

**Table 14 Summary of activities for the SHS Men’s and Youth Program**

<b>Community</b>	<b>Community Meetings</b>	<b>Health Days/Activities</b>	<b>No</b>	<b>Other</b>
<b>Werenbun</b>	None identified	Men’s health education information half-day	7	
<b>Barunga</b>	Community men’s meeting about men’s health	None identified		
<b>Manyllaluk</b>	None identified	None identified		
<b>Wugularr</b>	Men’s meeting about issues, e.g. family law court, erectile dysfunction	Health screening and education and barbeque	18	Men’s camp
<b>Bulman</b>	Community men’s meeting about men’s health	<ul style="list-style-type: none"> <li>Health education</li> <li>Health screening</li> <li>School sex education class</li> </ul>	20 10 30	Men’s camp
<b>Weemol</b>	<ul style="list-style-type: none"> <li>Community men’s meeting about men’s health</li> <li>Community Health Committee about men’s health</li> <li>Community elders about petrol-sniffing youth</li> </ul>	None identified		Petrol-sniffing group session for users
<b>Mataranka</b>	<ul style="list-style-type: none"> <li>Community men’s meeting about men’s health</li> <li>Community Health Committee about men’s centre and petrol-sniffing youth</li> <li>Council about men’s resource centre</li> </ul>	None identified		
<b>Jilkminggan</b>	None identified	<ul style="list-style-type: none"> <li>School sex education class</li> <li>School class about petrol and other drugs</li> <li>Men’s health screen and education</li> </ul>	40 NFP <sup>14</sup>	
<b>Minyerri</b>	None identified	<ul style="list-style-type: none"> <li>School sex education class</li> <li>School class about petrol and other drugs</li> <li>Health screening and education/sexual health</li> </ul>	8 NFP 20 NFP	Men’s camp
<b>Ngukurr</b>	None identified	None identified		Men’s camp
<b>Urapunga</b>	None identified	None identified		Men’s camp
<b>Binjari</b>	Men’s conference	None identified		

<sup>14</sup> NFP – No figure provided

## Women's and Maternal Health Program

<b>The vision</b>	"our woman: seen, cared, heard and getting what they need."
<b>The Goal</b>	"to improve the health and well being of all women in the SHS area in the Katherine East region."

### ***The key components***

Key components of the Women's and Maternal Health Program were:

- to enable informed choice through education and information;
- a greater focus on health promotion, prevention and early intervention;
- better coordination of health services; and
- to improve health outcomes for all Indigenous women in the SHS region.

### **Summary**

#### ***Program description***

The Women's and Maternal Health Program aimed to engage women in the remote communities, support culturally appropriate health-related activities, integrate with the service providers and community women to achieve best practice standards for well women's health screening, antenatal care and women with chronic disease.

#### ***Overview of activities***

Key activities of the Women's and Maternal Health Program included:

- support for the breast screening program with education and promotion of mammography screening plus providing transportation;
- escorting community women of all ages on bush trips for camping, fishing, collecting bush tucker and pandanus leaf or trips directed by community members that enhanced health and well being;
- organising a two day camp for women from all SHS communities to meet and discuss health issues;
- development of a Cessation of Smoking in Pregnancy Program;
- engaging an elder woman as CBW/mentor to support Women's and Maternal Health Program and help identify women's needs and identify women at risk;
- investing time with individual community women teaching life skills;
- instigating women's health screening as a Medicare item;
- reviewing client recall systems in clinics and having input into systems in clinics that were not yet computerised;
- responding to requests from the communities to develop health promotion activities for specific community groups of women, e.g. women with chronic disease;
- meeting with community councils and the Chief Minister's Office to establish a Domestic Violence Program.

### ***Interface with clinic:***

The Women's and Maternal Health Program interaction with the community clinics was characterised by:

- performing women's health checks and antenatal care at the clinics;
- providing formal antenatal education programs for Aboriginal Health Workers (AHWs) in Wugularr and Barunga;
- promotion of women-centred Central Australian Rural Practitioners Association (CARPA) protocols to clinic staff; and
- working to establish effective recall systems for the follow-up of women.

### ***Impact of remoteness/nature of community life:***

Impacts of remoteness/nature of community life on the Women's and Maternal Health Program included:

- community visits that were cancelled due to the inability to find sufficient relief staff;
- inability to access communities due to the poor weather conditions and shortage of SHS vehicles; and
- cancelled activities due to community funeral commitments.

### ***Linkage with other programs***

The Women's and Maternal Health Program linkages with other programs included:

- the Women's and Maternal Health Coordinator worked with the Social Worker for program development and follow-up of antenatal women admitted to hospital;
- rewriting domestic violence protocols with the Social Worker;
- development of link with Specialist Outreach Service Coordinator for the follow-up of women with obstetric or gynaecological aberrancies;
- antenatal education development in coordination with SHS Education Unit;
- development of response to new NT midwifery legislation in collaboration with Katherine Region Women's Health Group.

**Table 15 Summary of activities for the SHS Women’s and Maternal Health Program**

<b>Community</b>	<b>Community Meetings</b>	<b>Health Days/Activities</b>	<b>No.</b>	<b>Other</b>	<b>No.</b>
<b>Werembun</b>	None identified	None identified		Women’s health screening	4
<b>Barunga</b>	None identified	<ul style="list-style-type: none"> <li>Women’s health information day</li> <li>Cessation of smoking in pregnancy program</li> <li>Lifestyle skills education one-on-one</li> </ul>	40	<ul style="list-style-type: none"> <li>Women’s health screening</li> <li>Antenatal screening &lt;20 weeks gestation</li> </ul>	10
<b>Manyallaluk</b>	None identified	None identified	NFP <sup>15</sup>	Antenatal screening <20 weeks gestation	1
<b>Wugularr</b>	None identified	<ul style="list-style-type: none"> <li>Women’s camp</li> <li>Financial planning for young women, one-on-one</li> </ul>	NFP	<ul style="list-style-type: none"> <li>Women’s health screening</li> </ul>	8
<b>Bulman</b>	None identified	<ul style="list-style-type: none"> <li>BBQ, film night and women’s health screening</li> </ul>	5	<ul style="list-style-type: none"> <li>Antenatal screening &lt;20 weeks gestation</li> <li>Bush trips</li> </ul>	7
<b>Weemol</b>	None identified	None identified	NFP		NFP
<b>Mataranka</b>	None identified	None identified		<ul style="list-style-type: none"> <li>Women’s health screening</li> <li>Antenatal screening &lt;20 weeks gestation</li> </ul>	2
<b>Jilkminggan</b>	None identified	None identified		<ul style="list-style-type: none"> <li>Women’s health screening</li> </ul>	2
<b>Minyerri</b>	None identified	None identified		<ul style="list-style-type: none"> <li>Women’s health screening</li> </ul>	6
<b>Ngukurr</b>	None identified	None identified		<ul style="list-style-type: none"> <li>Women’s health screening</li> <li>Antenatal screening &lt;20 weeks gestation</li> </ul>	16
<b>Urapunga</b>	None identified	None identified		<ul style="list-style-type: none"> <li>Antenatal screening &lt;20 weeks gestation</li> </ul>	16
<b>Binjari</b>	None identified	None identified			

<sup>15</sup> NFP – No figure provided

## Child Health Program

### **Program description**

To improve the health and well being of children through assessment and follow-up of children up to five years of age, school health promotion activities and health screening for school aged children. The focus of the Child Health Program was to provide client and staff education, participate in, collect data for and report to Department of Health and Community Services (DHCS) on the Growth Action and Assessment (GAA) Program for children up to five years of age. The Child Health Coordinator worked in collaboration with the community clinics and schools to collect school health and the GAA data.

<b>The vision</b>	"our children: seen, cared, heard and getting what they need."
<b>The goal</b>	"to improve the health and well being of all children in the Katherine East region."

A Child Health Coordinator was appointed at the beginning of October 2003 and a Child Health Educator was employed at the same time. The Child Health Program was developed and approved by the SHS Board ready for implementation. As the new coordinator was previously the SHS nutritionist, this allowed input into the plan and to have a working knowledge of the position prior to commencement.

### **The key components**

Key components of the Child Health Program were:

- a greater focus on health promotion, prevention and early intervention;
- better coordination of services;
- child health workforce development; and
- leadership in child health.

### **SHS GAA Program**

The GAA Program was implemented in the DHCS clinics in 1998 and was the monitoring and growth promotion program for children under five years of age in rural and remote communities of the NT. The aims of the program were to:

- ensure that growth promotion and assessment occurred in a more coordinated way across the NT;
- ensure that appropriate intervention was taken at an individual level in children who were failing to grow; and
- provide a mechanism for feeding back community-level information to communities and territory Health Services to assist with planning, decision-making and resource allocation.

SHS reported one key achievement of the trial was that of the 380 children in all the communities, 360 were screened – of these, 33% of children were anaemic, 10% wasted, 18% underweight and 15% of stunted growth.

### **Aural Health Program**

Prior to SHS, only children attending school were screened as part of the Aural Health Program. As part of SHS, 389 out of 400 children (aged up to four years) were screened –32% had clinical reviews and 15% were referred to the doctor (including an Ear Nose and Throat Specialist).

### ***Overview of activities:***

Key activities of the Child Health Program were:

- to formalise the schedule for Growth Action and Assessment Program data collection, promote the Growth Action and Assessment Program with communities, assist with the data collection, collate data and report on findings;
- to prepare and deliver GAA feedback for Community Health Committees;
- to forward GAA data to DHCS;
- the data collection and follow-up from screening for the Healthy School Aged Kids;
- to provide recruitment and support CBWs for child health programs in Wugularr;
- the trachoma education at Bulman primary school;
- the development of a template for school screening on Communicare;
- the preparation and administration of school health programs; Healthy Lifestyles Weeks, Safe Living Weeks, Healthy Lifestyles and Relationships Days; and
- the identification, training and support for CBWs and AHWs to work with the Child Health Program, i.e. Wugularr, Ngukurr.

### ***Interface with clinic:***

The Child Health Program interaction with the community clinics was characterised by:

- an active role in the Growth Action and Assessment Program and Healthy School Aged Kids programs; and
- collaboration between hospitals and clinics when children were discharged from hospital with ongoing needs, providing support as appropriate.

### ***Impact of remoteness/nature of community life:***

Impacts of remoteness/nature of community life on the Child Health Program included:

- inability to contact particular council staff members regarding a community program for Worms Awareness Week; and
- programs cancelled due to community funeral commitments, weather conditions, illness of contact person in the community and shortage of SHS vehicles.

### ***Linkage with other programs:***

The Child Health Program linkages with other programs included:

- school education programs that were coordinated with the SHS Education Unit;
- the nutritionist, Men's and Women's Health Coordinators participating in school health promotion activities, e.g. Healthy Lifestyles Weeks;
- cross-age programs that were held with the Aged Care Coordinator, e.g. bush tucker collecting excursions.

**Table 16 Summary of activities for the SHS Child Health Program**

<b>Community</b>	<b>Community Meetings</b>	<b>Health Days/Activities</b>	<b>No.</b>	<b>Other</b>
<b>Werenbun</b>	None identified	Growth Action and Assessment Program	4	
<b>Barunga</b>	Community Health Committee – present GAA data	<ul style="list-style-type: none"> <li>Growth Action and Assessment Program</li> <li>Healthy School Aged Kids</li> </ul>	26 NFP*	Hospital discharge summary audit (child)
<b>Manyallaluk</b>	None identified	Growth Action and Assessment Program	12	
<b>Wugularr</b>	Community Health Committee – present GAA data	<ul style="list-style-type: none"> <li>Growth Action and Assessment Program</li> <li>Healthy School Aged Kids</li> </ul>	42 90	
<b>Bulman</b>	Community Health Committee – present GAA data Clinic about failure to thrive list of children	<ul style="list-style-type: none"> <li>Growth Action and Assessment Program</li> <li>Trachoma education at school</li> <li>School health week x 9 sessions</li> </ul>	30 122 NFP	Training of AHWs about GAA
<b>Weemol</b>	None identified	None identified		
<b>Mataranka</b>	None identified	<ul style="list-style-type: none"> <li>Growth Action and Assessment Program</li> <li>Healthy School Aged Kids</li> <li>School health week x 5 sessions</li> <li>Follow-up and perform immunisations</li> </ul>	29 26 62 NFP	Training for CBWs
<b>Jilkinggan</b>	Community Health Committee – present GAA data	<ul style="list-style-type: none"> <li>School health week x 4 sessions</li> <li>Show Growth Action and Assessment Program video and deliver GAA poster to crèche staff</li> <li>Young mums about worms, anaemia and food for kids</li> <li>Healthy School Aged Kids</li> </ul>	73 12 NFP	
<b>Minyerri</b>	None identified	Growth Action and Assessment Program	69	Follow-up underweight child.
<b>Ngukurr</b>	None identified	School health week x 3 sessions	239	
<b>Urapunga</b>	None identified	Growth Action and Assessment Program	132	
<b>Binjari</b>	None identified	None identified		

<sup>16</sup> NFP – No figure provided

## Nutrition Program

Prior to the inception of SHS, nutrition services in the Katherine East area were supplied by both DHCS and the Jawoyn Association and included funding from several charity foundations. The Nutrition Program was historically a strong program prior to SHS developing their plan. However, the coverage of the pre-existing program was not extensive and centred on the community of Wugularr. This program was (and continued to be) funded by the Fred Hollows Foundation and was augmented by the Jawoyn Association. Effectively, SHS expanded the existing program to include the entire SHS population.

