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<th>Name</th>
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Executive Summary .................................................................................................................................. i

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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>Healthy for Life</td>
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<td>Aboriginal and Torres Strait Islander Health Performance Framework</td>
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<td>Registered Training Organisation</td>
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Executive Summary

Introduction

The Council of Australian Governments (COAG) has pledged to develop and implement strategies to address Indigenous disadvantage, and has identified six high level targets for closing the gap between Indigenous and non-Indigenous Australians. On 29 November 2008, COAG agreed to an historic $1.6 billion National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes to address the first of the COAG Closing the Gap targets: to close the life expectancy gap within a generation. The Commonwealth’s contribution to the Indigenous Health NPA is the $805.5 million Indigenous Chronic Disease Package (ICDP) funded over four years from 2009-2013.

The aims of the ICDP are to:

- tackle chronic disease factors, in particular smoking
- improve chronic disease management and follow-up care
- expand and support the Indigenous health workforce.

The ICDP is a complex Package comprising 14 discrete measures, each primarily focussed on one of the priority areas identified above. The measures include a range of health promotion and social marketing activities, reforms to existing programs, and new initiatives and funding to increase the size and capacity of primary care services to deliver effective care to Indigenous Australians.

The ICDP is being managed across seven divisions of the Department of Health and Ageing (DoHA), with overall governance lying with the Office for Aboriginal and Torres Strait Islander Health (OATSIH).

This document

This document is a Monitoring and Evaluation Framework for the ICDP. The purpose of the Framework is to:

- guide the ongoing monitoring and implementation of the ICDP measures from 2009/10 to 2012/13
- inform an independent Package-wide evaluation of the ICDP to be completed in 2012/13
- guide the work of the Sentinel Sites project (a formative and place-based analysis of the ICDP at a local level) and individual measure evaluations
- inform policy and planning on closing the gap in Indigenous health.

The Monitoring and Evaluation Framework will facilitate an assessment of the success of the Package and individual measures in achieving the goals of:

- reducing chronic disease risk factors such as smoking, poor nutrition and lack of physical activity
- identifying chronic disease as early as possible
- providing effective treatment and ongoing management of chronic disease
- building the workforce and the primary health care system’s capacity to more effectively address chronic disease in the Indigenous population.

The Framework also includes indicators to assess the effectiveness of the Package in reducing chronic disease-related morbidity and mortality among Indigenous Australians in the longer term – beyond the scope of the 2012/13 ICDP evaluation.

The Monitoring and Evaluation Framework has been designed to:

- include a broad range of both qualitative and quantitative data
- maximise use of existing program and survey data
EXECUTIVE SUMMARY

- make provision for considering a number of contextual issues concerning:
  - the extent to which the Package is designed to address identified needs and priority areas (preventative health, primary health and workforce capacity)
  - the extent to which the Package and measures are effectively inter-linked and build upon and complement existing policies and programs
  - the appropriateness, effectiveness and efficiency of the ICDP governance and program management arrangements.

The Monitoring and Evaluation Framework will facilitate both a formative and summative evaluation – looking to define not only the impacts and the results of the Package, but also to identify the key lessons learned about how to design, manage and implement a complex inter-related package of measures delivered across multiple settings and sectors. It has taken account of the timing of the roll-out of the various ICDP measures, and the resources allocated to monitoring and evaluation activity within the Package.

The development of the Framework involved consultations with ICDP program managers, peak bodies, stakeholders involved in delivering the ICDP, State/Territory Departments of Health, the Sentinel Sites contractor, and a Reference Group comprising key stakeholder representatives and expert advisors.

