? Is participation linked to particular geographical areas or types of service?	Extent of increase over time, and profile of participating practices	PIP IHI	Annually
	What implications does service participation have for equity of access?	Evidence of service participation across geographical locations	Program documentation	Year 4
	What are the barriers to participation?	Perceptions of services regarding barriers to participation	Consultation with Indigenous health services and general practices	Years 2, 4 Six monthly/ annually
▪ Registered practices have measures in place to encourage the registration of eligible Indigenous Australians.	How many practices are registering patients?	***Number of practices receiving payments for registering patients by service type***	PIP IHI	Annually
	What measures do participating services put in place in order to meet their obligations under the measure? What new systems had to be put in place?	Evidence of new measures, by service type	Consultation with Indigenous health services and general practices	Year 4
	What is the administrative burden of these	Experiences and perceptions of participating	Consultation with	Year 4

[47] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[48] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
B3, Part A [47] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[48]**	**Data collection**
	changes? How could they be reduced?	services with regard to participating in the measure, by service type	Indigenous health services and general practices	Six monthly/ annually
	Are the eligibility criteria workable? How are they applied in practice?	Experiences and perceptions of participating services with regard to participating in the measure, by service type	Consultation with Indigenous health services and general practices	Year 4
Eligible Indigenous Australians consent to participate.	How many people consent? What is the rate of patient registration over time?	***Number of patient registrations by service type (Indigenous health service, mainstream general practice)***	PIP IHI	Annually
	Why might people decline to participate?	Identification of reasons for non-participation	Community members consultation	Year 4 Six monthly/ annually
Outputs (year 1 and ongoing) (continued)				
	How many patients are registered by different types of health services?	Number of patients registered by general practices compared to number of patients registered by ACCHSs Registrations by ASGC	PIP IHI	Annually
	How many patients are re-registered annually?	Proportion of patients to be re-registered by service type Number of years of registration	PIP IHI	Annually
▪ Registered general practices attend cultural awareness training within 12 months.	Do general practice staff undergo cultural awareness training as required? In what time frame? What staff attended cultural awareness training (noting that two staff must attend, one of them being a GP)?	Number and profile of general practice staff to undertake training	Consultation with general practices and program managers	Year 4
	What is the nature/provider of the training undertaken?	Number and type of providers of training	Consultation with general practices	Year 4

Activities				
B3, Part A [49] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[50]**	**Data collection**
▪ Introduce an Indigenous Health Incentive (IHI) under the Practice Incentives Program (PIP).	What was the expected uptake of the PIP IHI?	Documentation regarding expected uptake of the PIP IHI	Program documentation	Year 4
	What are the mechanics of the payment system?	Documentation regarding eligibility, processes, and payment of the PIP IHI	Program documentation	Year 4
	How was compliance monitored?	Documented processes for ensuring compliance with PIP IHI requirements	Program documentation	Year 4
▪ Communicate the intent of the measure and the availability of practice payments.	How was the measure communicated to general practice and Indigenous health services?	Documentation of information dissemination to general practices and Indigenous health services	Program documentation	Year 4
	What information did services seek?	Number and type of enquiries	PIP IHI	Annually

Aim
▪ To support general practices and Indigenous health services to provide better health care for Indigenous Australians, including best practice management of chronic disease.

[49] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[50] For reference to data sources, see Volume 3, Appendix E

Program Logic B3 (Part B): Supporting Primary Care Providers to Coordinate Chronic Disease Management

Medium-term results (year 4+)	▪ The barriers to accessing services necessary in the management of chronic diseases are overcome. ▪ There is increased capacity in local networks of health professionals to provide coordinated care for Indigenous Australians with chronic disease.
Early results (years 2-4)	▪ Indigenous Australians with chronic disease are able to obtain the health services recommended in care plans. ▪ Appropriate referral to the Care Coordination and Supplementary Services becomes normal practice in the management of chronic disease by general practitioners.
Outputs (year 1 and ongoing)	▪ There is collaborative development of local CCSS arrangements (including funds management), strengthening linkages between general practices, Indigenous health services, Divisions, specialists and allied health services. ▪ Care coordinators are trained and established in their roles. ▪ Effective local CCSS referral mechanisms are established (and appropriate referrals are made by GP clinics and Indigenous health services). ▪ Assistance is provided by the CCSS in line with measure guidelines.
Activities	▪ Employ new care coordinators and augment existing care coordination structures to: – arrange the services identified in care plans – ensure there are arrangements in place for patients to get to appointments – transfer and update patients' medical records – assist patients to participate in regular reviews by their primary care provider – assist Indigenous Australians referred to the Program to: ▪ access services in accordance with their care plans and in consultation with their home practice ▪ adhere to treatment regimens ▪ develop chronic condition self management skills ▪ connect with appropriate community based services. ▪ Provide a flexible pool of funds to assist patients in the CCSS to access medical specialist and allied health services in accordance with their care plan. ▪ Provide guidelines for the development and negotiation of local arrangements for implementing the CCSS.
Aims	▪ To support general practices, Indigenous health services and allied health professionals to provide coordinated, quality health care for Indigenous Australians with chronic disease. ▪ To improve the patient journey through improved coordination between and within health organisations. ▪ To remove or reduce barriers to meeting the aims of chronic disease care plans.

Medium-term results (year 4+)				
B3, Part B [51] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[52]**	**Data collection**
▪ The barriers to accessing services necessary in the management of chronic diseases are overcome.	Do Indigenous Australians with chronic disease get the health services they require to manage their conditions and avoid negative health outcomes?	Increased access by participants to MBS items for allied health and specialist services (pre and post)	MBS	Year 4
	To what extent are barriers to access overcome?	Reduction in self-reported barriers to accessing health care	HPF# 3.12	Year 4 Data collected 6 yearly: Baseline 2004-05
▪ There is increased capacity in local networks of health professionals to provide coordinated care for Indigenous Australians with chronic disease.	To what extent are primary and allied health professionals better equipped to respond to the needs of Indigenous Australians with chronic disease?	Evidence of increased capacity	Consultation with Indigenous health services, general practices, allied health professionals, NACCHO and affiliates, Divisions of General Practice, care coordinators	Year 4
	To what degree do the care coordinator and availability of funds support local system capacity?	Evidence of increased capacity	Consultation with Indigenous health services, general practices, allied health professionals, care coordinators, communities, NACCHO and affiliates, Divisions of General Practice	Year 4
	Are the new systems and mechanisms for coordinated care sustainable?	Extent to which systems and mechanisms for coordinated care are embedded within services	Consultation with Indigenous health services, general practices, allied health professionals, care coordinators, communities, NACCHO and affiliates, Divisions of General Practice	Year 4

[51] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[52] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
B3, Part B [53] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[54]**	**Data collection**
▪ Indigenous Australians with chronic disease with an identified need are able to obtain the health services recommended in care plans.	How many Indigenous Australians are accessing care coordination services?	***Number of care coordination services provided to Indigenous Australians.***	Program documentation	Annually
	What barriers or facilitators have been identified?	Identification of barriers or facilitators to obtaining recommended health services	Consultation with Indigenous health services, general practices, and allied health professionals	Year 4
	What assistance is purchased or obtained on behalf of Indigenous patients referred to care coordination?	Type of care coordination services purchased with supplementary services funding	Program documentation	Annually
▪ Appropriate referral to the Care Coordination and Supplementary Services becomes normal practice in the management of chronic disease by general practitioners.	Are general practitioners aware of the support available through the CCSS?	Level of GP awareness and perceptions of CCSS	Health workforce survey	Year 4
	To what extent do general practitioners refer to the service?	Number and profile of referrals, and increase over time	Program documentation	Year 4
	Are referrals made in response to patient needs?	Primary reasons for referral to the service	Program documentation	Year 4
	Do health professionals value the service?	Satisfaction with/rating of health professionals	Health workforce survey	Year 4
	Do patients value the service?	Satisfaction with/rating of Indigenous Australians in contact with B3b	Community members consultation	Year 4 Six monthly/ annually