### ***Aims***

The aims of the Nutrition Program included:

- education concerning tucker that is good, tasty, safe, available, affordable, nutritious, varied and eaten;
- developing the confidence of community members in their knowledge of how to be well nourished and have less diet-related disease;
- encouraging communities to take action on their nutrition needs;
- promoting people enjoying good food, growing well, being active, feeling well and not getting sick from unbalanced diets;
- promoting communities enjoying traditional food-related practices and passing these stories and skills on to the children of these communities.

### ***Program description***

The coordinator role was to develop relationships with community stores, schools, clinics, and women's centres and respond to needs and requests of the communities in relation to nutritional advice and health promotion. The Nutrition Coordinator was also to develop best practice protocols in collaboration with other service providers and interested parties to increase the range and access of more suitable foods for community people and to support clients in the communities with specific nutritional requirements.

### ***Overview of activities***

The nutritionists were responsible for activities in two main areas:

1. Food security – to determine what food was available in community stores, how reliable the food supply was, and how much control communities had over their food supply.
2. Nutritional health promotion – in advising groups such as community store committees, mothers and school children on nutrition issues.

The nutritionists were responsible for a number of nutritional programs:

**Growth Action and Assessment Program** – this included clinical data collection for children aged up to five years at all clinics. Plans were actioned when children's height, weight, and head circumference or haemoglobin fell below recommended levels. Six-monthly assessments were conducted in April and October and a report provided to each community and to DHCS (business information management).

**Healthy School Aged Kids** – a clinical assessment was conducted annually and a report was provided to the Child Health Nurse in Darwin. This program was a recent development and so was not as well established as the GAA in the SHS communities.

**Market Basket Survey** – an annual survey conducted over many years by the DHCS Nutritionist, it surveyed the availability and pricing of selected food items from community stores. A report was then provided to the DHCS Project Officer of the Nutrition and Physical Activity Unit in Darwin.

**Failure To Thrive** – Failure To Thrive related to the Growth Action and Assessment Program where an action plan was implemented should a child fail to gain weight satisfactorily or was hospitalised with poor nutritional status.

Other key activities of the Nutrition Program were:

- communication and reporting to the Fred Hollows Foundation (who funded part the program);
- conducting the Market Basket Survey at all community stores. This was completed by the Store Manager or SHS Nutritionist at the Store Manager's request. Feedback was provided to stores, the Fred Hollows Foundation, Community Health Committees and SHS.
- responding to requests for nutritional support from the communities and clinics;
- the assessment and support for clients who required nutritional support when leaving hospital and returning to their community;
- the promotion of 'product of the month' at Wugularr store in cooperation with the Store Manager;
- provision of support (recipes, cooking advice, health promotional activities, menu development) to Wugularr Women's centre for their school lunch program;
- the facilitation of culturally appropriate cooking demonstrations for community groups;
- participation in school programs such as the Nutrition and Physical Activity (Barunga, Ngukurr, Minyerri and Wugularr) and the Healthy Kids project (Wugularr);
- arrangements for an inter-community visit to meal-providing women's centres by community women who would like to have similar arrangements in their own communities;
- escorting community members on bush tucker trips, hunting, fishing, etc;
- the recruitment and training of two CBWs in Ngukurr.

***Interface with clinic:***

The Nutrition Program interacted with the community clinics by responding to requests for education and/or resources regarding nutrition for both clinic staff and clients (e.g. diabetes group education sessions at Barunga and helping to establish a walking group in Barunga).

***Impact of remoteness/nature of community life:***

Impacts of remoteness/nature of community life on the Nutrition Program included:

- the Nutrition Coordinator having to leave Katherine to undergo medical treatment that was not available in the region;
- community funeral commitments that resulted in people being away from the community for extended periods;
- the inability to locate an individual in the community who requested the support of a nutritionist;
- non-attendance at diabetes support group activities; and
- the women's centre workers unable to attend nutrition conference in Alice Springs due to resourcing issues.

***Linkage with other programs:***

The Nutrition Program linkages with other programs included:

- participation in Food Alliance for Remote Australia, with the combined aim to improve capacity of individuals and communities to manage their own health through access to more suitable food choices;
- training for staff at the aged care centre in Wugularr in combination with the Aged Care Coordinator, regarding modified diets for clients with chronic disease;
- the development of strong links with other nutritionists in the Katherine region with a view to sharing resources and working towards best practice through peer support;
- discussion and preparation of training and resources for nutrition CBWs in collaboration with SHS Education Unit;
- working with the SHS Education Unit to develop a caution guide for clinic staff when using vitamin supplements.

**Table 17 Summary of activities for the SHS Nutrition Program**

<b>Community</b>	<b>Community Meetings</b>	<b>Health Days/Activities</b>	<b>Other</b>
<b>Werenbun</b>	None identified	None identified	
<b>Barunga</b>	Providing information to the clinic about food allergies and intolerance	<ul style="list-style-type: none"> <li>Mothers and carers of young children workshop</li> <li>Nutrition session at football clinic</li> <li>Food stall at Barunga festival</li> <li>Nutrition session with antenatal group</li> <li>One session with diabetes group</li> </ul>	<ul style="list-style-type: none"> <li>Delivery of anaemia resources to clinic</li> <li>Delivery of healthy food resources to store</li> <li>Market Basket Survey</li> </ul>
<b>Manyllaluk</b>	Providing feedback to the community store about Market Basket Survey	Healthy cooking session for mothers with infants and how to incorporate bush tucker	Market Basket Survey
<b>Wugularr</b>	None identified	Cooking training at women's centre	Market Basket Survey
<b>Bulman</b>	Discussion with the community council about community store at Weemol	Healthy schools program	Market Basket Survey
<b>Weemol</b>	None identified	None identified	
<b>Mataranka</b>	Discussion with the school about nutrition health promotion	Diabetes and food information session at community hall	
<b>Jilkmिंगgan</b>	<ul style="list-style-type: none"> <li>Providing information about diabetes and food</li> <li>Discussion with the community council about school breakfast program</li> <li>Discussion with the school Nutrition Worker about support and advice for program</li> </ul>	Cooking demonstration at crèche	
<b>Minyerri</b>	<ul style="list-style-type: none"> <li>Discussion with the crèche about children's snacks</li> <li>Discussion with the community store about nutrition promotion</li> </ul>	<ul style="list-style-type: none"> <li>Nutrition session at football clinic</li> <li>Diabetes workshop</li> </ul>	Market Basket Survey
<b>Ngukurr</b>	None identified	Fruit and vegetable promotion at Ngukurr festival	Market Basket Survey
<b>Urapunga</b>	<ul style="list-style-type: none"> <li>Discussion with the community store and the Fred Hollows Foundation about secure food supply in wet season</li> <li>Providing feedback to the Community Health Committee about Market Basket Survey data.</li> </ul>	None identified	Market Basket Survey

## Frail and Aged Care Program

The allocation of resources and programs for Aged Care was complex. As with the Nutrition Program, the new SHS Frail and Aged Care Program also inherited an established program known as the Commonwealth-funded Community Aged Care Packages (CACPs). The Jawoyn Association had been augmenting CACPs since 2000. The role of the SHS Aged Care Coordinator was to manage these packages and improve on the program.

The SHS Frail and Aged Care Coordinator developed an aged care plan, which was approved by the SHS Board in October 2003. The aged care plan aimed to:

- complete a needs analysis of all aged people (55 years and over) in the SHS communities;
- encourage optimal nutritional requirements for aged adults, through improved access to healthy foods;
- promote staying at home for the frail aged;
- increase workforce in communities to respond to aged care issues;
- promote the traditional role of the elderly;
- promote social/emotional well being;
- provide opportunities for self-management/knowledge of chronic conditions;
- encourage all aged care people in communities to be immunised with fluvax yearly/pneumovax as per schedule;
- promote appropriate palliative care service;
- promote a safe environment for the aged in the community; and
- prevent falls and injuries in aged people.

### ***Program description:***

The Aged Care Coordinator was responsible for the CACP. The program also provided advice and support to Home and Community Care (HACC) and coordinated and liaised with aged care services for clients over the age of 50 in the Katherine East region. The program supported aged care assessments for those 55 years and over and arranged respite care and transport for remote area clients and other aged care service providers.

### ***Overview of activities***

Key activities of the Aged Care Program were:

- providing training for aged care workers (in conjunction with Katherine Region Allied Health Service) at Barunga and Wugularr;
- presenting aged care information to the Wugularr Community Health Committee;
- weekly visits to seven clients with CACPs and fortnightly visit to one CACP client;
- monthly claims for CACPs, six-monthly reports to DoHA;
- monthly reports to Red Cross for the management of CACPs;
- provision of recipes and support to the Meals On Wheels Program at Mataranka;
- delivery of equipment (i.e. beds, walking frames, toilet seats);
- arrangements and transport for clients to and from respite care in Katherine;

- organisation and administration of bush trips and outings for Aged Care clients (e.g. Pandanus collection, fishing, trips to town, women's meetings);
- support for Mataranka Day Centre/Drop in Centre Program for the elderly;
- attendance of meetings (i.e. disability rights);
- conference attendance (e.g. palliative care/continence);
- the introduction of respite vehicle program with NT Carers; and
- the sewing program at Barunga and Manyallaluk.

### ***Interface with clinic***

The Aged Care Program interaction with the community clinics was characterised by:

- assessment and support for home modification for aged care clients;
- assistance with 55 years and over health assessments;
- provision of education to clinic staff regarding 55 years and over health assessment;
- development of a template on Communicare for 55 years and over health assessments in collaboration with Clinic Nurse Coordinator from the Wugularr community;
- revision of care plans for aged care clients located at the clinics;
- transport for clients to the clinics for assessment; and
- communication with clinics regarding client condition and social circumstances.

### ***Impact of remoteness/nature of community life***

Impacts of remoteness/nature of community life on the Aged Care Program included the cancellation of bush trips, meetings and training due to:

- lack of accommodation in community;
- community funeral commitments;
- weather restricting entry into the community;
- community request; and
- shortage of SHS vehicles.

### ***Linkage with other programs***

The Aged Care Program linkages with other programs included:

- liaising with the SHS Education Unit to prepare training for aged care workers;
- support of overlapping programs with the Child Health Coordinator;
- linked participation with the Nutrition Coordinator on projects (e.g. meals for aged clients in the communities);
- collaboration with the Aged Care Assessment Team to assess eligibility of clients for aged care assistance;
- coordination and liaison with Service Providers (e.g. NT Carers, Red Cross Darwin, KRAHRS Allied Health Team and Katherine Region Aged and Disability Services).