The Monitoring and Evaluation Framework

The Monitoring and Evaluation Framework comprises three Volumes, with the content as follows:

<table>
<thead>
<tr>
<th>Volume</th>
<th>Content</th>
</tr>
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</table>
| Volume 1 | • Introduction  
• Policy/program context  
• Contextual issues  
• Measuring and attributing ICDP results and outcomes  
• Monitoring and evaluation roles and responsibilities  
• Data sources and issues  
• Key evaluation tasks to be conducted by ICDP evaluator  
• Ethical and privacy issues  
• Package-wide program logic  
• A set of key indicators  
| Package-wide Monitoring and Evaluation Framework |
| Volume 2 | • ICDP measure program logic  
| Volume 3 | • ICDP measure Monitoring and Evaluation Framework  
• Appendices |

A matrix has been developed that sets out the sources of data that will feed into the ICDP Monitoring and Evaluation Report. Data will be collected/analysed at both a whole of Package level (eg surveys of the ICDP workforce, consultations with key stakeholders) and at the individual measure level (eg data obtained from program documentation, interviews with stakeholders involved in managing or delivering a specific measure).

Nature and type of data utilised

A wide range of quantitative and qualitative data will be collected and/or analysed under the Monitoring and Evaluation Framework. These include data on:

- morbidity and mortality
- clinical outcomes
- chronic disease risk factors
- ICDP program / measure uptake and participation
EXECUTIVE SUMMARY

- service utilisation
- health workforce
- service capacity
- stakeholder and consumer knowledge, attitudes, experiences and perceptions
- users and non-users of services and programs.

Data will variously be available at a population health level, at a universal program level (eg PBS), at ICDP level (eg ICDP program data) and at local level (eg Sentinel Sites).

Much of this data can be extracted and analysed by the ICDP evaluator from existing sources. In addition, a number of evaluation activities have been identified to be undertaken by the ICDP evaluator. These include one or more surveys of the ICDP workforce, a survey of ICDP funded services and organisations, a longitudinal survey of healthy lifestyle program participants, two rounds of stakeholder consultations, and field visits to various locations throughout the country.

Measuring outcomes

It is apparent that changes to chronic disease morbidity and mortality rates sought by the NPA will not be achieved within the life of the ICDP evaluation (ie by 2012/13). However, by the end of the four year ICDP implementation period, it could be expected that the Package would have begun to influence the access to and the capacity of the health workforce, chronic disease management, and system capacity to impact chronic disease risk factors. Given the complex multi-faceted determinants of chronic disease risk factors, any substantial reduction in the risk behaviours may take longer to realise. It is more realistic to expect changes in the capacity building, organisational and institutional factors in the initial four-year period. The Package may also have impacted on ‘clinical surrogate’ end points (such as HbA1C, blood pressure) in this period that will deliver positive chronic disease outcomes in the longer term. The Monitoring and Evaluation Framework focuses on these results within the life of the ICDP implementation. However, it also identifies the late-medium term and longer-term population-based changes and outcomes that can be utilised to effectively monitor the impact of the Package beyond 2013.

The Monitoring and Evaluation Framework contains a program logic and a comprehensive list of monitoring and evaluation questions, indicators and measures for the ICDP as a whole and each of its individual measures. From this comprehensive document, a list of key indicators has been compiled. In producing this list, consideration was given to identifying the key results for each of the three priority areas of the ICDP, and the availability, appropriateness and robustness of the data available to measure progress against these preliminary outcomes.
1 Introduction and overview

1.1 This document

This document presents the Monitoring and Evaluation Framework for the Indigenous Chronic Disease Package (ICDP) component of the Council of Australian Governments (COAG) National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.

The Framework was commissioned by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) of the Department of Health and Ageing (DoHA) and was developed by a team led by Urbis Pty Ltd. The Department has made some changes to the Monitoring and Evaluation Framework since Urbis provided its commissioned report to reflect the staggered nature of implementation plans of some of the ICDP measures.

An External Monitoring and Evaluation Framework Reference Group was formed to advise on the Framework. The membership of that group is found in Volume 3, Appendix A.

1.2 The aims of the Monitoring and Evaluation Framework

The aims of the Monitoring and Evaluation Framework are to:

- guide the ongoing monitoring and reporting on the implementation of the ICDP measures over a four-year period from 2009/10 to 2012/13
- inform an independent Package-wide evaluation of the ICDP (due for completion in 2012/13)
- guide the work of the Sentinel Sites project (a formative and placed-based analysis of the ICDP at a local level) and individual measure evaluations
- inform policy and planning on closing the gap in Indigenous health, including future funding decisions.