[53] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[54] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
B3, Part B [55] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[56]**	**Data collection**
▪ There is collaborative development of local CCSS arrangements (including funds management), strengthening linkages between general practice, Indigenous health services, Divisions, specialists and allied health services.	How are arrangements for making use of funds and human resources developed?	Local arrangements are documented and in place	Consultation with Indigenous health services, general practices, and allied health professionals	Years 2, 4 Six monthly/ annually
	How did this differ from area to area? What good practice has emerged?	Evidence of collaborative development, including innovations and partnerships	Consultation with Indigenous health services, general practices, and allied health professionals	Years 2, 4 Six monthly/ annually
	How useful were the guidelines for establishing local CCSS arrangements?	Stakeholder perceptions	Consultation with SBOs, Divisions of General Practice, Indigenous health services, general practices, and allied health professionals	Year 4
	What were the benefits of this collaborative approach for organisations, local networks and patients?	Stakeholder perceptions	Consultation with SBOs, Divisions of General Practice, Indigenous health services, general practices, and allied health professionals	Year 4
	What factors inhibited the effective development of CSS arrangements?	Stakeholder perceptions	Consultation with SBOs, Divisions of General Practice, Indigenous health services, general practices, and allied health professionals	Year 4
• Care coordinators are trained and established in their roles.	Were care coordinators deployed in areas of need (ie where there is demand for the services)?	Number of PIP IHI practices and registered patients per care coordinator placement	PIP IHI Program documentation	Annually
	Were care coordinators provided with adequate information, training and orientation to perform their roles?	Nature of the training/orientation provided to care coordinators by fund	Program documentation	Annually

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[56] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
B3, Part B [55] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[56]**	**Data collection**
		holders	Consultation with care coordinators	Six monthly/ annually
	Were they effective in their roles?	Perceptions of participating health professionals	Consultation with Indigenous health services, general practice, and allied health professionals	Year 4
▪ Effective local CCSS referral mechanisms are established (and appropriate referrals are made by GP clinics and Indigenous health services).	What mechanisms are put in place for referral to CCSS support?	Number of referrals to CCSS	Program documentation	Annually
	Do GPs and other health professionals refer patients? In what numbers? For what types of assistance?	Number and types of referrals	Program documentation	Annually
Outputs (year 1 and ongoing) (continued)				
▪ Assistance is provided by the CCSS in line with measure guidelines.	What assistance is actually provided to patients? Is this within the program guidelines? Is it appropriate for patient needs? Who is referred?	Number of assistance 'events' Number and type of services supported through the supplementary services pool Profile of referred patients	Program documentation	Annually
	Do patients value the assistance provided?	Extent to which patients utilise and value the assistance provided	Community members consultation	Year 4 Six monthly/ annually

Activities				
B3, Part B [57] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[58]**	**Data collection**
▪ Employ new care coordinators and augment existing care coordination structures.	To what extent did B3b activities augment existing care coordination structures rather than create new ones?	Evidence of existing care coordination structures	Consultation with service providers	Year 4
	Were recruitment targets met?	Number of care coordinators recruited compared to target	Program documentation	Year 4

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[58] For reference to data sources, see Volume 3, Appendix E

Activities				
B3, Part B [57] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[58]**	**Data collection**
▪ Provide a flexible pool of funds to assist patients in the CCSS Program to access medical specialist and allied health services in accordance with their care plan.	What funds were made available?	Extent of funding pool	Program documentation	Year 4
	How were funds distributed? On what basis?	Evidence of criteria for funding	Program documentation	Year 4
	What guidelines were established for using funds (at national, state/territory and local levels)?	Evidence of guidelines	Program documentation	Year 4
▪ Provide guidelines for the development and negotiation of local arrangements for implementing the CCSS.	What guidance and oversight was provided by DoHA in helping arrangements to be developed locally? How were these guidelines used? How prescriptive were they? How useful were they?	Documentation of guidelines developed and distributed	Program documentation	Year 4
		Perceived usefulness of guidelines	Consultation with Indigenous health services, general practices and allied health professionals	Year 4

Aims

- To support general practices, Indigenous health services and allied health professionals to provide coordinated, quality health care for Indigenous Australians with chronic disease.
- To improve the patient journey through improved coordination between and within health organisations.
- To remove or reduce barriers to meeting the aims of chronic disease care plans.

Program Logic B4: Helping Indigenous Australians Self-manage their Chronic Disease

Medium-term results (year 4+)	▪ Indigenous Australians with chronic disease in contact with B4 activities are better able to self-manage their health condition. ▪ Participating health services have more information, staff, and resources available to support Indigenous Australians with chronic disease to self-manage their condition.
Early results (years 2-4)	▪ Participants in B4 activities have an improved understanding of their health condition and of chronic disease. ▪ Participants in B4 activities are better able to plan for and implement personal health goals. ▪ Primary health care services involved in B4 are able to offer more support services for Indigenous Australians with chronic disease. ▪ The workforce implementing B4 is adequately trained and resourced to deliver the measure.
Outputs (year 1 and ongoing)	▪ There are strong participation rates for B4 activities. ▪ Accredited courses successfully provide the necessary skills and information to deliver B4.
Activities	▪ Train 400 existing health professionals, over 4 years, (e.g. nurses and Aboriginal health workers) to deliver Chronic Disease Self-Management programs to Indigenous Australians who have an established chronic disease. ▪ Support health services to address a greater range of health needs, assist them to better manage specific Indigenous needs at a local level and increase collaboration between health services.
Aims	▪ To slow the progression of chronic disease for those with established chronic disease. ▪ To support individuals with chronic disease to self-manage their condition more effectively.

Medium-term results (year 4+)

B4 [59] **Outcomes Hierarchy**	**Evaluation questions**	**Indicators**	**Potential data sources**[60]	**Data collection**
▪ Indigenous Australians with a chronic disease (who are in contact with B4 activities) are better able to self-manage their health condition.	What evidence is there that more Indigenous Australians with a chronic disease are able to (and do) self-manage their condition?	Perceptions of participants in B4 regarding their capacity to self-manage their condition	Consultation with B4 participants	Year 4
		Case studies/evidence provided by B4 workforce.	Consultation with B4 workforce and primary health care services	
▪ Participating health services have more information, staff, and resources available to support Indigenous Australians with chronic disease to self-manage their condition.	What evidence is there of an increase in available services and an increase in demand for services?	Number of participating health services that report an increased number of Indigenous Australians participating in chronic disease self-management activities	Organisational survey	Year 4
	What evidence is there of contribution to long-term capacity of the Indigenous workforce and health system?	Reports of increased capacity to support Indigenous Australians to engage in CDSM and healthy lifestyle choices	Health workforce survey	Year 4
			Consultation with B4 workforce and services	Year 4

Early results (years 2-4)

B4 [61] **Outcomes Hierarchy**	**Evaluation questions**	**Indicators**	**Potential data sources**[62]	**Data collection**
▪ Participants in B4 activities: - have an improved understanding of their health condition and of chronic disease - are better able to plan for and implement personal health goals.	How has participants' understanding of and behaviour in relation to their health conditions changed?	Perceptions of participants in B4 activities regarding the impact on knowledge, planning and behaviour	Consultation with B4 participants	Year 4
▪ Primary health care services involved in B4 are able to offer more support services for Indigenous Australians with chronic disease.	What evidence is there of increased supports and referrals in participating organisations to assist individuals to self-manage?	Level of organisational support reported by B4 workforce for the work that they do	Health workforce survey	Year 4
▪ The workforce implementing B4 is	How effective is the training which is provided?	Level of B4 workforce satisfaction with	Health workforce survey	Year 4

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[62] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
B4 [61] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[62]**	**Data collection**
adequately trained and resourced to deliver the measure.		training and resources provided.	Training feedback surveys	Year 4
			Consultation with B4 workforce and service providers	Year 4
				Six monthly/ annually

Outputs (year 1 and ongoing)				
B4 [63] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[64]**	**Data collection**
▪ There are strong participation rates for B4 activities.	How many health care professionals have been trained to deliver B4 activities?	***Number of workers provided with chronic disease self management support training***	Program documentation	Annually
	How many chronic disease self-management sessions or activities have been conducted?	***Number of participants in chronic disease self management sessions or activities***	Program documentation	Annually
▪ Accredited courses successfully provide the necessary skills and information to deliver B4.	To what extent do B4 providers feel equipped to deliver the measures?	Level of B4 providers' satisfaction with training provided	Health workforce survey	Year 4

Activities				
B4 [65] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[66]**	**Data collection**

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[66] For reference to data sources, see Volume 3, Appendix E

Activities				
B4 [65] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[66]**	**Data collection**
▪ Train 400 existing health professionals (eg nurses and Aboriginal health workers) to deliver Chronic Disease Self Management programs to Indigenous Australians who have an established chronic disease.	How many health professionals are trained? What kind of training is required? How is the training designed and delivered?	Documentation of types of training and program design, number of participants	Program documentation	Year 4
▪ Support health services to address a greater range of health needs, better manage specific needs of Indigenous Australians at a local level and increase collaboration between health services.	What kind of support has been provided? What has been most helpful? Least helpful?	Level of stakeholder satisfaction regarding support provided Evidence of increased collaboration	Consultation with program managers, NACCHO and affiliates, Divisions of General Practice	Years 2, 4 Six monthly/ annually

Aims
▪ To slow the progression of chronic disease for Indigenous Australians with established chronic disease.
▪ To support Indigenous Australians who have a chronic disease to self-manage their condition more effectively.