**Table 18 Summary of activities for the SHS Frail and Aged Care Program**

<b>Community</b>	<b>Community Meetings</b>	<b>No.</b>	<b>Health Days/Activities</b>	<b>No.</b>	<b>Other</b>	<b>No.</b>
<b>Werenbun</b>	None identified		None identified		<ul style="list-style-type: none"> <li>• Outings with CACP client (e.g. Edith Falls)</li> <li>• Fortnightly visits</li> </ul>	1 NFP
<b>Barunga</b>	HACC meeting with council	7	Women's health information day	40	<ul style="list-style-type: none"> <li>• HACC end of year party</li> <li>• Weekly CACP visits</li> <li>• Deliver HACC meals</li> <li>• Bush trips</li> </ul>	9 1 NFP NFP
<b>Manyllaluk</b>	Women's centre about storage of food and cleaning products	NFP	<ul style="list-style-type: none"> <li>• Education about storage of food and cleaning women's centre</li> <li>• Eye program for reading glasses</li> </ul>	1 NFP	HACC end of year party	13
<b>Wugularr</b>	<ul style="list-style-type: none"> <li>• Workers at aged care facility</li> <li>• Client focus meetings at clinic</li> <li>• Community Health Committees – present aged care data</li> </ul>	3 NFP NFP	<ul style="list-style-type: none"> <li>• Education to clinic staff about 55 year and over health assessments</li> <li>• Health assessment, chronic disease care plans</li> </ul>	3 4	<ul style="list-style-type: none"> <li>• Aged care training</li> <li>• HACC end of year party</li> <li>• Weekly CACP visits</li> <li>• HACC assessments</li> <li>• Bush trips</li> </ul>	3 9 6 4 NFP
<b>Bulman</b>	<ul style="list-style-type: none"> <li>• Council – needs of old people staying in the community</li> <li>• Council training about HACC</li> <li>• Women's centre regarding the Meals On Wheels Program</li> <li>• Family meeting about aged client</li> </ul>	9 NFP NFP NFP	<ul style="list-style-type: none"> <li>• Eye program for reading glasses</li> <li>• AHW training about 55 year and over health assessments</li> </ul>	10 1		

## Chronic Disease Program

The Chronic Disease Program was the last major program to be developed as instigation was dependent upon the extra funding that was to be made available when the Roper River communities were included in the trial. This also gave sufficient funding for a Chronic Disease Coordinator position. The Chronic Disease Program framework was developed in April 2003 by the Medical Director.

The Chronic Disease Program was overtaken by the clinical activities around health assessments, care planning and review – as a consequence there was little activity in the Chronic Disease Program.

## Discharge Liaison Program

### ***Program description:***

Staff consisted of a Discharge Liaison Officer who was appointed in August 2003 and a Social Worker who was appointed in March 2004. The Discharge Liaison Officer was subsequently seconded to another position within SHS and the role was combined with the role of Social Worker. This combination remained for the duration of the trial.

This position was mostly town-based, but the Social Worker/Discharge Liaison Officer often accompanied other coordinators on community visits.

The Discharge Liaison Officer role was designed to establish and strengthen the relationship between the hospital, the community clinics and service providers to support clients on admission to and discharge from hospital and ensure follow-up for the client when necessary.

The addition of the Social Worker to the role helped to increase the involvement of a wider range of service providers and allowed greater understanding of the social circumstances involved in the client's discharge from and admission to hospital.

This position within SHS was a source of advice and information and worked closely with the Women's and Maternal Health Coordinator.

### ***Overview of activities:***

Key activities of the Discharge Liaison Program were to:

- establish a database of SHS hospital patients;
- help to formulate a Memorandum of Understanding (MOU) between hospital and SHS for the release of client information;
- visit hospital clients twice weekly and establish if discharge follow-up was required;
- liaise with hospital, community clinic and other service providers to support community clients on discharge from hospital;
- support the development and delivery of the antenatal program for young mothers;
- provide advice and support for health promotion activities in the fields of domestic violence and child protection;
- foster working relationships with Family and Community Services in terms of establishing ongoing support for SHS clients and families; and
- conduct regular meetings with NT service providers looking at service provision for women (such as crèches, women's centres and crisis centres).

### ***Interface with community clinic:***

The Discharge Liaison Program interaction with the community clinics was characterised by:

- informing clinics of follow-up requirements on hospital discharge of clients;
- acting as a conduit for communication between the clinics and the hospital for client information; and
- visiting hospital clients at the clinics' request.

### ***Impact of remoteness/nature of community life:***

Impacts of remoteness/nature of community life on the Discharge Liaison Program included:

- lack of transport options to return clients to their communities;
- lack of support for community clients when in Katherine due to lack of transport and accommodation options in Katherine; and
- clients having to stay in Katherine due to services being unavailable in their communities (e.g. physiotherapy).

### ***Linkage with other programs:***

The Discharge Liaison Program linkages with other programs included:

- development of strong working relationship with Katherine Hospital Discharge Planner and Aboriginal Liaison Officer;
- collaboration with Women's and Maternal Health Coordinator of the antenatal program for young mothers and links with maternity inpatients and coordinator;
- referring hospital discharge patients to coordinators (e.g. Failure to Thrive child to Child Health Coordinator, antenatal woman to Women's and Maternal Health Coordinator);
- collaboration with the Aged Care Coordinator regarding hospital admission and discharge for aged care clients who were more likely to require hospital services;
- referring children to the Child Health Coordinator for monitoring and follow-up for children at risk on discharge from hospital.

**Table 19 Summary of activities for the SHS Discharge Liaison Program**

<b>Community</b>	<b>Community Meetings</b>	<b>Health Days/Activities</b>	<b>Other</b>
<b>Katherine</b>	<ul style="list-style-type: none"> <li>• Women's crisis centre</li> <li>• Centrelink</li> <li>• FACS</li> <li>• National youth participation strategy</li> </ul>	None identified	<ul style="list-style-type: none"> <li>• Twice weekly hospital visits.</li> <li>• Social week intervention/month</li> <li>• Hospital</li> <li>• Discharge</li> <li>• Non-hospital</li> </ul>
<b>Barunga</b>	<ul style="list-style-type: none"> <li>• Women's centre about financial issues</li> <li>• Community Health Committee about hospital admission and discharge</li> </ul>	Participate in antenatal program	Accompany aged care coordination on visit
<b>Manyllaluk</b>	None identified	None identified	
<b>Wugularr</b>	Community Health Committee about hospital admission and discharge	None identified	Accompany women's health coordination on visit
<b>Bulman</b>	None identified	None identified	
<b>Weemol</b>	None identified	None identified	
<b>Mataranka</b>	None identified	None identified	
<b>Jilkinggan</b>	None identified	None identified	
<b>Minyerri</b>	None identified	None identified	
<b>Ngukurr</b>	None identified	None identified	
<b>Urapunga</b>	None identified	None identified	

## Appendix J SHS Care Coordination Index

The index measured and scored individual coordinated care programs on six important domains in care coordination, each of which are made up of one or more criteria. These domains and the criteria associated with them are presented in the table below.

**Table 20 Domains and criteria associated with the Care Coordination Index**

Domain	Criteria
<b>Initial assessment and care planning</b>	Care/Service Coordinator involvement in initial assessment
	Quality of initial assessment
	Quality of care planning
<b>Evaluation and monitoring</b>	Quality of client contacts
	Flexibility of care plan
	Involvement of healthcare professionals in monitoring
<b>Service arrangements</b>	The extent of structured service delivery
	Quality of trial follow-up
	Flexibility of service arrangements
<b>Participating community member education</b>	Extent of structured education programs
<b>Involvement of GPs</b>	Involvement of GP in meeting client needs
<b>Involvement of other service providers</b>	Care/Service Coordinator involvement in changing settings
	Care/Service Coordinator involvement with other service providers in changing client settings
	Care/Service Coordinator involvement with GP in changing client settings

The Care Coordination Index was adapted from an evaluation tool developed and copyrighted by S.A. Squared Michigan, Inc. and used for a study by Chen et al. (2000).<sup>17</sup>

### **Scoring of the Care Coordination Index**

An overall care coordination score for each trial was identified. Rather than a numeric descriptor, the score was expressed in terms of a qualitative descriptor, ranging from *no care coordination process*, through to *high care coordination process*. This overall score was derived from the criteria scores attributed to each of the six domains. The domain scores were also qualitative in nature, and again ranged from *low process* to *high process*.

For the purposes of comparison between the first and second administrations, the National Evaluator (NE) returned to the allocation of numeric scores for each of the six domains and their associated criteria scores.

Local Evaluators (LEs) assigned a score to each criteria score under each domain. Some criteria scores ranged between zero and three while others ranged from one to three. LEs were able to add or subtract 0.3 to each criteria score to reflect a '+' or '-' grade. For instance, a '3-' is expressed as 2.7.

The overall domain score is an average of the criteria scores constituting the domain. An overall process score was then calculated by summing the six domain scores. The overall process score, which is an indicator of the level of care coordination process, was then described as 'high', 'moderate' or 'low', as presented below:

<sup>17</sup> Chen A, Brown R, Archibald N et al. (2000), *Best Practice in Coordinated Care*, Mathematica Policy Research Inc., Princeton NJ.

**Table 21 Care Coordination Index scores**

<b>Overall scores</b>	<b>Level of care coordination process</b>
14 and above	High
11, 12 and 13	Moderate
10 and below	Low

### **SHS Care Coordination Index – domain scores**

The table below describes the domain scores under the first and second administrations of the Care Coordination Index for the Wugularr clinic in the SHS trial, and discusses changes against each domain over these administrations. Each criteria score in the Care Coordination Index was associated with a standard definition, and these are reported in the first and second columns in the table following.

**Table 22 Care Coordination Index for SHS under the first and second administrations**

1st Administration Score October 2003	2nd Administration Score September 2005	Discussion of Care Coordination Index over the 1st and 2nd administrations
<b>Initial Assessment and Care Planning</b>		
This domain reflects the effectiveness of the trial in terms of the extent of Care and Service Coordinators' involvement in the initial assessment process, the quality of the initial assessment and the quality of the care planning.		
<p><b>Score: 0.3</b></p> <p><b>Definition:</b></p> <p>There was no initial assessment or care planning.</p>	<p><b>Score: 2.7</b></p> <p><b>Definition:</b></p> <p>The Care/Service Coordinator personally performed the initial assessment of the patient as soon as possible after referral. The initial assessment was extremely thorough, and all clients' problems and potential problems were identified, and the trial developed an individual plan of care, in conjunction with all other involved service providers, tailored to eliminate the clients' problems.</p>	<p>At early trial, a chronic disease register existed which was created by the District Medical Officer 18 months prior to the start of the Katherine East Coordinated Care Trial. Most patients on the register had care plans, however they were not complete. These care plans followed a template provided by the regional health service provider at the time, DHCS.</p> <p>By end trial, SHS had implemented a Care Coordination Model. Health assessments under the model are multi-disciplinary in that they involve the AHW, CBW, Nurse, Medical officer, specialist doctors, allied health personnel, Chronic Disease Coordinator and Program Coordinators. A system of care plan review has also been put into place.</p> <p>Case studies found that while patients were not aware of the term 'care plan', they could describe the care-planning process.</p>
<b>Evaluation and monitoring</b>		
This domain reflects the trial's level of care coordination in terms of quality of client contacts, flexibility of the care plan to changing client needs and the involvement of healthcare professionals in monitoring client progress.		
<p><b>Score: 0.3</b></p> <p><b>Definition:</b></p> <p>Client contacts were unfocused and sporadic.</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b></p> <p>Some elements of client contacts were structured. Responses to problems may have been somewhat mechanical. The Care/Service Coordinator may have lacked knowledge, training or protocols on resolving problems.</p>	<p>At early trial, there was very little evidence of care plan review as imminent changeover of health services from DHCS to SHS significantly affected staffing stability, and the majority of early trial staff, including Clinical Nurse Consultants, were relieved. By end trial, SHS had put into place a system for regular review with clinical records providing evidence of regular review of care plans.</p>
<b>Service arrangement</b>		
This domain reflects the effectiveness of the trial with respect to the level of structured service delivery, the quality of trial follow-up and the flexibility of services to respond to changing care plans.		
<p><b>Score: 0.7</b></p> <p><b>Definition:</b></p> <p>The trial identified needed services. There was no planned follow-up. Despite goals not being achieved, the care plan is not modified in any way.</p>	<p><b>Score: 2.7</b></p> <p><b>Definition:</b></p> <p>The trial arranged for services as part of the overall plan of care. The trial followed-up to determine if the service was delivered and whether it achieved its intended goal. If the goal was not achieved, the care plan was modified accordingly.</p>	<p>At early trial, adjustments to services were driven by needs identified on an ad hoc basis rather than through regular review, and service arrangements and existing care coordination were significantly effected by the changeover of health services. By end trial SHS Population Health Programs and Allied Health service providers were actively involved in the care plan process. There was also an increase in primary health care resources and improved access to care through culturally appropriate services.</p>

1st Administration Score October 2003	2nd Administration Score September 2005	Discussion of Care Coordination Index over the 1st and 2nd administrations
<b>Participating community member education</b>		
This domain measures the level of care coordination in the trial with respect to the extent to which it achieves delivery of structured education programs to clients.		
<b>Score: 1.7</b> <b>Definition:</b> Trial personnel were expected to provide some education, but there were no standard guidelines on what was to be taught.	<b>Score: 2.3</b> <b>Definition:</b> Same as previous administration	While some community education was prevalent at early trial, anticipated health service changeover affected health promotion activity provided by DHCS, with very little activity for the two years preceding the trial. By end trial, the clinic was active in community education and health promotion activities, with involvement with the school, store and other community groups. Additionally, SHS Community Development Officers improved access to care through the development and support of Community Health Committees.
<b>Involvement of GPs</b>		
This domain assesses the trial's effectiveness in involving GPs in meeting client needs.		
<b>Score: 1</b> <b>Definition:</b> The Care/Service Coordinator talked with the GP periodically, but only to resolve specific problems or issues.	<b>Score: 2.7</b> <b>Definition:</b> The Care/Service Coordinator held regularly scheduled discussions with the GP to conduct initial assessment and care planning and to evaluate and monitor the clients' progress.	At end trial, the frequency of GP visits to the trial doubled. The SHS model of coordinated care resulted in increased GP presence in the community and involvement in care planning and review.
<b>Involvement of other service providers</b>		
This domain measures the extent of care coordination in the trial in terms of the level of involvement of the Service Coordinators with clients, GPs and other service providers in changing client settings.		
<b>Score: 1</b> <b>Definition:</b> The Care/Service Coordinator prepared the client only to transfer to the next setting. They had no involvement with providers prior to or subsequent to the client's move. They did not keep the GP abreast of the client's progress.	<b>Score: 2</b> <b>Definition:</b> After the client moved to another setting, the Care/Service Coordinator ceased to be involved. They kept the GP abreast of the client's progress to some degree.	At early trial, there was very little Allied Health input into assessment and care coordination and all care provided was episodic rather than planned. By end trial, Allied Health services were involved in care planning and care coordination, local 'community-based workers' were employed to assist with chronic disease program, and there was increased stability of resident Remote Area Nurses and AHWs.