The Monitoring and Evaluation Framework will facilitate an assessment of the success of the Package and individual measures in achieving the goals of:

- reducing chronic disease risk factors such as smoking, poor nutrition and lack of physical activity
- identifying chronic disease as early as possible
- providing effective treatment and ongoing management of chronic disease
- building the workforce and the primary health care system’s capacity to more effectively address chronic disease in the Indigenous population.

The Monitoring and Evaluation Framework will also facilitate an assessment of the Package in reducing chronic disease-related morbidity and mortality among Indigenous Australians in the longer term – beyond the scope of the 2012/13 ICDP evaluation.

1.3 The key tasks

The development of the Monitoring and Evaluation Framework has been a complex undertaking involving the following key tasks:

- clarification of the aims and objectives of the ICDP as a whole and each of the individual measures
- documentation of the core activities to be undertaken under each of the measures
- documentation of the planned timetable of ICDP activities from 2009/10 to 2012/13
- identification of all key stakeholders involved in designing, managing or delivering the ICDP
articulation of a program logic for the Package and for each of its individual measures – stipulating the key results that could be expected to be achieved in the immediate, medium and longer term

the development of a comprehensive Monitoring and Evaluation Framework for the Package as a whole and for each of its individual measures setting out – for each identified result – key evaluation questions, indicators, data sources and timing

the development of a set of key indicators to assess progress against ICDP objectives.

In developing the Monitoring and Evaluation Framework, the following parameters were agreed with DoHA.

- The Monitoring and Evaluation Framework should include a broad range of both qualitative and quantitative data.
- The Monitoring and Evaluation Framework should make use of existing program and survey data sources as much as possible – recommending the collection of additional program or survey data only where a major gap in data is identified.
- The Monitoring and Evaluation Framework should make provision for considering a number of contextual issues concerning:
  - the extent to which the Package is designed to address identified needs and priority areas (preventative health, primary health and workforce capacity)
  - the extent to which the Package and measures are effectively inter-linked and build upon and complement existing policies and programs
  - the appropriateness, effectiveness and efficiency of the ICDP governance and program management arrangements.
- The Monitoring and Evaluation Framework should facilitate both a ‘formative’ and ‘summative’ evaluation – looking to define not only the impacts and the results of the Package, but also to identify the key lessons learned about how to design, manage and implement a complex inter-related package of measures delivered across multiple settings and sectors.
- The Monitoring and Evaluation Framework has to take account of the timing of the roll-out of the various ICDP measures, and the resources allocated to monitoring and evaluation activity within the Package.

1.4 The process

The development of the Monitoring and Evaluation Framework involved a series of activities. These included:

- Document review
  - background policy documents and papers
  - ICDP and measure project sheets, program guidelines and reporting mechanisms (as available)
  - examples of previous evaluations of similar initiatives or programs

- Data review
  - review of ongoing population-based surveys and data collections on chronic disease morbidity and mortality, including those on risk factors – drawing extensively on those utilised in the Aboriginal and Torres Strait Islander Health Performance Framework Report (HPF)\(^1\)
  - review of existing administrative and program data sets eg Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), OATSIH Service Reporting (OSR), Healthy for Life (H4L), and the Australian Primary Care Collaboratives (APCC) to identify relevant data

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INTRODUCTION AND OVERVIEW

- review of ICDP measure data (existing or proposed) to be collected by program managers from 2009/10 to 2012/13

- Over 60 stakeholder consultations, including:
  - ICDP program managers
  - ICDP program deliverers
  - key stakeholder organisations (eg National Aboriginal Community Controlled Health Organisation (NACCHO) and Affiliates, the Australian General Practice Network (AGPN), State/Territory Health Departments
  - evaluation and subject area experts in relevant fields

- Monitoring and Evaluation Reference Group
  - meetings and discussions with members of the Reference Group

- Sentinel Sites contractor
  - meetings and discussions with the team from Menzies School of Health Research responsible for the Sentinel Sites component of the ICDP monitoring and evaluation measure.