Program Logic B5 (Part A): Increasing Access to Specialist and Multidisciplinary Team Care

Medium-term results (year 4+)	▪ Indigenous Australians with or at risk of chronic disease are able to access a wider range of on-going specialist care in urban locations. ▪ The care coordination for patients that benefit from B5 services is improved.
Early results (years 2-4)	▪ Indigenous Australians with chronic disease who are in contact with B5 services utilise and value the enhanced services. ▪ An increasing number of specialists are able to provide services for Indigenous Australians with or at risk of chronic disease in urban primary health care locations.
Outputs (year 1 and ongoing)	▪ Effective fund-holding arrangements are in place in priority locations (as per work plan). ▪ Potential outreach service host organisations are informed about the Urban Specialist Outreach Assistance Program (USOAP). ▪ Medical specialists are identified who are able to provide services in underserviced urban areas. ▪ Participating medical specialists demonstrate increased cultural awareness. ▪ Increased specialist services are available to urban communities.
Activities	▪ Establish new medical specialist outreach services for Indigenous Australians living in urban locations, particularly those with or at risk of chronic disease. ▪ Increase access to specialist medical care in urban primary care settings for the management and treatment of chronic disease. ▪ Ensure that all participating clinicians have undertaken appropriate cultural awareness training.
Aim	▪ To contribute to better health outcomes for Indigenous Australians through increasing access to medical specialist services in urban areas.

Medium-term results (year 4+)

B5, Part A [67] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [68]	Data collection
▪ Indigenous Australians with or at risk of chronic disease are able to access a wider range of on-going specialist care in urban locations.	How many Indigenous Australians with, or at risk of, chronic disease have accessed ongoing specialist care in urban outreach locations?	***Number of Indigenous Australians receiving specialist care in urban areas through this measure***	Program documentation	Annually
▪ Care coordination for Indigenous Australians that benefit from B5 services is improved.	To what extent has care coordination improved in urban outreach locations?	Extent to which care coordination has improved over time	Consultation with outreach hosts and service providers	Year 4
	What is the impact of B5 activities on the primary health care team?	Extent of reported improvement to communication, information sharing, referral and follow-up	Health workforce survey	Year 4

Early results (years 2-4)

B5, Part A [69] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [70]	Data collection
▪ Indigenous Australians with chronic disease who are in contact with B5 services utilise and value the enhanced services.	To what extent are Indigenous Australians with chronic disease accessing specialist care?	Number of Indigenous Australians who are seen by USOAP specialists	Program documentation	Annually
	How satisfied are people with the services which they access?	Level of satisfaction of Indigenous Australians who access USOAP services	Community members consultation	Year 4
▪ An increasing number of specialists are able to provide services for Indigenous Australians with or at risk of chronic disease in urban primary health care locations.	To what extent has the USOAP increased specialist service delivery in urban outreach locations?	Number of visits per location provided by specialists through USOAP	Program documentation	Annually
	How well have visiting specialists interacted with outreach host teams?	Level of satisfaction of outreach host teams and specialists	Consultation with outreach hosts services providers	Year 4

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[68] For reference to data sources, see Volume 3, Appendix E

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[70] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
B5, Part A [71] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [72]**	**Data collection**
▪ Effective fund-holding arrangements are in place in priority locations (as per work plan).	Are fund-holding arrangements in place in all priority locations? How well have the fund-holding arrangements operated? What, if any, challenges or difficulties have been experienced?	Extent to which priority locations have fund-holding arrangements in place Level of satisfaction with arrangements	Consultation with fund-holders and outreach services	Year 4 Six monthly/ annually
▪ Potential outreach service host organisations are informed about USOAP.	How are outreach service agreements negotiated? What, if any, difficulties have been experienced in establishing outreach services?	Perceptions of fund-holders and outreach services	Consultation with fund-holders and outreach services	Years 2, 4 Six monthly/ annually
	What type of host organisations are providing outreach?	Type of organisations participating in USOAP, and location	Program documentation	Year 4
▪ Medical specialists are identified who are able to provide services in underserviced urban areas.	How was the need for particular specialist services identified?	Documentation regarding identification of need	Consultation with fund-holders and program managers	Year 4
	How many of the participating providers are new to specialist outreach (eg not moving from MSOAP to USOAP)?	Extent to which USOAP increases pool of outreach specialists	Consultation with fund-holders and program managers	Year 4
▪ Participating medical specialists demonstrate increased cultural awareness.	How has cultural awareness been demonstrated?	Demonstration/examples of increased cultural awareness Perceived effectiveness of cultural awareness component	Consultation with program managers and service providers	Year 4
▪ Increased specialist services are available to urban communities.	How many specialists are providing services through the USOAP?	Number of specialists participating	Program documentation	Annually
	What kind of specialist services are being provided in urban outreach host organisations?	Types of services provided, and levels of demand	Program documentation	Annually

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[72] For reference to data sources, see Volume 3, Appendix E

Activities				
B5, Part A [73] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[74]**	**Data collection**
▪ Establish new medical specialist outreach services for Indigenous Australians living in urban locations, particularly those with or at risk of chronic disease.	How were specialists recruited? To what extent was this successful?	Number of expressions of interest, number who sign up, number who withdraw	Consultation with fund-holders	Year 4
▪ Increase access to specialist medical care in urban primary health care settings for the management and treatment of chronic disease.	How well established is the referral process to urban outreach specialists? How well does it work?	Extent to which referral process is perceived to work smoothly	Consultation with fund-holders, outreach service hosts	Year 4
	To what extent has information sharing and care coordination been encouraged across specialists and primary health care providers? What has been the impact of having specialists in the primary health care setting?	Level of increase of care coordination and information sharing	Consultation with fund-holders, outreach service hosts, specialists	Year 4
		Reported impact of specialist presence in the primary health care setting	Consultation with fund-holders, outreach service hosts, specialists	Year 4
▪ Ensure that all participating clinicians have undertaken appropriate cultural awareness training.	What kind of cultural awareness training is provided or encouraged? Who provides this?	Type and extent of training required	Program documentation	Annually

Aim
▪ To contribute to better health outcomes for Indigenous Australians through increasing access to medical specialist services in urban areas.

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[74] For reference to data sources, see Volume 3, Appendix E

Program Logic B5 (Part B): Increasing Access to Specialist and Multidisciplinary Team Care

Medium-term results (year 4+)	▪ Indigenous Australians with or at risk of chronic disease are able to access on-going specialist and multi-disciplinary care in rural and remote locations. ▪ Care coordination for patients that benefit from B5 services is improved.
Early results (years 2-4)	▪ Indigenous Australians with chronic disease who are in contact with B5 services utilise and value the enhanced services. ▪ An increasing number of specialists and allied health professionals provide services for Indigenous Australians in rural and remote locations. ▪ Care coordination systems and relationships between specialists, allied health professionals and primary health providers are strengthened.
Outputs (year 1 and ongoing)	▪ Effective fund-holding arrangements are in place in each state and the Northern Territory. ▪ Advisory Forums have allied health and Indigenous health representation. ▪ Potential outreach service hosts and the broader medical community are informed of the MSOAP-ICD. ▪ Medical specialists and allied health professionals are identified who are able to provide services in underserviced rural and remote areas. ▪ Participating health professionals demonstrate cultural awareness. ▪ More specialist and allied health professionals are available to deliver services to rural and remote communities.
Activities	▪ Expand provision of medical specialist outreach services for Indigenous Australians living in rural and remote locations, particularly those with or at risk of chronic disease. ▪ Encourage multi-disciplinary working arrangements and skill sharing with rural and remote health professionals. ▪ Ensure that all participating clinicians have undertaken cultural awareness training.
Aim	▪ To increase access to a range of health services, including expanded primary health care, provided to people in rural and remote Indigenous communities for the treatment and management of chronic disease.