# Appendix K SHS Community Capacity Index

## Description of Wuglarr Community Health Committee's development over the duration of the trial

Network partnerships	Description
<p><b>First administration:</b> Level 1</p> <p><b>Second administration:</b> Level 2</p> <p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has ability to define community groups within the community and initiate communication with them.</p> <p><b>Level 2:</b> Community Health Committee is recognised by the community as a legitimate conduit for health issues discussion.</p> <p><b>Level 3:</b> Community Health Committee has the ability to maintain the network between community groups.</p>	<ul style="list-style-type: none"> <li>The Wuglarr Community Health Committee was established in July 2003 and, by the time of the first assessment, network partnerships had begun to form with the relevant stakeholders groups within the community. The Community Health Committee felt that the community was united and that they were aware of, and in communication with, all the groups in the community, although at the time they were not recognised as the primary link for health discussion.</li> <li>By the second assessment, networks between the Community Health Committee and community had developed further. The Community Health Committee felt it was increasingly engaged in discussion of health issues with the community via both community participation in Community Health Committee meetings and feedback to community groups and members. The Local Evaluator (LE) received positive feedback from community groups about the Community Health Committee's role and "voice" for health issues. Further feedback from the community illustrated that although the Community Health Committee was communicating with relevant community groups, they were not connecting to the wider community as effectively. The evaluation indicated that Wuglarr Community Health Committee had established communication with the community and was recognised as a legitimate conduit for health-related issues.</li> </ul>
Knowledge transfer	Description
<p><b>First administration:</b> Level 1</p> <p><b>Second administration:</b> Level 1</p> <p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability to engage community groups and discuss their health issues and explain the SHS model and trial timeline.</p> <p><b>Level 2:</b> Community Health Committee has the ability to relay this knowledge accurately to SHS via the SHS Board and can explain the 'Money Story' to community members.</p> <p><b>Level 3:</b> Community Health Committee has the ability to both relay issues to the SHS Board and provide feedback to community groups on a regular basis.</p>	<ul style="list-style-type: none"> <li>At the time of the first assessment, the Community Health Committee was communicating informally with the community about health issues. As there were SHS Board Members active on the Community Health Committee, the Committee was already engaged in relaying community feedback of identified health issues to the SHS Board (level 2). Despite this, the Community Health Committee was scored at level one because of its inability to achieve some of the requirements of level one of the capacity framework. This included the inability of any Community Health Committee member to explain the SHS model or the trial timeline diagram. It was considered that delays in the trial disseminating this information to the Community Health Committee were the cause of these inabilities and, as such, somewhat out of the control of the Committee.</li> <li>The Community Health Committee members interviewed at the second assessment were more aware of the Money Story, although not confident in explaining it. Communication had continued to strengthen between the Community Health Committee, SHS services and the SHS Board. Also, communication with the community had expanded to informing the community of important issues from the trial, although still mainly through informal family network channels. The community echoed views of increased communication between the Community Health Committee and some community groups. However, there were still some groups that were not linked via family networks and remained unengaged with the Community Health Committee. At the time of the second assessment, the Community Health Committee was still not confident about explaining the SHS model, trial timeline and Money Story. Although still at level one, there was noticeable development in the engagement of key sectors in the community and effective communication links with SHS, and the SHS Board.</li> </ul>

Problem solving		Description
<b>First administration:</b>	<b>Level 1</b>	<ul style="list-style-type: none"> <li>At the initial assessment, the Community Health Committee was confident in their problem-solving capabilities and were discussing identified health issues with both the community and the SHS Board. There was some supporting evidence from the community perspective, with several community members reporting Community Health Committee involvement in addressing some of the issues.</li> <li>At the second assessment, the Community Health Committee was confident that they could communicate relevant health issues and help initiate mechanisms to address these issues. Similarly the community stakeholder groups indicated increased Committee involvement in health-related problem solving (although there was some confusion amongst stakeholder groups in differentiation between the Community Health Committee and the trial). Several more examples of issues being addressed in the community were cited by the community groups who also noted a feeling of involvement in the problem-solving loop.</li> </ul>
<b>Second administration:</b>	<b>Level 2</b>	
<b>Criteria:</b>		
<b>Level 1:</b> Community Health Committee has the ability (with education team support) to identify and discuss community health issues as articulated by the community.		
<b>Level 2:</b> Community Health Committee has the ability to instigate mechanisms for problem solving, elicit support from SHS and coordinate problem solving with the community, SHS Board and SHS services.		
<b>Level 3:</b> Community Health Committee has the ability to sustain a framework for problem solving within the community.		

Infrastructure	Description
<p><b>First administration:</b> Level 1</p> <p><b>Second administration:</b> Level 2</p>	
<p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability to call, run and document regular meetings with support from the education team.</p> <p><b>Level 2:</b> Community Health Committee has acceptance by the community as the legitimate conduit for health issues and works effectively with the education team to call and run meetings. Community Health Committee have an understanding of financial issues (Money Story).</p> <p><b>Level 3:</b> Community Health Committee has the ability to operate in the community without support from the education team and is able to act as an effective community voice on health issues.</p>	<ul style="list-style-type: none"> <li>By the first administration, the Community Health Committee was conducting and documenting meetings with the support of the CDOs and as such reached a level-one score for infrastructure capacity. The Community Health Committee had some difficulty conducting regular meetings as a result of cancellations by community members (due to important community issues). As a result, they only averaged one meeting every two months. Although many in the community were aware of the Community Health Committee, many were still not aware of (or involved in) the Community Health Committee meetings.</li> <li>At the second assessment, the Community Health Committee was taking more active control of meetings. The Community Health Committee decided when to hold meetings and felt that they were useful to the Community Health Committee and the community. The LE also received positive feedback from the community about the usefulness of the Community Health Committee meetings. This was mainly from those with an active stake in community health issues (such as those involved in the Women's or Men's groups). The Community Health Committee had also developed their understanding of the basics of the Money Story.</li> </ul>

## Description of Bulman Community Health Committee's development over the duration of the trial

Network partnerships		Description
<b>First administration:</b>	<b>Level 2</b>	<ul style="list-style-type: none"> <li>Bulman Community Health Committee had its first meeting in July 2003. By the time of the first administration, the Bulman Community Health Committee had already developed a level two capacity in network partnerships. The Community Health Committee felt they were communicating effectively to many people in the community about health issues and that the community would come to them with their health concerns. Evidence from the community members indicated there was still some identity confusion between the Community Health Committee and SHS. However, it was clear that Bulman Community Health Committee had developed networks with the relevant community stakeholder groups and leaders and had begun to address the health issues of some individuals.</li> <li>By the second administration, the Community Health Committee had maintained and further developed relationships within the community and health-related stakeholder groups. The small size of the community coupled with key members of the community being involved in the Community Health Committee account for this development. The fact that some of these key members of the community were also engaged in the SHS Board may help to explain the persistent identity confusion between the Community Health Committee and SHS. Despite this, the Community Health Committee and SHS were seen as effective and continued to be the legitimate health conduit of the community.</li> </ul>
<b>Second administration:</b>	<b>Level 3</b>	
<b>Criteria:</b>		
<b>Level 1:</b>	Community Health Committee has ability to define community groups within the community and initiate communication with them.	
<b>Level 2:</b>	Community Health Committee is recognised by the community as a legitimate conduit for health issues discussion.	
<b>Level 3:</b>	Community Health Committee has the ability to maintain the network between community groups.	
Knowledge transfer		Description
<b>First administration:</b>	<b>Level 1</b>	<ul style="list-style-type: none"> <li>At the first administration, the Community Health Committee had defined and engaged the important stakeholder groups of the community and had gained significant involvement by key members of the community. Despite some feedback questioning the Community Health Committee's capacity to clearly explain the trial model and timeline, the Community Health Committee was firmly engaged with the community and the SHS Board.</li> <li>At the second administration, the Community Health Committee had developed its understanding of the trial model, timeline and Money Story and continued the development of community network partnerships, enabling increased knowledge-transfer. Some limitations persisted in information-diffusing to community members outside direct links with the Community Health Committee or community stakeholder groups, indicating that the Committee had not yet reached a level three.</li> </ul>
<b>Second administration:</b>	<b>Level 2</b>	
<b>Criteria:</b>		
<b>Level 1:</b>	Community Health Committee has the ability to engage community groups and discuss their health issues and explain the SHS model and trial timeline.	
<b>Level 2:</b>	Community Health Committee has the ability to relay this knowledge accurately to SHS via the SHS Board and can explain the 'Money Story' to community members.	
<b>Level 3:</b>	Community Health Committee has the ability to both relay issues to the SHS Board and provide feedback to community groups on a regular basis.	
Problem solving		Description
<b>First administration:</b>	<b>Level 2</b>	<ul style="list-style-type: none"> <li>The Community Health Committee was identifying and discussing health issues of the community by the first administration and was already eliciting support to address several of these issues, examples of which were domestic violence and nutrition concerns.</li> <li>The Community Health Committee continued to demonstrate a well developed problem-solving capacity and had developed working relationships with CDOs and community stakeholder groups to address health concerns. However, there were no further issues addressed by the time of the second administration.</li> </ul>
<b>Second administration:</b>	<b>Level 2</b>	
<b>Criteria:</b>		
<b>Level 1:</b>	Community Health Committee has the ability (with education team support) to identify and discuss community health issues as articulated by the community.	
<b>Level 2:</b>	Community Health Committee has the ability to instigate mechanisms for problem solving, elicit support from SHS and coordinate problem solving with the community, SHS Board and SHS services.	
<b>Level 3:</b>	Community Health Committee has the ability to sustain a framework for problem solving within the community.	