The stakeholder consultation process has been iterative involving, in some cases, two or three sets of discussions in order to:

- clarify delivery mechanisms for individual measures (some of which were still evolving while the Monitoring and Evaluation Framework was being developed)
- confirm key measure activities, targets and timelines
- check and standardise language and terminology within and across measure descriptions and guidelines
- identify the range and type of information and data that could be collected by ICDP program managers on an ongoing basis through various reporting mechanisms
- obtain feedback on various drafts of the Monitoring and Evaluation Framework.

A number of stakeholders (ICDP program managers and NACCHO) also participated in half-day workshops designed to articulate the Program Logics and to identify key evaluation questions and issues to be included in the Monitoring and Evaluation Framework.
2 The ICDP and the policy context

2.1 Overview

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap in Indigenous disadvantage.\(^2\)

A number of agreements, strategies and statements of intent have since been developed to provide the framework for the implementation of $4.6 billion in Indigenous-specific funding over ten years to implement reforms in the areas of health, early childhood development and employment, and improvements in remote housing and service delivery.

Understanding the context within the various frameworks and instruments that have been developed to achieve the target of closing the gap in Indigenous disadvantage has been an important step in developing a Framework for the ICDP that will meet COAG and stakeholder expectations. The following section provides an overview of these.

2.2 Policy context

In November 2008, the National Indigenous Reform Agreement (Closing the Gap) (NIRA) set out the original objectives, outcomes, outputs, performance indicators and performance benchmarks agreed by COAG in its Closing the Gap commitments\(^3\). It also provided a link to other National Agreements and National Partnership Agreements (NPAs) which include elements that will contribute to the implementation of Closing the Gap measures.

In developing the Framework, the original COAG commitments relating to the performance indicators and performance benchmarks outlined in the NIRA were considered.

COAG agreed six targets to close the gap:

- closing the life expectancy gap within a generation
- halving the gap in mortality rate for Indigenous children under five within a decade
- ensuring all Indigenous four year olds in remote communities have access to early childhood education within five years
- halving the gap for Indigenous students in reading, writing and numeracy within a decade
- halving the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020
- halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

To achieve these targets, COAG has developed a number of strategic platforms or building frameworks in seven broad areas:

- early childhood
- schooling
- health
- economic participation
- healthy homes
- safe communities
- governance and leadership.

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\(^2\) Council of Australian Governments (COAG) 20 December 2007, Communiqué, Melbourne

\(^3\) Council of Australian Governments (COAG) 2008, National Indigenous Reform Agreement (Closing the Gap),
THE ICDP AND THE POLICY CONTEXT

As at July 2009, a number of new Indigenous-specific NPAs were agreed by COAG to support the implementation of the Closing the Gap commitments under the NIRA\(^4\). These included the NPAs on:

- Indigenous Early Childhood Development
- Remote Service Delivery
- Indigenous Economic Participation
- Remote Indigenous Housing
- Closing the Gap in Indigenous Health Outcomes
- Remote Indigenous Public Internet Access.

Each of these NPAs support the NIRA, with linkages to other NPAs and/or National Agreements.

The NPA on *Closing the Gap in Indigenous Health Outcomes* has been the key focus in developing the Monitoring and Evaluation Framework\(^5\). This NPA supports the NIRA and will be implemented in the context of, and consistent with other National Agreements, including the National Healthcare Agreement (NHA) and the National Disability Agreement as well as other NPAs including:

- Hospital and Health Workforce Reform National Partnership Agreement (under the NHA)
- Preventative Health National Partnership Agreement (under the NHA)

An overview of the range of National Agreements and NPAs is presented in Figure 1 (see next page).