Medium-term results (year 4+)

B5, Part B [75] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [76]	Data collection
▪ Indigenous Australians at risk of, or with, chronic disease are able to access on-going specialist and multi-disciplinary care in rural and remote locations.	How many Indigenous Australians with, or at risk of, chronic disease have accessed ongoing specialist and multidisciplinary care in rural and remote locations where MSOAP-ICD services are provided?	***Number of services provided by multidisciplinary health professional outreach teams in rural and remote Indigenous communities***	Program documentation	Annually
		Number of patients (total number, by service over reporting period)	Program documentation	Annually
	Overall, how many types of services are being provided by MSOAP-ICD?	Types of services provided by MSOAP-ICD	Program documentation	Annually
▪ Care coordination for Indigenous Australians that benefit from B5 services is improved.	To what extent has care coordination improved in rural and remote locations?	Extent to which care coordination has improved from baseline	Consultation with participating services	Year 4
				Six monthly/ annually
	What is the impact of MSOAP- ICD activities on the primary health care team?	Extent of improvement to communication, information sharing, referral and follow-up	Consultation with participating services	Year 4

Early results (years 2-4)

B5, Part B [77] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [78]	Data collection
▪ Indigenous Australians with chronic disease who are in contact with B5 services utilise and value the enhanced services.	To what extent are Indigenous Australians with chronic disease accessing specialist care?	Number of Indigenous Australians seen by MSOAP-ICD specialists	Program documentation	Annually
	How satisfied are people with the services which they access?	Level of satisfaction of Indigenous Australians who access MSOAP-ICD services	Community members consultation	Year 4
▪ An increasing number of specialists and allied health professionals provide services for Indigenous Australians in rural and remote locations.	To what extent has the MSOAP-ICD increased specialist service delivery in rural and remote areas?	Number of visits per location and the number of patients in total over a reporting period through MSOAP-ICD	Program documentation	Annually

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Early results (years 2-4)

B5, Part B [77] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [78]	Data collection
	To what extent has the MSOAP-ICD increased allied health service delivery in rural and remote areas?	Number of visits per location and the number of patients in total over a reporting period through MSOAP-ICD	Program documentation	Annually
	To what extent has the MSOAP-ICD increased GP service delivery in rural and remote areas?	Number of visits per location and the number of patients in total over a reporting period through MSOAP-ICD	Program documentation	Annually
	How well having visiting specialists interacted with outreach host teams?	Level of satisfaction of outreach host teams and specialists	Consultation with outreach hosts and service providers	Year 4
▪ Care coordination systems and relationships between specialists, allied health professionals and primary health providers are strengthened.	How is the specialist integrated into the primary health care team of the outreach service? To what extent are communication pathways defined? How is continuity of care ensured?	Extent of protocols or agreements for integration of care Evidence of communication pathways Evidence of care coordination through meetings or other means	Consultation with outreach hosts and service providers	Year 4

Outputs (year 1 and ongoing)

B5, Part B [79] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [80]	Data collection
▪ Effective fund-holding arrangements are in place in each state and the Northern Territory.	Are funding-holding arrangements in place? How well have the fund-holding arrangements operated? What, if any, challenges or difficulties have been experienced?	Extent to which fund-holding arrangements are in place Level of satisfaction with the arrangements	Consultation with fund-holders and outreach service hosts	Years 2, 4 Six monthly/ annually
	To what extent have the fund-holding arrangements facilitated the operation of the MSOAP-ICD?	Perceptions of participating services	Consultation with fund-holders and outreach service hosts	Years 2, 4 Six monthly/ annually
▪ Advisory Forums have allied health and Indigenous health representation.	To what extent have allied health and Indigenous health representatives participated in the Advisory Forums?	Extent of allied health and Indigenous health participation in Advisory Forums	Consultation with Advisory Forum members	Year 4

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[80] For reference to data sources, see Volume 3, Appendix E

Outputs (year 1 and ongoing)				
B5, Part B [79] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [80]**	**Data collection**
	How effective have the Advisory Forums been in providing guidance to MSOAP-ICD?	Extent of effectiveness of Forums in MSOAP-ICD	Consultation with Advisory Forum members	Year 4
▪ Potential outreach service hosts are informed of the MSOAP-ICD.	What type of host organisations are providing outreach?	Type of organisations participating in MSOAP, and location	Program documentation	Annually
▪ Medical specialists and allied health professionals are identified who are able to provide services in underserviced rural and remote areas.	How was need for particular specialist services identified?	Documentation regarding identification of need	Program documentation	Year 4
	To what extent are the participating providers new to MSOAP?	Extent to which MSOAP-ICD has increased overall pool of outreach specialists	Program documentation, and comparison with MSOAP	Year 4
▪ Participating medical specialists demonstrate cultural awareness.	How has cultural awareness been demonstrated?	Demonstration/examples of increased cultural awareness Perceived effectiveness of cultural awareness component	Consultation with program managers and service providers	Annually
▪ Increased specialist and allied health professionals are available to rural and remote communities.	How many specialists are providing services through the MSOAP-ICD?	Number of specialists participating	Program documentation	Annually
	How many allied health professionals are providing services through the MSOAP-ICD?	Number of allied health professionals participating	Program documentation	Annually
	To what extent has the MSOAP-ICD increased access to services which were previously unavailable?	Extent of new services which are provided	Consultation with service providers	Year 4
	What kind of specialist services are being provided in rural and remote host organisations?	Type of specialist services provided through MSOAP-ICD, and demand	Program documentation	Annually
	What kind of allied health services are being provided in rural and remote host organisations?	Type of allied health services provided by MSOAP-ICD, and demand	Program documentation	Annually
	What kind of GP services are being provided through the MSOAP-ICD?	Type of GP services provided through MSOAP-ICD, and demand	Program documentation	Annually

Activities				
B5, Part B [81] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [82]**	**Data collection**
▪ Expand provision of medical specialist outreach services for Indigenous Australians living in rural and remote locations, particularly those with, or at risk of, chronic disease.	How were specialists recruited? To what extent was this successful?	Number of expressions of interest, number who sign up, number who withdraw	Consultation with fundholders	Year 4
	How are other allied health professionals and GPs recruited for rural outreach services? To what extent has this been successful?	Number of expressions of interest, number who sign up, number who withdraw	Consultation with fundholders	Year 4
▪ Encourage multi-disciplinary working arrangements and skill sharing with rural and remote health professionals.	How were multi-disciplinary working arrangements and skill sharing encouraged? What was required to make this happen?	Experiences and perceptions of participating services	Consultation with fundholders, outreach services, specialists	Year 4
▪ Ensure that all participating clinicians have undertaken cultural awareness training.	What kind of cultural awareness training is provided or encouraged? Who provides this?	Type and extent of training provided	Program documentation	Year 4

Aim
▪ To increase access to a range of health services, including expanded primary health care, provided to people in rural and remote Indigenous communities for the treatment and management of chronic disease.

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[82] For reference to data sources, see Volume 3, Appendix E

Program Logic C1: Workforce Support, Education and Training

Medium-term results (year 4+)	▪ There are more people working in the health workforce who are trained to provide quality primary health care to Indigenous Australians. ▪ Participants in C1 activities intend to continue working in primary health care and other services assisting Indigenous Australians. ▪ Primary health care services improve their capacity to identify and provide quality care for Indigenous Australians with or at risk of chronic disease.
Early results (years 2 - 4)	▪ Participants in C1 activities are effectively oriented, trained and supported to provide quality care to Indigenous Australians. ▪ Participants in C1 activities value and benefit from the training and the placements.
Outputs (year 1 and ongoing)	▪ The measure is implemented in accordance with the workplan: – the workforce required to implement C1, C2 and C3 is oriented and trained – 38 additional GP registrar training posts in Indigenous health services are allocated – 50 additional nursing scholarships per year and 50 additional nursing placements per year are allocated.
Activities	▪ Provide orientation and training to Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) including: – orientation and training of 166 ATSIOWs appointed through C2 and C3 measures – support and monitoring of the ATSIOWs through collaborative networks, and – two national ATSIOW workshops/conferences. ▪ Fund additional GP registrar training posts in Indigenous health services, building on and managed by the GP Education and Training (GPET) Program. ▪ Fund 50 additional nursing scholarships per year and 50 additional nursing placements per year administered through the Nursing Scholarship and Placement Program.
Aims	▪ To expand the primary health care workforce assisting Indigenous Australians, through employment, education and training initiatives. ▪ To increase the capacity of Indigenous and mainstream health organisations to provide continuity of care for Indigenous Australians with chronic and complex health conditions. ▪ To encourage trainee health professionals to work in primary health care services assisting Indigenous Australians.