Infrastructure	Description
<p><b>First administration:</b> Level 1</p> <p><b>Second administration:</b> Level 1</p>	<ul style="list-style-type: none"> <li>At the first administration, the Community Health Committee was conducting regular, minuted meetings, with collaborative control between themselves and SHS. It was noted that the regularity of these meetings could be interrupted by deaths and funerals and in reality they achieved a meeting every two months. The Community Health Committee did not have a confident understanding of the Money Story. Whilst the community were aware of the Community Health Committee meetings, there was little participation from them at this time.</li> </ul>
<p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability to call, run and document regular meetings with support from the education team.</p> <p><b>Level 2:</b> Community Health Committee has acceptance by the community as the legitimate conduit for health issues and works effectively with the education team to call and run meetings. Community Health Committee have an understanding of financial issues (Money Story).</p> <p><b>Level 3:</b> Community Health Committee has the ability to operate in the community without support from the education team and is able to act as an effective community voice on health issues.</p>	<ul style="list-style-type: none"> <li>At the second administration, the community profile of the Bulman Community Health Committee had improved. The Community Health Committee was taking an informed interest in their finances and those of SHS and felt the Community Health Committee meetings useful to the community. In the community there continued to be some identity confusion between the Community Health Committee and SHS. Despite this, the Community Health Committee was viewed positively by the community and members of community stakeholder groups participated in Community Health Committee meetings. The community stakeholder groups regarded the Community Health Committee as the legitimate health body and felt that they were working to solve health issues in conjunction with the CDOs.</li> </ul>

## Description of Ngukurr Community Health Committee's development over the duration of the trial

Network partnerships	Description
<p><b>First administration:</b> &lt; Level 1</p> <p><b>Second administration:</b> Level 2</p> <p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has ability to define community groups within the community and initiate communication with them.</p> <p><b>Level 2:</b> Community Health Committee is recognised by the community as a legitimate conduit for health issues discussion.</p> <p><b>Level 3:</b> Community Health Committee has the ability to maintain the network between community groups.</p>	<ul style="list-style-type: none"> <li>At the first administration, the Ngukurr Community Health Committee had an awareness of all community groups that existed. At this time only part of the community recognised the Community Health Committee as a potential conduit for voicing their health concerns. Many of the community who knew of the Community Health Committee still saw it as an extension of SHS. There had been little contact between the Community Health Committee and the community. Therefore, whilst the Community Health Committee was aware of the community dynamics, they were not yet communicating with all factions of the community. The main difficulties the Ngukurr Community Health Committee faced in developing networks with the community were the complex and divided nature of the community and the short length of time the trial had been in operation.</li> <li>At the second administration, although still not well known, the Community Health Committee felt they had engaged more of the community. The Community Health Committee reported that they were not accepted by all the community and that this had impacted on their effectiveness. The Community Health Committee was continuing in their attempts to engage the community under difficult circumstances. The need to engage groups with varied interests and sometimes conflicting views, coupled with the large size of the community, made the development of networks difficult. Despite this, some progress had been made with community engagement and awareness by the second assessment.</li> </ul>
Knowledge transfer	Description
<p><b>First administration:</b> &lt; Level 1</p> <p><b>Second administration:</b> Level 2</p> <p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability to engage community groups and discuss their health issues and explain the SHS model and trial timeline.</p> <p><b>Level 2:</b> Community Health Committee has the ability to relay this knowledge accurately to SHS via the SHS Board and can explain the 'Money Story' to community members.</p> <p><b>Level 3:</b> Community Health Committee has the ability to both relay issues to the SHS Board and provide feedback to community groups on a regular basis.</p>	<ul style="list-style-type: none"> <li>At the first administration, due to the limited networks and engagement with the community, there was little evidence that knowledge transfer was happening and as a result the Ngukurr Community Health Committee had not yet reached level one.</li> <li>At the second administration, the Community Health Committee still considered knowledge was not being transferred to the community, although the core group within the Community Health Committee had developed their ability and efforts to engage with the community. Knowledge transfer was considered to be at level one due to the fact that the Community Health Committee had developed its capacity to communicate information with the community, although, due to problems with network partnerships, this was yet to become effective.</li> </ul>
Problem solving	Description
<p><b>First administration:</b> Level 1</p> <p><b>Second administration:</b> Level 1</p> <p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability (with education team support) to identify and discuss community health issues as articulated by the community.</p> <p><b>Level 2:</b> Community Health Committee has the ability to instigate mechanisms for problem solving, elicit support from SHS and coordinate problem solving with the community, SHS Board and SHS services.</p> <p><b>Level 3:</b> Community Health Committee has the ability to sustain a framework for problem solving within the community.</p>	<ul style="list-style-type: none"> <li>By the first administration, evidence from Community Health Committee meeting minutes indicated that the Community Health Committee was identifying and discussing community health issues. At this time the Community Health Committee was only establishing minimal network partnerships in the community and was, as yet, unable to coordinate problem-solving strategies throughout the community.</li> <li>This situation remained similar at the second administration. Although the Community Health Committee had increased their community exposure they still had little contact with the community concerning health problems. Problem-solving capacity did not develop and remained at level one.</li> </ul>

Infrastructure	Description
<p><b>First administration:</b>      <b>Level 1</b></p> <p><b>Second administration:</b>      <b>Level 2</b></p>	<ul style="list-style-type: none"> <li>Although by the first administration Community Health Committee meetings were being run at regular intervals, the infrastructure had not developed to link the meetings and the results of the meetings to the community in a meaningful way.</li> <li>This situation remained at the second administration.</li> </ul>
<p><b>Criteria:</b></p> <p><b>Level 1:</b> Community Health Committee has the ability to call, run and document regular meetings with support from the education team.</p> <p><b>Level 2:</b> Community Health Committee has acceptance by the community as the legitimate conduit for health issues and works effectively with the education team to call and run meetings. Community Health Committee have an understanding of financial issues (Money Story).</p> <p><b>Level 3:</b> Community Health Committee has the ability to operate in the community without support from the education team and is able to act as an effective community voice on health issues.</p>	

# Appendix L SHS Service utilisation

## Excluded MBS items

MBS Item Numbers	Description	Date of effect
10993, 10996	Services provided by a Practice Nurse in a general practice	1 February 2004
10950, 10952, 100954, 10956, 10958,	People with chronic and complex conditions who are being managed through an Enhanced Primary Care (EPC) multidisciplinary care plan may be eligible for up to five allied health services per year	1 July 2004
10951	Services provided by diabetes educators	1 November 2004
10975, 10976, 10977	People with chronic and complex conditions who are being managed through an EPC multidisciplinary care plan may be eligible for up to three dental services per year	1 July 2004
10998	Practice Nurses in rural areas to undertake a wider range of procedures	1 January 2005
710	Aboriginal and Torres Strait Islander adult health check	1 May 2004
712	Introduction of a new Medicare item for GPs to undertake comprehensive medical assessments of residents of aged care homes	1 July 2004
10990, 64990, 74990	\$5 bulk-billing incentive for every bulk-bill medical service provided to Commonwealth concession card holders and children under 16	1 February 2004
10991, 64991, 74991	\$5 bulk-billing incentive increased to \$7.50 in regional, rural and remote Australia	1 May 2004
10991, 64991, 74991	Extension of the \$7.50 bulk-billing incentive for Commonwealth concession card holders and children under 16 to: <ul style="list-style-type: none"> <li>outer suburban and semi-rural areas identified by the Department as areas of workforce shortage with lower bulk-billing rates in Qtr 1, 2004</li> <li>greater Townsville and Darwin because they are isolated cities</li> <li>ACT and Queanbeyan which have chronic workforce shortages</li> </ul>	1 September 2004
	Rebates for all GP services to increase from 85% to 100% of the scheduled fee	1 January 2005
1, 2, 97, 98, 601, 602, 697, 698, 5000, 5067	Rebates for after-hours GP services to increase by \$10	1 January 2005
10992	New bulk-billing incentive item enabling medical practitioners not based in eligible areas but providing out of surgery after-hours services to access higher bulk-billing rebate (\$7.65) which applies when claimed in conjunction with some of the new and existing after-hours items.	1 January 2005

## Description of the CART® Modelling Tool

Classification and Regression Trees (CART) is a robust decision-tree tool (developed by the Salford Systems) for data mining, predictive modelling and data pre-processing. It searches for important patterns and relationships evident in the data.

CART decision trees and variable importance tables were used in this analysis to determine the most significant drivers of utilisation.

CART trees assign cases with similar characteristics into “nodes” based on a series of decision “rules”. This is done by selecting the best splitting rule at each stage, partitioning the dataset using that splitter and repeating.

The modelling dataset is further divided into learn and test datasets within the tree algorithm, with the learn data being used to identify the splits to use at each stage and the test data being used to prune the tree back by removing spurious splits after a large tree is grown.

The variable importance tables reflect the contribution each variable makes in predicting the target variable. Variables are identified regardless of whether they are included in the decision tree.

# Appendix M South Western Aboriginal Medical Service Aboriginal Corporation (SWAMSAC) trial objectives and interventions

The following table describes the four main trial objectives and supporting sub-objectives.

**Table 23 SWAMSAC trial objectives and sub-objectives**

<b>Objectives &amp; Sub-objectives</b>	
<b>1</b>	<b>To improve service provision to Aboriginal people through the coordination of care.</b>
1.1	To improve health outcomes for Aboriginal people with care planning that responds to the causes of illness and major disease burdens among Aboriginal people.
1.2	To identify and appropriately respond to the health needs of Aboriginal clients through the development and review of best practice assessment and care-planning tools.
1.3	To continue to develop alternative services to more appropriately address immediate health needs and prevent illness through decision-making processes based on "Our Health, Our Way".
<b>2</b>	<b>To increase the involvement of Aboriginal people in care coordination decisions concerning their health.</b>
2.1	To increase personal responsibility for health and well being of Aboriginal people through participation in care coordination, personal development and health education strategies.
2.2	To empower the community to understand and identify local health service needs through development strategies.
2.3	To increase the involvement of the Aboriginal community in decisions concerning their health and well being through communication and feedback strategies.
<b>3</b>	<b>To improve access to coordinated care health and health-related services for Aboriginal people.</b>
3.1	To improve collaboration and coordination across sectors associated with client health and well being and promote "Our Health, Our Way" of working for the South West Aboriginal community.
3.2	To implement effective and "Our Health, Our Way" service agreements with other health service providers.
<b>4</b>	<b>To extend and develop the capacity to support the care coordination operations by strengthening the organisation and management structure of SWAMSAC.</b>
4.1	To continue the development of comprehensive information systems to identify the health service needs of the South West Aboriginal community and individual clients.
4.2	To identify the appropriate models of funding required to support an Aboriginal coordinated care model operated by a community-controlled health service through the evaluation of trial performance.
4.3	To continue to train and appropriately resource SWAMSAC management and health workers to deliver coordinated health services to Aboriginal people and to develop a South West health workforce that supports "Our Health, Our Way".

## **Interventions**

There were 28 interventions in the trial. The interventions and strategies were reviewed and refined as part of the Perth workshop involving SWAMSAC, Office for Aboriginal Health (OAH) and the Office for Aboriginal and Torres Strait Islander Health (OATSIH) during October 2002. Discussion of each strategy has been drawn from the trial's Detailed Design Proposal, Version 4.1, September 2002.

The SWAMSAC interventions (or strategies) are detailed below.

**Table 24 SWAMSAC trial Interventions**

<b>Intervention 1</b>	Client identification and enrolment
<b>Intervention 2</b>	Delivering best practice care through care protocols
<b>Intervention 3</b>	“Our Health, Our Way”
<b>Intervention 4</b>	Client transport
<b>Intervention 5</b>	Outreach services
<b>Intervention 6</b>	Special community-based programs
<b>Intervention 7</b>	Alternative services
<b>Intervention 8</b>	Purchase of services and agreements “Our Health, Our Way”
<b>Intervention 9</b>	Health assessment tools
<b>Interventions 10</b>	Health assessment
<b>Intervention 11</b>	Care planning
<b>Intervention 12</b>	Care coordination
<b>Intervention 13</b>	Client ownership of care plan
<b>Intervention 14</b>	Health education for clients
<b>Intervention 15</b>	Fund holding
<b>Intervention 16</b>	Local trial management
<b>Intervention 17</b>	Community involvement from Board of Management
<b>Intervention 18</b>	Building Board of Management knowledge of care coordination
<b>Intervention 19</b>	Strategic partnerships
<b>Intervention 20</b>	SWAMSAC Internal Reference Group
<b>Intervention 21</b>	Health Worker Team meetings
<b>Intervention 22</b>	Trial start-up phase
<b>Intervention 23</b>	Independent monitoring of trial
<b>Intervention 24</b>	Local evaluation
<b>Intervention 25</b>	Training and communication programs
<b>Intervention 26</b>	Client information systems
<b>Intervention 27</b>	Improved analysis of health needs
<b>Intervention 28</b>	Cost of service provision

# Appendix N SWAMSAC Care Coordination Index

## Care Coordination Index Report

The index measured and scored individual coordinated care programs on six important domains in care coordination, each of which are made up of one or more criteria. These domains and the criteria associated with them are presented in the table below.