### 2.3 The Indigenous Chronic Disease Package

The ICDP is the Commonwealth's $805.5 million contribution to the NPA on Closing the Gap in Indigenous Health Outcomes and is the subject of this Monitoring and Evaluation Framework.

The aims of the ICDP are encapsulated in the NPA on Closing the Gap in Health Outcomes Commonwealth Implementation Plan\(^6\) which has three main elements:

- tackle chronic disease risk factors (priority area: tackling smoking)
- improve chronic disease management and follow-up care (priority area: primary health care services that can deliver)
- workforce expansion and support (priority area: fixing the gaps and improving the patient journey).

Figure 2 sets out the aims of the ICDP (as defined in the Commonwealth Implementation Plan).

Table 1 lists the 14 measures that make up the ICDP, and the amount of funding allocated to each

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\(^4\) Council of Australian Governments (COAG) 2 July 2009, Communiqué, Darwin


THE ICDP AND THE POLICY CONTEXT

Figure 1 – Closing the Gap in Indigenous Disadvantage – Pathway Diagram

INTERGOVERNMENTAL AGREEMENT (IGA) ON FEDERAL FINANCIAL RELATIONS

- Close the life expectancy gap within a generation
- Halve the gap in mortality rates for Indigenous children under five within a decade
- Halve the gap for Indigenous students in reading, writing and numeracy within a decade
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade
- Within five years, all four year olds in remote Indigenous communities have access to a quality early childhood education program
- At least halve the gap for Indigenous students in Year 12 or equivalent attainment rates by 2020

Early childhood
Schooling
Health
Economic participation
Healthy homes
Safe communities
Governance and leadership

National Indigenous Reform Agreement

CoA Targets
Building Block
National Agreements
Strategies

National Urban and Regional Service Delivery Strategy
The National Urban and Regional Service Delivery Strategy outlines a plan for action for collaborative effort by the Commonwealth and State/Territory Governments to improve service delivery, particularly through the implementation of National Agreements (NAs) and National Partnerships (NPs) in urban and regional areas.

National Integrated Strategy for Closing the Gap in Indigenous Disadvantage
The Integrated Strategy provides an overview of how the National Partnerships (NPs) and National Agreements will collectively contribute to closing the gap. Measures include the contribution that private and community sector initiatives in education, employment, health and housing can make to the success of the overall Strategy, and any further reforms that may be needed.

National Strategy for Food Security in Remote Indigenous Communities
This Strategy outlines five actions to increase the consumption of healthy foods and reduce the diet-related burden of disease for Indigenous people in remote Australia and help close the gap in Indigenous disadvantage. The Strategy will be piloted in up to 10 remote Indigenous communities, beginning by March 2010. The Working Group on Indigenous Reform (WGIR) will report to COAG in mid-2010 on the further development of the Strategy.

Overarching Bilateral Indigenous Plans (OBIP) with each jurisdiction
Overarching Bilateral Indigenous Plans (OBIPs) will replace Overarching Bilateral Agreements. The purpose of the OBIPs is to draw together all Indigenous work being undertaken in each jurisdiction to Close the Gap. OBIPs are being negotiated with each jurisdiction.

National Partnership Implementation Plans
All OBIPs will incorporate implementation plans for each Indigenous-specific National Partnership Agreement.
Figure 2 – Aims of the Indigenous Chronic Disease Package

**AIMS OF THE ICDP**

**Tackle chronic disease risk factors**
- Reduce the Indigenous smoking rate and the burden of tobacco-related chronic disease for Indigenous communities (A1)
- Assist Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices (A2 + B4)
- Improve Indigenous Australians’ awareness of and access to health services to better promote their health and well-being (A3)