Medium-term results (year 4+)

C1 [83] **Outcomes Hierarchy**	**Evaluation questions**	**Indicators**	**Potential data sources** [84]	**Data collection**
▪ There are more people working in the health workforce who are trained to provide quality primary health care to Indigenous Australians.	Do participants in C1 activities feel they have the required skills to provide quality care to Indigenous Australians?	Level of confidence with skills as reported by participants in C1 activities to provide quality care to Indigenous Australians	Health workforce survey	Year 4
▪ Participants in C1 activities intend to continue working in primary health care and other services assisting Indigenous Australians.	Do participants in C1 activities intend to continue working in primary health care and other services assisting Indigenous Australians in the future?	Self-reported intentions to continue working in primary health care and other services assisting Indigenous Australians.	Health workforce survey	Year 4
▪ Primary health care services improve their capacity to identify and provide quality care for Indigenous Australians with or at risk of chronic disease.	To what extent has there been an improvement in the capacity of services to provide quality care to Indigenous Australians with chronic disease as a result of C1 activities?	Improvements in quality of care as identified by patients and health care providers	Community members consultation	Year 4
			Organisational survey	Year 4
			Consultation with primary health care services	Year 4

Early results (years 2-4)

C1 [85] **Outcomes Hierarchy**	**Evaluation questions**	**Indicators**	**Potential data sources** [86]	**Data collection**
▪ Participants in C1 activities are effectively oriented, trained and supported to provide quality care to Indigenous Australians.	Do ATSIOWs feel the orientation and training provided has increased their ability to provide quality care to Indigenous Australians?	Level of ATSIOW satisfaction with the orientation, training and support provided	Health workforce survey	Year 4
			Consultation with ATSIOWs and other stakeholders	Year 4
▪ Participants in C1 activities value and benefit from the training and the placements.	To what extent do general practice registrars and nurses involved in placements feel their experience, orientation and training has increased their ability to provide quality care to Indigenous Australians?	Level of participating general practice registrar and nurse satisfaction with training and placement provided Evidence of increased ability to provide quality care	Health workforce survey Consultation with general practice registrars and nurses	Year 4

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[86] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
C1 [85] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [86]**	**Data collection**
	How likely are general practice registrars and nurses involved in placements to choose a career in Indigenous health?	Level of uptake of general practice placements, length of time before vacancies are filled	GPET documentation	Year 4
		Level of uptake by nurses of scholarships and placements, length of time before vacancies are filled	Program documentation	Year 4
		Future intentions as reported by participating registrars and nursing placements	Health workforce survey	Year 4

Outputs (year 1 and ongoing)				
C1 [87] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [88]**	**Data collection**
▪ The measure is implemented in accordance with the workplan: – the workforce required to implement C1, C2 and C3 is oriented and trained – 38 additional GP registrar training posts are allocated – 50 additional nursing scholarships per year and 50 additional nursing placements per year are allocated.	Have orientation and training been delivered as originally planned?	***Number of ATSIOWs trained each year***	Program documentation	Annually
	Have GP training posts and nursing scholarships been promoted and allocated as anticipated?	***Number of GP registrar placements each year***	GPET documentation	Annually
		Number of nursing scholarships provided each year	Program documentation	Annually
		Number of nursing clinical placements each year	Program documentation	Annually

Activities				
C1 [89] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [90]**	**Data collection**

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88 For reference to data sources, see Volume 3, Appendix E

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90 For reference to data sources, see Volume 3, Appendix E

Activities				
C1 [89] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[90]**	**Data collection**
▪ Provide orientation and training to Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) including: – orientation and training of 166 ATSIOWs appointed through C2 and C3 measures – support and monitoring of the ATSIOWs through collaborative networks, and – two national ATSIOW workshops/conferences.	What level and type of training was provided?	Description of range and type of training provided	Program documentation	Year 4
	What kind of support and monitoring of the ATSIOWs takes place?	Number and type of support and monitoring activities which take place	Program documentation	Year 4
			Health workforce survey	Year 4
			Consultation with ATSIOWs and primary health care services, Divisions of General Practice, other stakeholders	Year 4
▪ Fund additional GP registrar training posts in Indigenous health services, building on and managed by the GP Education and Training (GPET) Program.	To what extent are services able to accommodate the additional general practice registrar posts?	Number of services requesting a general practice registrar, proportion of services who request a registrar	GPET documentation	Annually
	What level of interest is there from general practice registrars to participate in the training posts?	Length of time before vacancies are filled, number of placements which are completed, number which are not completed	GPET documentation	Annually
▪ Fund 50 additional nursing scholarships per year and 50 additional nursing placements per year administered through the Nursing Scholarship and Placement Program.	To what extent are services able to accommodate the additional nursing placements?	Number of services requesting nursing placements, number of vacancies and length of time before being filled, number of nurses seeking placements	Program documentation	Year 4
	What level of interest is there from nurses to apply for scholarships and seek placements?	Number of nursing students seeking scholarships, number of scholarships unallocated	Program documentation	Year 4

Aims

- To expand the primary health care workforce assisting Indigenous Australians, through employment, education and training initiatives.
- To increase the capacity of Indigenous and mainstream health organisations to provide continuity of care for Indigenous people with chronic and complex health conditions.
- To encourage trainee health professionals to work in primary health care services assisting Indigenous Australians.

Program Logic C2: Expanding the Outreach and Service Capacity of Indigenous Health Organisations

Medium-term results (year 4+)	▪ Access to Aboriginal Community-Controlled Health Services (ACCHSs) for Indigenous Australians with or at risk of chronic disease is improved. ▪ ACCHSs enhance their system and workforce capacity to respond to increased service demand. ▪ Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) have established effective community links to increase access to ACCHSs and other health services by Indigenous Australians.
Early results (years 2-4)	▪ Practice managers have developed or enhanced practice systems to ensure effective recall, referral and follow up for Indigenous Australians with or at risk of chronic disease. ▪ Stronger links are forged between ACCHSs and other health service providers to improve continuity of care for Indigenous Australians with or at risk of chronic disease. ▪ Collaboration is improved between participating ACCHSs and other health providers to identify and address barriers to the provision of primary health care to Indigenous Australians. ▪ Indigenous Australians in contact with participating primary health care providers utilise and value the enhanced services.
Outputs (year 1 and ongoing)	▪ The measure is implemented in accordance with the workplan, eg: – 86 ATSIOWs, 43 practice managers and 33 additional health workforce positions are recruited and retained – capital infrastructure works relevant to this measure are undertaken.
Activities	▪ Fund 86 full time equivalent ATSIOW positions to be filled by local Indigenous Australians in Aboriginal Community Controlled Health Services. ▪ Fund 43 practice managers. ▪ Fund 33 additional health workforce positions to support rural and remote services meet expected increase in service demand. ▪ Fund capital infrastructure to house/accommodate expanded workforce and fund clinic upgrades due to service expansion.
Aims	▪ To increase the service capacity of ACCHSs to provide care for Indigenous Australians with chronic disease. ▪ To improve the accessibility of ACCHSs for the communities they service. ▪ To generate interest and encourage more people to work in primary health care services assisting Indigenous Australians.

Medium-term results (year 4+)

C2 [91] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [92]	Data collection
▪ Access to ACCHSs for Indigenous Australians with or at risk of chronic disease is improved.	To what extent have the ATSIOW positions contributed to improved access to ACCHSs?	Number of people who access ACCHSs	OSR	Annually
		Evidence (case examples) from ACCHSs regarding extent of contribution of ATSIOW position to increase access	Consultation with ACCHSs	Year 4
	To what extent are these positions providing support which was not previously available? To what extent are they addressing locally identified needs?	Perceptions of ATSIOWs, ACCHSs and other stakeholders	Consultation with ATSIOWs, ACCHSs, NACCHO and Affiliates and other stakeholders	Year 4
▪ ACCHSs enhance their system and workforce capacity to respond to increased service demand.	To what extent has this measure assisted ACCHSs to increase their system and workforce capacity?	Number of ATSIOWs and practice managers employed in ACCHSs	OSR	Annually
		Perceptions of ATSIOWs, practice managers, ACCHSs and other stakeholders	Consultation with ATSIOWs, practice managers, ACCHSs NACCHO and Affiliates	Year 4
▪ ATSIOWs have established effective community links to increase access to ACCHSs and other health services by Indigenous Australians.	What kinds of community links have the ATSIOWs established? How have they accomplished this?	Evidence of linkages developed or enhanced by ATSIOWs Evidence of positive outcomes and increased access resulting from these linkages	Consultation with ATSIOWs, ACCHSs and other stakeholders Service statistics	Year 4