**Table 25 Domains and criteria associated with the Care Coordination Index**

Domain	Criteria
Initial assessment and care planning	Service Coordinator involvement in initial assessment
	Quality of initial assessment
	Quality of care planning
Evaluation and monitoring	Quality of client contacts
	Flexibility of care plan
	Involvement of healthcare professionals in monitoring
Service arrangements	The extent of structured service delivery
	Quality of trial follow-up
	Flexibility of service arrangements
Participating community member education	Extent of structured education programs
Involvement of GPs	Involvement of GP in meeting client needs
Involvement of other service providers	Care/Service Coordinator involvement in changing settings
	Care/Service Coordinator involvement with other service providers in changing client settings
	Care/Service Coordinator involvement with GP in changing client settings

The Care Coordination Index was adapted from an evaluation tool developed and copyrighted by S.A. Squared Michigan, Inc. and used for a study by Chen et al. (2000).<sup>18</sup>

### Scoring of the Care Coordination Index

An overall care coordination score for each trial was identified. Rather than a numeric descriptor, the score was expressed in terms of a qualitative descriptor, ranging from *no care coordination process*, through to *high care coordination process*. This overall score was derived from the criteria scores attributed to each the six domains. The domain scores were also qualitative in nature, and again ranged from *low process* to *high process*.

For the purposes of comparison between the first and second administrations, the NE returned to the allocation of numeric scores for each of the six domains and their associated criteria scores.

Local Evaluators (LEs) assign a score to each criteria score under each domain. Some criteria scores ranged between zero and three while others ranged from one to three. LEs were able to add or subtract 0.3 to each criteria score to reflect a '+' or '-' grade. For instance, a '3-' is expressed as 2.7.

The overall domain score is an average of the criteria scores constituting the domain. An overall process score was then calculated by summing the six domain scores. The overall process score, which is an indicator of the level of care coordination process, was then described as high, medium or low, as presented following:

<sup>18</sup> Chen A, Brown R, Archibald N et al. (2000), *Best Practice in Coordinated Care*, Mathematica Policy Research Inc., Princeton NJ.

**Table 26 Care Coordination Index scores**

<b>Overall scores</b>	<b>Level of care coordination process</b>
14 and above	High
11, 12 and 13	Moderate
10 and below	Low

### Care Coordination Index - Criteria Scores

The table below describes the criteria scores under the first, second and third administrations of the Care Coordination Index and discusses changes against each criterion over the first and second, second and third, as well as changes between first and third administrations for completeness. Each criteria score in the Care Coordination Index is associated with a standard definition, and these are reported in the second, third and fourth columns in the table following.

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Initial Assessment and Care Planning</b>						
This domain reflects the effectiveness of the trial in terms of the extent of Care and Service Coordinators' involvement in the initial assessment process, the quality of the initial assessment and the quality of the care planning.						
<b>Criterion 1: Service Coordinator involvement in initial assessment</b>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Care/Service Coordinator's role was limited</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p><b>Score: 2.3</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under both administrations, health workers were primarily responsible for initial health assessments. In a small number of cases, Registered Nurses (RNs) completed the initial health assessments.</p> <p>Under both administrations, there was a considerable time gap between the time of referral and assessment for a proportion of clients.</p> <p>Under both administrations, some clients were completing their own health assessments. This was supported by findings in a care plan audit revealed under the second administration.</p>	<p>Under the third administration, only a small number of clients were still being enrolled to the trial to replace those that had exited.</p> <p>While in the previous administration, some health assessments were completed by clients, all health assessments were completed by Aboriginal Health Workers (AHWs) under the third administration.</p> <p>Under the second administration, there was considerable gap between the time of referral and assessment for a proportion of clients.</p> <p>Under the third administration, however, allocation of health worker, health assessment and care planning occurred within one to two weeks of referral. This was a result of only a small number of health assessments taking place.</p>	<p>Under the earlier administrations, some clients were found to be completing their own health assessments and there were considerable time gaps between the time of referral and assessment. These issues were resolved under the third administration, although there were only a small number of clients still being enrolled into the trial.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<p><b>Criterion 2:</b></p> <p><b>Quality of initial assessment</b></p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> The initial assessment and care plan was not individualised.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The initial assessment and care plan was not individualised.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, the initial assessment was an interview between the AHW and the client to record the client's history and health status. It was found that on a number of occasions the client was left to complete the health assessment on their own.</p> <p>Under the second administration, there were separate health assessments for children and for adults. Some clients continued to complete their health assessments. As the health assessment tool was designed to be implemented by trained AHWs and followed up by GPs, it was found that not all health needs were captured in the health assessments.</p> <p>Furthermore, a care plan audit showed that 34% of complex client's health assessments were left incomplete.</p>	<p>Fewer health assessments were conducted under the third administration as a result of only a small number of clients being enrolled to the trial. There was no change to the health assessment process between the two administrations.</p>	<p>Throughout the trial, the health assessment process consisted of an interview between the AHW and the client to record the client's history and health status. Under the earlier administrations, it was found that a number of clients were completing their own health assessments. This issue was resolved under the third administration, although only a small number of clients were enrolled to the trial under the third administration.</p> <p>There were separate assessments for adults and children from the second administration onwards.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Criterion 3: Quality of care planning</b>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The trial may have tracked variations from targets or group averages to improve overall process and outcomes of care for all patients</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> No care planning.</p>	<p>Under the first administration, there was minimal communication between clients, AHWs and the Trial Manager in the development of the care plan.</p> <p>Under both administrations, the care-planning process essentially involved the selection of generic protocols based on the clients' health assessments and entered by the AHWs.</p>	<p>Under the second administration, care plans were being printed for 2,000 clients and it was expected that AHWs would conduct interviews with these clients to review the plan recalls and obtain signed agreement with the clients regarding their care plans. However, this did not occur under the third administration.</p> <p>Furthermore, it was reported under the second administration that individualised care plans were to be generated by the SWAMSAC GPs for chronic clients. This also did not occur under the third administration as SWAMSAC management and GPs felt that the time investment required to generate these care plans would be wasteful due to the absence of appropriate clinical guidelines to support useful care planning.</p> <p>Under the third administration, SWAMSAC management reported that the trial care plan model was inappropriate and this was considered to be a major shortcoming in the trial's ability to conduct care coordination.</p>	<p>Throughout the trial period, the care-planning process was mechanical and did not allow for the inclusion of individualised goals of the client, and it was revealed under the third administration that most clients had not seen their care plans.</p> <p>Throughout the trial, there were no guidelines in place for conducting care planning.</p>
<b>Evaluation and monitoring</b>	<p>This domain reflects the trial's level of care coordination in terms of quality of client contacts, flexibility of the care plan to changing client needs and the involvement of healthcare professionals in monitoring client progress.</p>					
<b>Criterion 1: Quality of client contacts</b>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Some elements of client contact were structured but others were not.</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> The trial conducted variance tracking only.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Some elements of client contact were structured but others were not.</p>	<p>Under both administrations, the process for follow-up involved the generation of recalls by the Communicare system. However, considerable slippage occurred in the follow-up of recalls.</p> <p>Under the first administration, some client contacts occurred informally and at times involved social and emotional support.</p> <p>Under the second administration, it was revealed that the level of client contact varied widely, with frequent contact with some clients and no contact with others.</p>	<p>Under the third administration, the process of monitoring recalls was modified, with the Care Development Officer reviewing a weekly list of all recalled clients. This was believed to have improved the frequency of client contacts.</p>	<p>Under the earlier administrations, there was no system of client monitoring within the trial. Under the third administration, a process was put into place for the monitoring of recalls. This improved the frequency of client contacts.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Criterion 2: Flexibility of care plan</b>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Responses to problems may have been somewhat mechanical.</p>	<p><b>Score 1.7:</b></p> <p><b>Definition:</b> Same as the previous administration.</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> The approach was population-based, not individualised.</p>	<p>Under both administrations, changes to client needs were identified only through client contact, which were unstructured and unsystematic.</p> <p>Under the second administration, it was found that client instructions and treatment plans were updated on the client medical record but not on the automated care plan.</p>	<p>Under the third administration, client issues continued to be identified through client contact; however, it was revealed that there were no appropriate guidelines for the monitoring of care plans and as such the care plans were not a central tool in reviewing the client's situation. Under the third administration, it was also evident that client instructions and treatment plans were reviewed only when clients presented themselves at SWAMSAC clinics, at which time updates were made to the client medical record but not to the automated care plan. This was in part due to problems reported by SWAMSAC with respect to the Communicare system.</p>	<p>Throughout the trial period, changes to client needs were identified through client contacts, which were unstructured and unsystematic. Under the third administration, it was revealed that there were no appropriate guidelines for the monitoring of care plans and, as such, changing client needs were not always captured in client care plans.</p>
<b>Criterion 3: Involvement of healthcare professionals in monitoring</b>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The care/service coordination staff may have lacked knowledge, training, or protocols on resolving problems outside the program's focus.</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> Same as in the previous administration.</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> Same as in the previous administration.</p>	<p>Under both administrations, AHWs received minimal training on care coordination processes. However, under the second administration, it was found that there was regular communication between the SWAMSAC GPs and AHWs concerning client health status.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>Under the third administration, AHWs continued to receive minimal training in care planning and monitoring processes with updates to client contacts largely limited to service recording under Communicare. AHWs also maintained regular communication with GPs with regard to client health status under the third administration.</p>	<p>Throughout the trial period, AHWs received minimal training on care coordination processes. Communication between the AHWs and GPs developed over the trial period.</p>

<b>Criteria</b>	<b>1st Administration Score</b> September 2004	<b>2nd Administration Score</b> April 2005	<b>3rd Administration Score</b> September 2005	<b>Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations</b>	<b>Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations</b>	<b>Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations</b>
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**Service arrangement**

This domain reflects the effectiveness of the trial with respect to the level of structured service delivery, the quality of trial follow-up and the flexibility of services to respond to changing care plans.

<b>Criterion 1: The extent of structured service delivery</b>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> The trial identified needed services.</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> The trial arranged for services in response to current client needs but not as part of an overall plan of care.</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, AHWs identified and made referral to external services according to the clients' care plan. Under the second administration, AHWs identified and arranged for services other than those identified by the generic recalls on client care plans. These services were arranged through obtaining referrals from the GPs.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>Under the third administration, the GP continued to be the source of referral for services other than those identified through generic recalls in the care plan. The services referred by the GP were not recorded on client care plans, as was the case under the second administration.</p>	<p>Under the first administration, AHWs arranged only for services that were generated from generic recalls on client care plans. Under the second and third administrations, other services were also arranged according to client needs.</p>
<b>Criterion 2: Quality of trial follow-up</b>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> There was no planned follow-up</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The trial followed-up to determine both whether the service was delivered and whether the immediate problem was resolved</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, there were no systematic processes to ensure that referrals to other agencies were satisfactory.</p> <p>Under the second administration, follow-up of services were ad hoc; however, a system of reviewing recalls were introduced in the week prior to the second administration.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>The process for follow-up and reporting of services continued to be ad hoc under the third administration. A system of reviewing recalls was in place under the second and third administrations.</p>	<p>Throughout the trial period, the follow-up of services were not based on client care plans. A system of follow-up of services was put into place under the second administration and was continued under the third administration.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Criterion 3: Flexibility of service arrangements</b>	<p><b>Score: 1</b></p> <p><b>Definition:</b> Despite the goals not being achieved and/or the client's situation/needs changing, the care plan was not modified in any way.</p>	<p><b>Score: 1</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p><b>Score: 1</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under both administrations, care plans did not reflect changing client needs and goals. As such, service arrangements were not adjusted according to goals identified on the care plan, but rather as a result of client contacts, which were generally unsystematic.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>Under the third administration, client reviews continued to occur through client contacts initiated by the client. There continued to be no individualisation of client contacts, and the care plans were still not modified according to changes in client status as a result of issues related to the setup of Communicare and the absence of guidelines for care planning and monitoring.</p>	<p>Throughout the trial period, service arrangements were not based on client care plans. Adjustments to service arrangements were based on client contacts, which were generally unsystematic.</p>
<b>Participating community member education</b>						
This domain measures the level of care coordination in the trial with respect to the extent to which it delivers structured education programs to clients.						
<b>Criterion 1: Extent of structured education programs</b>	<p><b>Score: 2</b></p> <p><b>Definition:</b> Trial personnel were expected to provide some education, but there were no standard guidelines on what was to be taught. There was no formal curriculum or protocol.</p>	<p><b>Score: 2.3</b></p> <p><b>Definition:</b> Same as 1st administration.</p>	<p><b>Score: 2.3</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under both administrations, AHWs provided some education to clients on an as-needs basis, although there were no guidelines to ensure that the education provided was systematic. A number of AHWs received specialist training on clinical and population health areas.</p> <p>Under the second administration, the SWAMSAC health promotion unit provided some community education including women's and men's health camps and community information stands.</p>	<p>Under the third administration, there continued to be the provision of some client education to clients, but not in any systematic way.</p> <p>AHWs continued to receive specialist AHW training in clinical and population health areas.</p> <p>Additionally, under the third administration, diabetes clinics were trialled with a focus on client education. Evaluation of these clinics indicated poor client interest and compliance. SWAMSAC management reported that further investigations of client education are to occur as part of post-trial arrangements.</p>	<p>Throughout the trial period, clients received some disease specific education. However, there were no guidelines or protocols for client education and, as such, client education was not provided systematically.</p> <p>Under the second and third administrations, SWAMSAC provided some community education such as health camps and diabetes clinics.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Involvement of General Practitioner (GP)</b>						
This domain assesses the trial's effectiveness in involving GPs in meeting client needs.						
<b>Criterion 1: Involvement of GP in meeting client needs</b>	<p><b>Score: 2.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator held regularly scheduled discussions with the GP to conduct initial assessment and care planning and to evaluate and monitor the client's progress</p>	<p><b>Score: 2</b></p> <p><b>Definition:</b> There was regular scheduled unstructured discussion, but the GP was not an integral part of the care coordination process.</p>	<p><b>Score: 2.3</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, weekly scheduled meetings were being held between AHWs and doctors. There was no systematic process for ensuring that client issues were raised and addressed at these meetings.</p> <p>These scheduled meetings continued under the second administration and additionally there was regular contact between GPs and AHWs as part of daily clinic functions.</p> <p>It was revealed under the second administration that chronic care plans were not reviewed and individualised by GPs; however, GPs committed to completing these under the third administration.</p>	<p>Under the third administration, GPs increased their level of involvement with the Social, Emotional and Well Being (SEWB) team in conducting client care. Furthermore, case conferences were now being held between the clinic, SEWB and St. John of God drug and alcohol service.</p> <p>Under the second administration, GPs had committed to conducting individualised care plans for chronic care clients. However this had not occurred under the third administration as GPs felt that the time invested in doing so would be wasteful due to the lack of clear guidelines for the development of care plans. Moreover, SWAMSAC developed a revised care model for post-trial arrangements and changes to care plans at this stage of the trial were seen as potential duplication of effort.</p>	<p>Over the trial period, the level of communication between GPs and AHWs developed. Throughout the trial period, GPs were not involved in reviewing or individualising care plans. Under the third administration, GPs increased their level of involvement with the SEWB team in conducting client care, and also engaged in case conferencing between the clinic, SEWB and St. John of God drug and alcohol service.</p>