**Primary health care services that deliver: improved chronic disease management and follow up care**
- Improve access to and quality use of PBS medicines for Indigenous Australians with chronic disease or chronic disease risk factors who attend a participating general practice or Indigenous health services in a non-remote area (B1)
- Provide increased funding to the MBS and PBS to meet higher utilisation costs by Indigenous Australians accessing complementary programs in this plan (B2)
- Encourage general practices to provide better health care for Indigenous Australians and improve the continuity of care for those with chronic health conditions (B3)
- Support Indigenous Australians to better manage or self-manage their chronic disease (A2 + B4)
- Increase access to specialist and multi-disciplinary team follow-up care for Indigenous Australians (B5)
- Monitor and evaluate the Closing the Gap Chronic Disease Initiative (B6)

**Fixing the gaps and improving the patient journey: workforce expansion and support**
- Build the Indigenous health workforce through education and training initiatives (C1)
- Increase the capacity of Indigenous and mainstream health organisations to provide better continuity of care for Indigenous people with chronic and complex health conditions (C2 + C3)
- Generate interest and encourage more health professionals to work in Indigenous health (C4)
- Ensure health service providers have access to relevant and culturally appropriate information to improve decision-making processes and inform management options for Indigenous Australians (C5)
### Table 1 – ICDP Funding by Measure 2009 - 2013

<table>
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<th>Priority Area</th>
<th>Key</th>
<th>Measure</th>
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<td>Tackle chronic disease factors</td>
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<td>National Action to Reduce Indigenous Smoking Rates</td>
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<tr>
<td></td>
<td>A2</td>
<td>Helping Indigenous Australians Reduce Their Risk of Chronic Disease</td>
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<td></td>
<td>A3</td>
<td>Local Indigenous Community Campaigns to Promote Better Health</td>
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<td>Primary health care services that deliver</td>
<td>B1</td>
<td>Subsidising PBS Medicine Co-payments</td>
<td>$88.70</td>
</tr>
<tr>
<td></td>
<td>B2</td>
<td>Higher Utilisation Costs for MBS and PBS</td>
<td>$140.40</td>
</tr>
<tr>
<td></td>
<td>B3</td>
<td>Supporting Primary Care Providers to Coordinate Chronic Disease Management</td>
<td>$115.08</td>
</tr>
<tr>
<td></td>
<td>B4</td>
<td>Improving Indigenous Participation in Health Care through Chronic Disease Self Management</td>
<td>$18.56</td>
</tr>
<tr>
<td></td>
<td>B5</td>
<td>Increasing Access to Specialist and Multidisciplinary Team Care</td>
<td>$70.78</td>
</tr>
<tr>
<td></td>
<td>B6</td>
<td>Monitoring and Evaluation</td>
<td>$39.94</td>
</tr>
<tr>
<td>Fixing the gaps and improving the patient journey</td>
<td>C1</td>
<td>Workforce Support, Education and Training</td>
<td>$17.74</td>
</tr>
<tr>
<td></td>
<td>C2</td>
<td>Expanding the Outreach and Service Capacity of Indigenous Health Organisations</td>
<td>$68.42</td>
</tr>
<tr>
<td></td>
<td>C3</td>
<td>Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care</td>
<td>$74.72</td>
</tr>
<tr>
<td></td>
<td>C4</td>
<td>Attracting More People to Work in Indigenous Health</td>
<td>$7.15</td>
</tr>
<tr>
<td></td>
<td>C5</td>
<td>Clinical Practice and Decision Support Guidelines</td>
<td>$3.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$805.5</td>
</tr>
</tbody>
</table>

The ICDP is being managed across seven Divisions of DoHA with primary responsibility for governance resting with OATSIH. (See Volume 3, Appendix C for ICDP measure management responsibility.)

#### 2.4 Broader contextual issues

The causes of Indigenous health disadvantage are complex, with a number of social factors contributing to higher morbidity and mortality rates among Indigenous Australians compared to non-Indigenous Australians. Equally, it is acknowledged that a large number of social determinants of Indigenous health rest outside the influence of the formal health sector.

---

Research on housing and health shows a relationship between inadequate housing and related infrastructure and poor health outcomes. Lack of access to water, sanitation and electricity is associated with higher rates of infectious diseases. Access to education is another important determinant of health and links in with other factors such as poverty, unemployment, quality of life and access to primary health services. Higher levels of education have been associated with reduced propensity to engage in health risk behaviours, particularly smoking. Lower health literacy is a barrier to health promotion activities. Meanwhile poor diet is a function of poverty and unemployment.