Early results (years 2-4)

C2 [93] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [94]	Data collection
▪ Practice managers have developed or enhanced practice systems to ensure effective recall, referral and follow up for	How effective have practice managers been at developing or enhancing practice systems to ensure effective recall, referral and follow up for Indigenous	Range and extent of activities undertaken by practice managers	Consultation with practice managers, ACCHSs	Year 4

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[94] For reference to data sources, see Volume 3, Appendix E

Early results (years 2-4)				
C2 [93] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [94]**	**Data collection**
Indigenous Australians with or at risk of chronic disease.	Australians with or at risk of chronic disease?	Examples of changes in practice recall, referral and follow up for Indigenous Australians	Consultation with practice managers, ACCHSs	Year 4
			Organisational survey	Year 4
Early results (years 2-4) (continued) ▪ Stronger links are forged between ACCHSs and other health service providers to improve continuity of care for Indigenous Australians with or at risk of chronic disease.	To what extent have stronger links been forged between ACCHSs and other health service providers to improve continuity of care for Indigenous Australians with or at risk of chronic disease? How has this impacted on access to/continuity of service?	Evidence of stronger links and impact on access and continuity of care	Consultation with ACCHSs and other health service providers	Year 4
		Perceptions of Indigenous community members	Community members consultation	Year 4
▪ Collaboration is improved between participating ACCHSs and other health providers to identify and address barriers to the provision of primary health care to Indigenous Australians.	How have activities undertaken across participating ACCHOs and other health services addressed the barriers to the provision of primary health care to Indigenous Australians?	Evidence of improved collaboration	Consultation with ACCHSs and other health service providers	Year 4
▪ Indigenous Australians in contact with participating primary health care providers utilise and value the enhanced services.	To what extent are the activities of C2 perceived to contribute to an enhanced service for Indigenous Australians?	Perceptions of Indigenous community members regarding utilisation and value of services as a result of the ATSIOW, practice manager or other health workforce positions	Community members consultation	Year 4

Outputs (year 1 and ongoing)				
C2 [95] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [96]**	**Data collection**
▪ The measure is implemented in accordance with the workplan: – 86 ATSIOWs, 43 practice managers and 33 additional health workforce positions are recruited and retained	To what extent is recruitment of all positions on schedule? What factors have impacted on the ability to recruit and retain people in these positions?	Level of success in recruiting and retaining staff Identified barriers and facilitators to recruitment and retention	Consultation with ACCHSs and other service providers	Years 2, 4

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Outputs (year 1 and ongoing)				
C2 [95] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [96]**	**Data collection**
– capital infrastructure works relevant to this measure are undertaken.	What capital works have been undertaken?	Number and type of capital works undertaken	Program documentation	Year 4

Activities				
C2 [97] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [98]**	**Data collection**
▪ Fund – 86 full time equivalent Aboriginal and Torres Strait Islander Indigenous Outreach Worker (ATSIOW) positions to be filled by local Indigenous ACCHSs – 43 practice managers – 33 additional health workforce positions to support rural and remote services meet expected increase in service demand.	How many ATSIOWs have been recruited? How many practice managers have been recruited? How many additional health professionals have been employed? What number/proportion of these have been filled by Aboriginal and Torres Strait Islander people?	***Number of ATSIOWs, practice managers and additional health professionals funded*** Number of ATSIOWs, practice managers and additional health professionals recruited, by Aboriginality	Program documentation	Annually
▪ Fund capital infrastructure to house/accommodate expanded workforce and fund clinic upgrades due to service expansion.	What infrastructure projects are required to implement C2? How are they determined?	Evidence of process for determining capital infrastructure needs under C2	Program documentation	Year 2

Aims
▪ To increase the service capacity of ACCHSs to provide care for Indigenous Australians with chronic disease.
▪ To improve the accessibility of ACCHSs for the communities they service.
▪ To generate interest and encourage more people to work in primary health care services assisting Indigenous Australians.

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Program Logic C3: Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care

Medium term results (year 4+)	▪ Access to mainstream primary health care for Indigenous Australians with or at risk of chronic disease is increased. ▪ General practices deliver better quality primary health care to Indigenous Australians. ▪ Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) have established effective community links to increase access to mainstream primary health care by Indigenous Australians.
Early results (years 2-4)	▪ Stronger links are forged between primary health care services to assist Indigenous Australians. ▪ Collaboration is improved between participating general practice networks and Indigenous health services to identify and address barriers to the provision of primary health care to Indigenous Australians. ▪ General practices have a greater understanding of Indigenous Australians' health needs and improved capacity to provide quality care. ▪ The State Based Organisations (SBOs) and the Australian General Practice Network (AGPN) provide effective leadership and coordination on Indigenous health activities within the Divisions' network. ▪ Specific initiatives addressing the needs of local Indigenous people are developed and implemented. ▪ Indigenous Australians in contact with participating primary health care providers value the enhanced services.
Outputs (year 1 and ongoing)	▪ The measure is implemented in accordance with the workplan: – 80 ATSIOWs and 80 IHPOs positions are recruited and retained.
Activities	▪ Funding for over 80 full time equivalent ATSIOW positions to be filled by local Indigenous Australians, spread across Divisions of General Practice. ▪ Funding for 80 full time equivalent Indigenous Health Project Officers (IHPOs) in SBOs and the AGPN. ▪ Funding for the AGPN and SBOs to provide state/territory and national leadership and coordination of the ATSIOWs and IHPOs.
Aims	▪ To generate interest and encourage more people to work in primary health care services assisting Indigenous Australians. ▪ To enhance the service capacity of mainstream primary health care providers to provide care for Indigenous Australians with chronic disease. ▪ To improve the accessibility and quality of general practice for Indigenous Australians.

Medium-term results (year 4+)				
C3 [99] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[100]**	**Data collection**
▪ Access to mainstream primary health care for Indigenous Australians with or at risk of chronic disease is increased.	To what extent have C3 activities contributed to improved access to mainstream primary health care?	Impact of activities undertaken to address barriers to access mainstream primary health care	Consultation with primary health care services and other stakeholders	Year 4
		Evidence (case examples) from general practice regarding extent of contribution of ATSIOW/IHPO positions to increased access	Consultation with ATSIOWs, IHPOs, general practices and other stakeholders	Year 4
	To what extent are these positions providing support which was not previously available? To what extend are they addressing locally identified needs?	Perceptions of ATSIOWs, IHPOs, general practices and other stakeholders	Consultation with ATSIOWs, IHPOs, general practices and other stakeholders	Year 4
▪ General practices deliver better quality primary health care to Indigenous Australians.	To what extent has the capacity of general practices to provide quality primary health care to Indigenous Australians improved?	Examples and impact of activities used to improve the capacity of mainstream primary health care to deliver culturally sensitive services for Indigenous Australians	Consultation with primary health care services and other stakeholders	Year 4 Six monthly/ annually
▪ Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs) have established effective community links to increase access to mainstream primary health care by Indigenous Australians.	What kinds of links have the ATSIOWs established? How have they accomplished this?	Evidence of linkages developed or enhanced by ATSIOWs Evidence of positive outcomes and increased access resulting from these linkages	Consultation with ATSIOWs, IHPOs, general practices and other stakeholders Service statistics	Year 4

Early results (years 2-4)				
C3 [101] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[102]**	**Data collection**
▪ Stronger links are forged between primary health care services to assist	To what extent have stronger links been forged between primary health care services as a result of C3	Evidence of stronger links with local Indigenous services to address shared	Program documentation	Year 4