Criteria	1st Administration Score September 2004	2nd Administration Score April 2005	3rd Administration Score September 2005	Discussion of changes to the Care Coordination Index over the 1st and 2nd administrations	Discussion of changes to the Care Coordination Index over the 2nd and 3rd administrations	Discussion of the overall changes to the Care Coordination Index over the 1st and 3rd administrations
<b>Involvement of other service providers</b>						
This domain measures the extent of care coordination in the trial in terms of the level of involvement of the Service Coordinators with clients, GPs and other service providers in changing client settings.						
<b>Criterion 1: Care/Service Coordinator involvement with client in changing settings</b>	<p><b>Score: 0.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator prepared the client only to transfer to the next setting.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator coordinated care only within the purview of a specific setting and communicated only with providers involved in the care plan for the current setting.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, AHWs were not involved with clients in any changing settings.</p> <p>Under the second administration, health workers were involved with clients in a variety of settings through transport and accompanying clients to their appointments. This did not always occur systematically and was minimal at times.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>Under the third administration, AHWs continued to demonstrate some involvement with clients under changing settings, however not in any systematic manner and at times the level of involvement was minimal.</p>	<p>Under the first administration, there was no involvement of AHWs with clients under changing client settings. This had changed under the second and third administrations where AHWs would transport and accompany clients to changing settings, although this was not systematic.</p>
<b>Criterion 2: Care/Service Coordinator involvement with other service providers in changing settings</b>	<p><b>Score: 0.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator has no involvement with providers either prior to or subsequent to a client's move to another setting</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> Same as the previous administration.</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p>Under the first administration, there was no involvement of other service providers under any client setting.</p> <p>Under the second administration, however, AHWs conducted daily rounds of the public hospitals to identify and monitor SWAMSAC clients who were admitted to hospital.</p>	<p>There was no change between the second and third administrations with respect to this criterion.</p> <p>Under the third administration, AHWs continued to conduct daily rounds of the public hospital to identify and monitor SWAMSAC clients who were admitted to hospital.</p>	<p>Under the first administration, there was no contact with service providers under changing client settings. Under the later administrations, however, AHWs conducted daily rounds of the public hospitals to identify and monitor Aboriginal clients who were admitted to hospital.</p>
<b>Criterion 3: Care/Service Coordinator involvement with GP in changing client settings</b>	<p><b>Score: 0.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator did not keep the GP abreast of the client's progress.</p>	<p><b>Score: 1.3</b></p> <p><b>Definition:</b> Same as previous administration.</p>	<p><b>Score: 1.7</b></p> <p><b>Definition:</b> The Care/Service Coordinator kept the GP abreast of the client's progress to some degree, but not fully. There was little or no agreement between the Care/Service Coordinator and the GP/client as to the level of involvement of the case manager.</p>	<p>Under the first administration, AHWs were not involved with clients in changing settings and as such did not inform GPs about changes to client settings.</p> <p>Under the second administration, AHWs referred clients to SWAMSAC GPs for assessment of progress; however, there was minimal communication with private GPs.</p>	<p>Under the third administration, the relationship between GPs and AHWs strengthened and both parties felt that there was effective communication between them. Communication between GPs and AHWs was generally informal, although there were some scheduled meetings.</p> <p>Under the third administration, there continued to be a lack of communication between AHWs and private GPs, and no formal guidelines for communicating with GPs.</p>	<p>Over the trial period, AHW involvement with clients under changing settings improved, as did the communication and relationships between SWAMSAC GPs and AHWs. Throughout the trial period, however, there was minimal communication between private GPs and AHWs. A large number of SWAMSAC clients visited private GPs.</p>

# Appendix O SWAMSAC Community Capacity Index Domain Scores

## Community Capacity Index – Domains and Indicators

The table below provides details of the two levels of indicators utilised in the SWAMSAC Community Capacity Index. In each of the four domains the corresponding high-level indicators and detailed indicators are presented.

**Table 27 Domains and indicators of the SWAMSAC Community Capacity Index.**

<b>Network Partnerships</b>
<p><b>High-level indicator</b></p> <p>The network has capacity to identify the organisations and groups with resources to implement/sustain a program.</p>
<p><b>Detailed indicators</b></p> <ul style="list-style-type: none"> <li>• There is a reservoir of potential leaders within the community who are available and interested in the community.</li> <li>• Members of the network can identify the outcomes the network desires to achieve.</li> <li>• Members of the network can identify the resources needed to achieve the desired outcomes/implement a program.</li> <li>• Members of the network can identify the individuals, groups or organisations within the network with resources necessary to achieve the desired outcomes/implement a program.</li> <li>• Members of the network can identify the other individuals or groups outside the network with resources necessary to achieve the desired outcomes/implement a program.</li> </ul>
<p><b>High-level indicator</b></p> <p>The network has capacity to deliver a program.</p>
<p><b>Detailed indicators</b></p> <ul style="list-style-type: none"> <li>• There are community members who are already taking on a visible leadership role in community activities.</li> <li>• Members of the network can state the benefits for themselves of their own involvement in the network.</li> <li>• Members of the network can describe the benefits other members will gain from involvement in the network.</li> <li>• Members of the network have formalised agreements within their group/organisation to implement/sustain a program.</li> <li>• There is tangible evidence that resources have been allocated to a program by network members.</li> </ul>
<p><b>High-level indicator</b></p> <p>There is a sustainable network established to maintain and resource a program.</p>
<p><b>Detailed indicators</b></p> <ul style="list-style-type: none"> <li>• Existing community leaders have experience, knowledge and skills in capacity-building efforts.</li> <li>• There is tangible evidence of investment in a program by groups and organisations beyond the original sponsoring group.</li> <li>• There is tangible evidence that a program is now 'owned' by the participants of the network.</li> <li>• There is tangible evidence that a program is being maintained by the network using its own resources.</li> </ul>

## Knowledge Transfer

### High-level indicator

The network has capacity to develop a program that meets local needs.

### Detailed indicators

- Members of the network have identified what resources will be transferred to others within the network.
- Members of the network have identified what resources from outside the network will be transferred to them.
- Members of the network have reviewed and changed the activity/program/initiative so that it meets local needs (i.e. target group needs).
- Members of the network have reviewed and modified the activity/program/initiative so that it meets the needs of the network.

### High-level indicator

The network has capacity to transfer knowledge in order to achieve the desired outcomes/implement a program within a network.

### Detailed indicators

- Members of the network have implemented some knowledge-transfer activities.
- Members of the network have reviewed and changed the activity/program/initiative so that it is evidence-based/reflects current good practices.
- Members of the network have made structural arrangements to support knowledge transfer.

### High-level indicator

The network has capacity to integrate a program into the mainstream practices of the network partners.

### Detailed indicators

- Members of the network have in place mechanisms to obtain feedback about progress towards achieving the desired outcomes/implementing a program.
- Members of the network have incorporated a program into the mainstream activities of each organisation and group within the network.

## Problem Solving

### High-level indicator

There is capacity within the network to work together to solve problems.

### Detailed indicators

- Members of the network have identified key players within the network to problem-solve difficulties encountered in achieving the desired outcomes.
- Members of the network have identified key players outside the network to problem-solve difficulties encountered in achieving the desired outcomes.
- There is evidence that members of the network recognise the strengths of key players within the network.
- Members of the network can gain agreement to work together to solve problems.

### High-level indicator

There is a capacity to identify and overcome problems encountered in achieving the desired outcomes.

### Detailed indicators

- Members of the network can gain agreement to work with others outside the network to solve problems.
- There is evidence that members of the network recognise the strengths of those both within and outside the network.
- Members of the network have adopted a well recognised problem-solving process.
- Members of the network have moved from identifying problems to implementing activities designed to overcome problems within the network.

### High-level indicator

There is a capacity to sustain flexible problem solving.

### Detailed indicators

- There have been demonstrations of problem solving across the network partners.
- There is evidence of flexibility in problem solving across the network.

## Infrastructure

### High-level indicator: policy investment

The network has capacity to develop program-related policy capital.

#### Detailed indicators

- Members of the network invest their own resources so that adequate program-related policies and plans are developed for the whole network.
- Members of the network are able to identify the benefits from their investment in program-related policy development.

### High-level indicator: financial investment

The network has capacity to develop financial capital.

#### Detailed indicators

- Members of the network invest resources so that the network can determine the costs and benefits of participation in the network.
- Members of the network invest financial resources in the network to maintain a partnership approach to program implementation.

### High-level indicator: human/intellectual investment

The network has capacity to develop human/intellectual capital.

#### Detailed indicators

- Members of the network invest in helping emerging leaders develop necessary experience and skills.
- Members of the network invest in education and training of network members to facilitate the achievement of network objectives.
- Members of the network can identify returns on investment in education and training.

### High-level indicator: social investment

The network has capacity to develop social capital.

#### Detailed indicators

- Members of the network invest in developing and maintaining social relations between the members of the network.
- There is evidence of responsiveness to the concerns of other partners in the network.

Table 28 provides a summary of the Community Capacity Index assessment for SWAMSAC in each of the four domains. Each domain is listed in the left hand column, under which is the indicative score for the domain in both the first and second administrations. The right hand column provides a description of SWAMSAC's development in the corresponding domain and major developments that correspond to each of the high-level indicators, including scores, at both the first and second administrations.