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Early results (years 2-4)				
C3 [101] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[102]**	**Data collection**
Indigenous Australians.	measure activities?	planning, priority setting and other issues	Consultation with ATSIOWs, IHPOs, general practices and Divisions of General Practice and local Indigenous services	Year 4
▪ Collaboration is improved between participating general practice networks and Indigenous health services to identify and address barriers to the provision of primary health care to Indigenous Australians.	To what extent has collaboration between participating general practice networks and Indigenous health services changed as a result of C3 measure activities? How has this impacted on access to/continuity of service?	Evidence of improved collaboration and impact of collaboration between the mainstream and Indigenous health sectors, including the NACCHO Affiliate	Program documentation Consultation with ATSIOWs, IHPOs, general practices and Divisions of General Practice and local Indigenous services	Year 4
		Perceptions of community members	Community members consultation	Year 4
▪ General practices have a greater understanding of Indigenous Australians' health needs and improved capacity to provide quality care.	What strategies have been developed to recruit and support the C3 measure workforce?	Nature and impact of strategies developed to recruit and support ATSIOWs and IHPOs	Program documentation	Annually
	Do ATSIOWs and IHPOs feel they have the required skills to provide quality care to Indigenous Australians?	Perceptions of ATSIOWs and IHPOs	Consultations with ATSIOWs and IHPOs	Year 4
	To what extent have activities undertaken across participating general practice networks improved their understanding of Indigenous Australians' health needs and increased their capacity to provide culturally appropriate care?	Evidence of changed knowledge and practices	Program documentation Consultations with AGPN, SBOs, Divisions of General Practice, IHPOs and ATSIOWs	Year 4
▪ The State Based Organisations (SBOs) and the Australian General Practice Network (AGPN) provide effective leadership and coordination on Indigenous health activities within the Divisions' network.	To what extent have the State Based Organisations (SBOs) and the Australian General Practice Network (AGPN) contributed, led and/or influenced the implementation of C3 measures across their network?	Number and type of activities undertaken by SBOs and the AGPN Perceived effectiveness of these activities	Consultations with AGPN, SBOs, Divisions of General Practice, IHPOs and ATSIOWs	Year 4
▪ Specific initiatives addressing the needs of local Indigenous people are developed and implemented.	What initiatives have been developed to address the needs of local Indigenous people?	Number and type of initiatives undertaken by Divisions, SBOs and the AGPN	Program documentation	Year 4
▪ Indigenous Australians in contact with participating primary health care providers value the enhanced services.	To what extent are the activities of C3 perceived to contribute to an enhanced service for Indigenous Australians?	Perceptions of Indigenous Australians who access mainstream primary health care services	Community members consultation	Year 4

Outputs (year 1 and ongoing)

C3[103] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[104]	Data collection
▪ The measure is implemented in accordance with the workplan, eg 80 ATSIOWs and 80 IHPOs positions are recruited and retained.	To what extent is recruitment of all positions on schedule? What factors have impacted on the ability to recruit and retain people in these positions?	Level of success in recruiting and retaining staff	Program documentation	Annually
		Identified barriers and facilitators to recruitment and retention	Consultation with SBOs and Divisions of General Practice	Years 2, 4
				Six monthly/ annually

Activities

C3[105] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[106]	Data collection
▪ Funding for over 80 full time equivalent Aboriginal and Torres Strait Islander Outreach Workers (ATSIOW) positions to be filled by local Indigenous Australians, spread across Divisions of General Practice.	How many ATSIOWs have been recruited?	***Divisions network, project officers*** Number of ATSIOWs recruited, by Aboriginality	Program documentation	Annually
▪ Funding for 80 full time equivalent Indigenous Health Project Officers (IHPOs) in SBOs and AGPN.	How many IHPOs have been recruited?	Number of IHPOs recruited by Aboriginality	Program documentation	Annually
▪ Funding for the Australian General Practice Network (AGPN) and State Based Organisations (SBOs) to provide state/territory and national leadership and coordination of the ATSIOWs and IHPOs.	What kind of leadership is expected from SBOs and AGPN? What kind of coordination activities are necessary?	Key results of early development of leadership roles for SBOs and AGPN, and change over time	Program documentation	Annually

Aims

- To generate interest and encourage more people to work in primary health care services assisting Indigenous Australians.
- To enhance the service capacity of mainstream primary health care providers to provide care for Indigenous Australians with chronic disease.
- To improve the accessibility and quality of general practice for Indigenous Australians.

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Program Logic C4: Attracting More People to Work in Indigenous Health

Medium-term results (year 4+)	▪ There are increased enrolments in relevant higher education and VET programs (as a step towards stronger representation by Indigenous Australians in clinical, allied and ancillary roles in the health sector). ▪ There is stronger demand for available primary health care and allied health positions in Aboriginal Community Controlled Health Services (ACCHSs). ▪ There is a high level of interest in advertised positions created under the ICDP.
Early results (years 2-4)	▪ There is increased awareness of the nature and variety of roles in Aboriginal Community Controlled Health Services amongst existing primary and allied health professionals. ▪ There are increased knowledge and positive perceptions of the opportunities for employment in the health sector among Aboriginal and Torres Strait Islander secondary school students.
Outputs (year 1 and ongoing)	▪ Targeted communications activity for secondary school students is based on evidence. ▪ Targeted communications activity for health professionals is based on evidence. ▪ There is timely development and implementation of communications activities. ▪ Target audiences are exposed to and aware of the messages communicated.
Activities	▪ Conduct research to explore the attitudes, perceptions, motivators and barriers to work and careers in the health sector among Aboriginal and Torres Strait Islander secondary school students. ▪ Develop and implement a targeted campaign to promote health careers to Aboriginal and Torres Strait Islander secondary school students. ▪ Develop and implement communications activities to promote and encourage primary health care and allied health professionals to work in ACCHSs.
Aim	▪ To promote careers in health to Indigenous Australians and to increase the supply of health professionals to the Aboriginal Community Controlled Health Services sector.

Medium-term results (year 4+)				
C4 [107] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[108]**	**Data collection**
▪ There are increased enrolments in relevant higher education and VET programs (as a step towards stronger representation by Indigenous Australians in clinical, allied and ancillary roles in the health sector).	Is the measure associated with an increase in the number of Indigenous Australians enrolled in health related tertiary education?	Indigenous enrolments and completions in health disciplines (Tertiary and VET)	HPF #3.18	Year 4 Data collected annually: Baseline 2009
▪ There is stronger demand for available primary and allied health positions in ACCHSs.	Do ACCHSs find it easier to find qualified health professionals to work in their services as employees or visiting health professionals?	Reduction in vacancies for clinical positions in ACCHSs	OSR	Year 4
			HPF# 3.20	Year 4 Data collected annually: Baseline 2006-07
			Consultations with ACCHSs	Year 4
▪ There is a high level of interest in advertised positions for ATSIOWs and other positions created by elements of the IDCP.	To what extent did the campaign contribute to promoting the availability of new positions created by the ICDP?	Number of applicants/new employees aware of/influenced by campaign messaging	Consultation with ICDP recruits	Year 4
			Health workforce survey	Year 4

Early results (years 2-4)				
C4 [109] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources[110]**	**Data collection**
▪ There is increased awareness of the nature and variety of roles in ACCHSs	Were the intended messages communicated to the target audience?	Increased awareness and understanding of the ACCHS environment	Health workforce survey	Year 4

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amongst existing primary and allied health professionals.	Were there shifts in knowledge of the work opportunities in the ACCHS sector?	Extent of improved perceptions of working in health	Health workforce survey	Year 4
▪ There are increased knowledge and positive perceptions of the opportunities for employment in the health sector among Aboriginal and Torres Strait Islander secondary school students.	Were the intended messages communicated to the target audience?	Increased awareness of career opportunities in the health sector	C4 Evaluation	To be determined
	Were there shifts in knowledge of the career opportunities in the health sector?	Extent of improved perceptions of working in health	C4 Evaluation	To be determined

Outputs
(year 1 and ongoing)

C4 [111] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [112]	Data collection
▪ Targeted communications activity for secondary school students is based on evidence.	What were the outcomes of the research?	Documentation of research outcomes	Program documentation	Year 4
	How did the research project guide the development of communications activities?	Link between research outcomes and communications strategy	Program documentation	
	What other evidence (eg literature, past research) supported the development of the communications?	Breadth of research base	Program documentation	
	Were communications activities developed with the input of experts in the field?	Extent of consultation/external input	Consultation with program managers and other stakeholders	
▪ Targeted communications activity for health professionals is based on evidence.	What evidence (eg literature, past research, past communications strategies) supported the development of the communications?	Links between evidence base and communications activities	Program documentation	Year 4
	What other evidence (eg literature, past research) supported the development of the communications?	Breadth of research base	Program documentation	
	Were communications activities developed with the input of experts in the field?	Extent of consultation/external input	Consultation with program managers and other stakeholders	
▪ There is timely development and implementation of communications activities.	Were communications activities developed according to schedule?	Timing milestones met	Program documentation	Year 4
	When did communications activity commence? When did they stop? Was the timing of communications activity appropriate?	External 'events' impacting on success of delivery	Consultation with program managers and other stakeholders	

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▪ Target audiences are exposed to and aware of the messages communicated.	What was the reach of the communications activity? How many secondary school students and existing health professionals were exposed to the messages?	***Number and type of culturally relevant information products disseminated to health professionals, schools and universities***	Program documentation	Year 4
	Did the communications 'cut through'? Did the target audiences see/hear the messages?	Secondary school student awareness of campaign messages	C4 Evaluation	To be determined
		Health professional awareness of campaign messages	Health workforce survey	Year 4

Activities

C4 [113] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources [114]	Data collection
▪ Conduct research to explore the attitudes, perceptions, motivators and barriers to work and careers in the health sector among Aboriginal and Torres Strait Islander secondary school students.	What research was conducted? What were the aims of the research? What was the scope and methodology? How were the specifications for the research developed?	Documented aims for and approach to the research	Program documentation	Year 4
	What were the key messages of the research? What limitations did the research have?	Findings and lessons taken from the research	Consultation with program managers	Year 4
▪ Develop and implement a targeted campaign to promote health careers to Aboriginal and Torres Strait Islander secondary school students.	What did the campaign comprise? How was it delivered? What messages were used? Who was targeted?	***Number and type of seminars and activities conducted***	Program documentation	Years 2, 4
		Documented details of communications activity (eg messages, channels, ***website usage data*** or other means, expenditure)	Program documentation	Year 4
	What budget was available for the communications campaign? What did this allow and what limitations did it impose?	Funding allocation and expenditure	Communications 'audit', and consultation with DoHA program managers	Year 4
	How was the campaign supported by the activities of other organisations? What did the campaign have to 'compete' with in terms of other sectors promoting careers to Aboriginal and Torres Strait Islander secondary students?	Other communications activity coordinated by other organisations	Consultation with DoHA program managers	Year 4

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▪ Develop and implement communications activities to promote and encourage primary and allied health professionals to work in ACCHSs.	What did the communications activities comprise? Who was targeted? Who was consulted? What was the rationale for the communications channels, messages and specific target audiences? How was this rationale developed?	Documented details of communications activity (eg messages, channels, expenditure)	Program documentation Consultation with program managers, NACCHO and affiliates	Years 2, 4
	What budget was available for the communications campaign? What did this allow and what limitations did it impose?	Funding allocation and expenditure	Communications 'audit', and consultation with program managers	Year 4

Aim
▪ To promote careers in health to Indigenous Australians and to increase the supply of health professionals to the Aboriginal Community Controlled Health Services sector.

Program Logic C5: Clinical Practice and Decision Support Guidelines

Early results (year 2 and ongoing)	▪ Primary health care providers have easy access to a comprehensive and useful resource which contributes to the provision of quality clinical care for Indigenous Australians with or at risk of chronic disease. ▪ Sustainable mechanisms for maintaining resources are in place. ▪ The web-based platform for the resource is developed. ▪ The resource is piloted and adapted as required for wider dissemination. ▪ An implementation strategy is developed and applied.
Outputs (year 1)	▪ Processes for ongoing review and updating of publicly available resources have been explored. ▪ Inclusion/exclusion criteria are developed and applied, and a body of appropriate resources approved.
Activities	▪ Review the literature and current resources, and identify guidelines, tools and resources which are available. ▪ Employ a contractor to develop the web-based platform for the resource. ▪ Conduct ongoing consultation with stakeholders, including focus groups during development and piloting of the resource.
Aim	▪ To support and promote individual primary health care providers to prevent and manage chronic disease in Indigenous Australians in an appropriate and timely manner.

Early results (year 2 and ongoing)				
C5 [115] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [116]**	**Data collection**
▪ Primary health care providers have easy access to a comprehensive and useful resource which contributes to the provision of quality clinical care for Indigenous Australians with or at risk of chronic disease.	What use is being made of the resource?	Extent of uptake by primary health care providers Analysis by sector level of contact with Indigenous patients	Health workforce survey	Year 4
			Consultation with program managers, Technical Reference Group, website contractor	Year 4
	Who is using the website? Who is not using it?	Reporting by website users, ICDP workforce and organisations	Website user survey	Year 4
			Health workforce survey	Year 4
			Organisational survey	Year 4
	How many times has the website been accessed? Which pages are being accessed most often?	Number of hits on the website Website hits per page	Program documentation	Year 4
	How accessible is the website?	Perceptions of website users	Website user survey	Year 4
	What content is most useful to users?	Perception of website users, and extent of continued use	Website user survey	Year 4
			Website user count	Annually
	What evidence is there that primary health care providers are incorporating the available information into their practice?	Extent of perceived impact of resource on clinical behaviour Evidence (examples) of improved practice	Website user survey	Year 4
			Consultation with primary health care providers	Year 4
	What impact has this information made on clinical behaviour?	Extent of perceived improvement to clinical practice	Health workforce survey	Year 4

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[116] For reference to data sources, see Volume 3, Appendix E

Early results (year 2 and ongoing)				
C5 [115] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [116]**	**Data collection**
			Consultations with primary health care providers	Year 4
	To what extent has the website increased best practice?	Perceptions of website users	Website user survey	Year 4
	In what ways has the provision of this information assisted the patient's journey?	Perceptions of website users	Website user survey	Year 4
	How relevant and useful is the website to actual practice?	Ratings of usefulness by website users	Website user survey	Year 4
	How satisfied are users with the resource? Who continues to use it?	Level of website user satisfaction with the resource	Website user survey	Year 4
			Health workforce survey	Year 4
	In what ways has the resource contributed to the overall package goals?	***Clinical practice and decision support guidelines developed and disseminated***	Consultation with program managers	Year 2
			Consultation with primary health care providers	Year 2
▪ Sustainable mechanisms for maintaining resources are in place.	To what extent is the website maintained as an up-to-date source of best practice clinical information?	Documented process for website maintenance; extent of agreement of users that site is up-to-date	Consultation with website contractor Website user survey	Year 4
	What, if any, processes are in place for sustainability?	Documented resourcing and process for website sustainability	Consultations with website contractor	Year 4
▪ The web-based platform for the resource is developed.	What can be learned from the process of developing the resource?	Lessons learned from the development of the website	Consultation with program managers, Technical Reference Group	Year 4
▪ The resource is piloted and adapted as required for wider dissemination.	What was learned from the pilot of the resource in Year 1? What changes were made as a result?	Results of pilot, and outcomes	Consultation with program managers, Technical Reference Group, website contractor and other stakeholders as identified (eg NACCHO, AGPN)	Year 4
	How was information about the website communicated to the target audience?	Documentation of information dissemination	Consultation with program managers	Year 4

Early results (year 2 and ongoing)

C5 [115] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[116]	Data collection
▪ An implementation strategy has been developed and applied.	What barriers or enablers were encountered in the implementation of the website?	Perceptions of those involved in the implementation of the website	Consultation with program managers, Technical Reference Group, website contractor	Year 4

Outputs (year 1 and ongoing)

C5 [117] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[118]	Data collection
▪ Processes for ongoing review and updating of publicly available resources have been explored.	What processes have been developed for review and updating of the website's resources?	Documentation of review and updating of resources	Program documentation	Year 4
▪ Inclusion/exclusion criteria are developed and applied, and a body of appropriate resources approved.	How effective were the criteria for including or excluding a resource from the website? How were the criteria developed?	Documented process of the application of criteria and decisions made	Program documentation	Year 4

Activities

C5 [119] Outcomes Hierarchy	Evaluation questions	Indicators	Potential data sources[120]	Data collection
▪ Review the literature and current resources, and identify guidelines, tools and resources which are available.	How comprehensive was the identification of key documents?	Documented literature and resource review, including search criteria, databases queried, list of key documents	Program documentation	Year 4
	What challenges were experienced in the search for appropriate tools?	Perceptions of those involved in the literature review	Consultation with program managers, Technical Reference Group	Year 4

[117] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[118] For reference to data sources, see Volume 3, Appendix E

[119] Where DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan, this has been indicated by the use of bold italics in the Framework tables.

[120] For reference to data sources, see Volume 3, Appendix E

Activities				
C5 [119] Outcomes Hierarchy	**Evaluation questions**	**Indicators**	**Potential data sources [120]**	**Data collection**
▪ Employ a contractor to develop the web-based platform for the resource.	Was the contractor employed?	Evidence of employment	Program documentation Consultation with program managers, Technical Reference Group	Year 4
▪ Conduct ongoing consultation with stakeholders, including focus groups and piloting of the resource.	What were the results of the consultations?	Lessons learned from the ongoing consultation	Consultation with program managers, Technical Reference Group	Year 4

Aim
▪ To support and promote individual primary health care providers to prevent and manage chronic disease in Indigenous Australians in an appropriate and timely manner.