Table 28 Summary of the Community Capacity Index assessment for SWAMSAC

Network Partnership	Description
<p><b>First administration: Level 1</b></p> <p><b>Second administration: Level 2</b></p> <p><b>High-level indicators:</b></p> <p>The network has capacity to identify the organisations and groups with resources to implement/sustain a program</p> <p>The network has capacity to deliver a program</p> <p>There is a sustainable network established to maintain and resource a program</p>	<p><b>Summary:</b></p> <p>At the first administration, SWAMSAC had developed all indicators to level one in the network partnerships domain. At the second administration all indicators had progressed to level two. This was an area of high activity during 2005 with SWAMSAC reporting networking activities at community, service provider and community organisation levels. Although this development was substantial, it did not occur until after the changes to management and governance and, as such, there remained insufficient time within the trial period to demonstrate sustainability of this development. Details of developments in the network partnerships high-level indicators include:</p>
	<p><b>Network capacity to identify program-related organisations</b></p> <ul style="list-style-type: none"> <li>At the first administration, SWAMSAC had attracted some community leaders to the SWAMSAC Board. The level of experience in health and organisational management varied significantly across Board Members and, as such, at the first administration the Board Members demonstrated variable levels of appreciation of the desired outcomes of the trial and of the resources needed to achieve this.</li> <li>By the second administration SWAMSAC had initiated a range of activities which demonstrated greater involvement in identifying community-based needs and resources. These included strategic planning activities involving trial staff and community groups/organisations, case conferencing with Silverchain and St John of God Drug and Alcohol Services and the development of a Memorandum of Understanding with Manjimup Hospital. SWAMSAC were seeking to combine their resources and expertise with these groups/organisations to develop a comprehensive facility that could be used for a whole of community approach to employment, training, meeting place and health services.</li> </ul>
	<p><b>Network has capacity to deliver a program</b></p> <ul style="list-style-type: none"> <li>At the first administration it was identified that there were potential leaders within the community who were reluctant to become involved with SWAMSAC (due to family and community conflicts). The SWAMSAC Board was aware of the need to groom potential leaders for future roles in the trial; however, at this stage there was no formal process in place to attract the interest and involvement of these potential leaders.</li> <li>By the second administration, SWAMSAC had conducted a series of community capacity-building workshops and follow-up feedback sessions with a range of communities and service providers. This process reportedly enabled identification of community leaders, involved SWAMSAC Board Members in community discussions and established links with service providers in community locations. SWAMSAC was exploring additional network developments in order to build capacity such as: joint submissions for funding with other organisations and investigation of cooperation/agreements with government departments (for example, the Ministry of Justice, Ministry of Housing, Department of Community Development and the Disabilities Commission).</li> </ul>
	<p><b>Establishment of a sustainable network to maintain and resource a program</b></p> <ul style="list-style-type: none"> <li>At the first administration SWAMSAC was attempting to form alliances with groups/organisations to implement/sustain the care coordination model. However, at the time this resulted in only one formal agreement. There was no evidence to show that resources had been allocated to SWAMSAC by any care groups/organisations.</li> <li>By the second administration the management and governance restructure had supported improvement of the capacity to resource and maintain the trial during the remaining period of the trial. Under the direction of a Business Advisor, changes to SWAMSAC Board procedures and greater involvement in strategic planning resulted in the increased knowledge and governance capacity of the Board. Additionally, community consultation forums and support of community-based networks increased SWAMSAC participation with communities.</li> </ul>

Knowledge Transfer	Description
<p><b>First administration: Level 1</b></p> <p><b>Second administration: Level 1</b></p> <p><b>High-level indicators:</b></p> <p>The network has capacity to develop a program that meets local needs</p> <p>The network has capacity to transfer knowledge in order to achieve the desired outcomes/ implement a program within a network</p> <p>The network has capacity to integrate a program into the mainstream practices of the network partners</p>	<p><b>Summary:</b></p> <p>At the first administration most indicators of knowledge transfer were only somewhat developed, the exception being the trial's limited capacity to integrate programs into the practices of their network partners. At the second administration there was little change in SWAMSAC's ability to transfer knowledge to the community (remained at level one); however, there was development in SWAMSAC's capacity to meet local needs and to integrate programs with network partners. Details of developments in the knowledge transfer high-level indicators include:</p> <p><b>Delivery of a program that meets local needs</b></p> <ul style="list-style-type: none"> <li>Only limited mechanisms and formal processes to proactively identify community/local needs were in place at the first administration. Local needs were identified mainly through the staff and SWAMSAC Board Members' close links with the community. The trial was actively promoting general awareness of the trial within the community through distributing flyers, a media campaign and through AHWs' and SWAMSAC Board Members' contacts with the community and other organisations.</li> <li>By the second administration SWAMSAC demonstrated capacity to investigate and meet local needs through specific activities. Community consultation forums and feedback workshops improved community awareness of SWAMSAC activities and provided a mechanism for the understanding of local needs. SWAMSAC's future role formed part of these forum discussions.</li> </ul>
	<p><b>First administration: Level 1</b></p> <p><b>Second administration: Level 2</b></p>
	<p><b>Knowledge transfer in order to achieve the desired outcomes</b></p> <ul style="list-style-type: none"> <li>At the first administration there were some knowledge-transfer activities in place to share information with stakeholders. These included the Trial Monitoring Group (TMG), Office Working Group meeting and Management meetings; however, these activities were initiated by the stakeholders. From the SWAMSAC Board's perspective little had changed in the trial's activities or objectives since the inception of the trial and there was limited evidence to demonstrate that this change was evidence-based.</li> <li>By the second administration, although they had commenced a review of knowledge-transfer activities, SWAMSAC reported insufficient remaining time within the trial period for changes to have had a demonstrable impact on trial activities. A new care model was planned for introduction under post-trial arrangements and implementation of best practice processes was planned for development to support the new care model.</li> </ul>
	<p><b>Integration of a program into the mainstream practices of the network partners</b></p> <ul style="list-style-type: none"> <li>There was little evidence of any formal attempt to integrate the service model into the mainstream practices at the time of the first administration. There were some procedures in place to obtain feedback from clients regarding services they received, e.g. complaints form, satisfaction survey and evaluation forms.</li> <li>By the second administration SWAMSAC had obtained considerable feedback from community and Health Service Providers, although formal mechanisms and procedures to continue these processes were not yet implemented. The Strategic Partners Group met during this reporting period to establish its terms of reference and further meetings were planned for post-trial.</li> </ul>

<p><b>Problem Solving</b></p> <p><b>First administration: &lt; Level 1</b></p> <p><b>Second administration: Level 2</b></p> <p><b>High-level indicators:</b></p> <p>There is capacity within the network to work together to solve problems</p> <p>There is a capacity to identify and overcome problems encountered in achieving the desired outcomes</p> <p>There is a capacity to sustain flexible problem solving</p>	<p><b>Description</b></p> <p><b>Summary</b></p> <p>At the first administration there was some capacity for problem solving within the trial. However, there was a very limited capacity to address problems related to trial outcomes or strategic and organisational-level problems. At the second administration SWAMSAC had developed substantial problem-solving capacity and demonstrated a range of problem-solving initiatives involving external partners. Details of developments in the problem-solving high-level indicators include:</p> <p><b>Capacity to work together to solve problems</b></p> <ul style="list-style-type: none"> <li>At the first administration a structured approach to problem solving within SWAMSAC was reported and varying delegations were given to each level of staff within the organisation. There was, however, little evidence of the trial initiating work with key players outside the trial to problem-solve difficulties encountered in achieving desirable outcomes, particularly with operational management issues.</li> <li>By the second administration SWAMSAC clinical staff had commenced case conferencing with mainstream service providers, specifically with Silverchain and St John of God Drug and Alcohol Services. In addition, SWAMSAC were working with Maternal and Child Health Services to improve service delivery in isolated communities. SWAMSAC also partnered with Noongar Employment and Enterprise Development Aboriginal Corporation (EEDAC) to explore a broad transport strategy utilising existing infrastructure.</li> </ul>
<p><b>Knowledge Transfer</b></p>	<p><b>Description</b></p> <p><b>Capacity to overcome problems in achieving desired outcomes</b></p> <ul style="list-style-type: none"> <li>At the first administration the SWAMSAC Board was able to describe a list of agencies that could assist in solving problems; however, they were limited to problems of an administrative or operational nature. There was limited evidence that the trial recognised the strength of external agencies and organisations in problem solving at a strategic and organisational management level.</li> <li>By the second administration SWAMSAC had developed business planning processes which identified problems that related to the post-trial period. These problems were primarily concerned with the need to reduce the level of service delivery under different funding arrangements. Strategies to address these problems have been primarily aimed at seeking collaboration and assistance from external service providers and other funding agencies.</li> </ul> <p><b>Capacity to sustain flexible problem solving</b></p> <ul style="list-style-type: none"> <li>There was little evidence the trial could solve problems with external partners.</li> <li>As described previously, SWAMSAC demonstrated a range of problem-solving initiatives involving external partners.</li> </ul>

<p><b>Infrastructure</b></p> <p><b>First administration: Level 1</b></p> <p><b>Second administration: Level 2</b></p> <p><b>High-level indicators:</b></p> <p>Policy investment: The network has capacity to develop program-related policy capital</p>	<p><b>Description</b></p> <p><b>Summary</b></p> <p>At the first administration SWAMSAC had developed a level-one capacity in three indicators of infrastructure. These were: policy, human/intellectual and social investment. The indicator of financial investment was identified as very limited at the first administration. These indicators are independent of each other; however, when aggregated they provide an indication of the sustainability of SWAMSAC's community capacity. At the second administration all infrastructure indicators had developed to level two. Subsequent to the Department review<sup>19</sup> SWAMSAC developed organisational policies and procedures, approached training of staff on a needs basis and identified potential future funding sources to reduce their reliance on a single source of funds. Details of developments in the infrastructure high-level indicators include:</p>
<p><b>Knowledge Transfer</b></p> <p>Financial investment: The network has capacity to develop financial capital</p> <p>Human/intellectual investment: The network has capacity to develop human/intellectual capital</p> <p>Social investment: The network has capacity to develop social capital</p>	<p><b>Description</b></p> <p><b>Policy investment</b></p> <ul style="list-style-type: none"> <li>At the first administration SWAMSAC had developed limited operational policy and procedure manuals which covered human resources, transport and finance and accounting. These were of variable quality and at times were not implemented. At that time, there was limited documentation on IT, clinical protocols, care coordination and, at the management level, program-related policies and plans.</li> <li>By the time of the second administration SWAMSAC had developed a comprehensive Human Resources Manual, a code of conduct and identified potential areas of policy and procedural development. While progress was achieved, SWAMSAC reported that further developments were put on hold until post-trial arrangements were in place.</li> </ul> <p><b>Financial investment</b></p> <ul style="list-style-type: none"> <li>There was limited evidence of a partnership approach to program implementation at the first administration. Similarly, there was no evidence to demonstrate that trial partners, or members of the trial network, had invested resources to determine appropriate models of funding to support an Aboriginal coordinated care model (as stated in the trial objectives).</li> <li>At the second administration SWAMSAC has reportedly assessed its ability to generate income as part of its post-trial business planning. Future income sources have been identified such as sponsorships from mining companies located at Collie, pharmaceutical companies and Aid agencies such as Oxfam.</li> </ul>

Knowledge Transfer	Description
	<p data-bbox="177 1245 197 1547"><b>Human/intellectual investment</b></p> <ul data-bbox="217 613 421 1547" style="list-style-type: none"> <li data-bbox="217 613 288 1547">• At the first administration SWAMSAC was supportive of external staff courses and further education and training, although there was limited evidence of the provision of formal internal training and development to support implementation of the trial's interventions.</li> <li data-bbox="308 613 421 1547">• By the second administration SWAMSAC had identified training priorities for staff. Training provided included training for first aid, medical receptionists and MYOB<sup>20</sup>. A computer skills audit was undertaken to identify future needs and computer refresher training is planned to involve NEEDAC staff as partners. It was planned that future training needs would also be identified from staff appraisals. Post-trial training is planned to be equitable across staff and matched to organisational objectives.</li> </ul> <p data-bbox="456 1375 477 1547"><b>Social investment</b></p> <ul data-bbox="496 613 679 1547" style="list-style-type: none"> <li data-bbox="496 613 568 1547">• At the first administration SWAMSAC was able to develop and maintain social relations with community members and organisations; however, this was limited to informal workshops and social functions and there was little evidence of formal plans or policies regarding social relations.</li> <li data-bbox="587 613 679 1547">• At the second administration SWAMSAC was involved in a number of social activities to support community development. However, the impact and sustainability of these activities was not determined. The most notable of these activities was the sponsorship of 10 community children to attend the Police Community Youth Clubs Quirkus circus training.</li> </ul>
	<p data-bbox="217 322 277 591"><b>First administration: Level 1</b> <b>Second administration: Level 2</b></p> <p data-bbox="496 295 557 591"><b>First administration: Level 1</b> <b>Second administration: Level 2</b></p>

<sup>19</sup> The Department review refers to the review of SWAMSAC governance and subsequent restructure under the Business Advisor's terms of reference.

<sup>20</sup> Mind Your Own Business (MYOB) is a provider of business accounting solutions that specialises in software, services and support for small-medium sized business.