In this complex context, it is important to note that the Monitoring and Evaluation Framework by necessity focuses on activities associated with the ICDP. As noted above, the ICDP forms part of a suite of initiatives within COAG’s commitment to Closing the Gap in Indigenous disadvantage with priority areas and targets across early childhood, schooling, health, economic participation, healthy homes, safe communities, governance and leadership. These Closing the Gap priority areas focus on many of the known social determinants of Indigenous health disadvantage. While focusing on the health context, the Monitoring and Evaluation Framework makes provision for the identification and exploration of factors that will potentially impact on Indigenous Australians’ ability to access or benefit from the ICDP measures.

It is also important to acknowledge that Indigenous health disadvantage has trans-generational elements. While this document does not aim to engage with the complex social or medical discourse surrounding these trans-generational components, three tiers that are particularly relevant to Closing the Gap measures have been identified:

- Indigenous health disadvantage must be understood in a historical context of injustice and dispossession.
- Responses to Indigenous disadvantage must consider the “reproduction of disadvantage across generations”.
- Some diseases have a hereditary predisposition.

While the monitoring and evaluation activities proposed in this document take into account the above mentioned trans-generational elements, the measurement of these is limited by the availability of data and the timeframe of monitoring and evaluation activities.

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12 Ibid p.92


3 The ICDP Framework approach and implementation

3.1 Introduction

This document contains the Monitoring and Evaluation Framework for the ICDP as a whole (Volume 1), and for each of the individual measures that make up the Package (Volume 2). Appendices to the Monitoring and Evaluation Framework are included in Volume 3.

<table>
<thead>
<tr>
<th>Volume</th>
<th>Content</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume 1</td>
<td>Program Logic for the ICDP as a whole</td>
<td>• ICDP aims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Outputs (Year 1 and ongoing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Early results (Years 2 – 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medium term results:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Early-medium term results (Years 4+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Late-medium term results (Years 5-10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Long-term outcomes (Years 10+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ultimate outcome</td>
</tr>
<tr>
<td>Volume 1</td>
<td>Set of key indicators</td>
<td></td>
</tr>
<tr>
<td>Volume 1</td>
<td>Monitoring and Evaluation Framework</td>
<td>• Key evaluation questions relating to each outcome/result specified in the program logic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Indicators and data sources relating to each evaluation question</td>
</tr>
<tr>
<td>Volume 2</td>
<td>Program Logic for each ICDP measure</td>
<td>• Measure aims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Outputs (Year 1 and ongoing)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Early results (Years 2 – 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medium term results:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Early-medium term results (Years 4+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Late-medium term results (Years 5-10)</td>
</tr>
<tr>
<td>Volume 2</td>
<td>Monitoring and Evaluation Framework</td>
<td>• Key evaluation questions relating to each outcome/result specified in the program logic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Indicators and data sources relating to each evaluation question</td>
</tr>
<tr>
<td>Volume 3</td>
<td>Appendices</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Measuring and attributing ICDP results and outcomes

3.2.1 Program logic

The approach to the development of the Monitoring and Evaluation Framework is embedded in the development of program logics for the individual measures within the ICDP and for the ICDP as a whole. A program logic is a diagrammatic representation of the intended outcomes of a program, including the various activities and outputs which are expected to lead to the proposed outcomes. The logic model is a visual way of making explicit the assumptions on which the program is grounded, that
is, if A is undertaken then B will take place. Program theory suggests that articulating those assumptions can guide those implementing the program, and the evaluator, in assessing the program’s implementation and monitoring any unexpected changes or developments which occur. The program logic model, then, can be used to guide change management over time by articulating what is intended and reflecting at each stage whether the intended results have been achieved.

One limitation of the program logic model is that it is a linear model, while social and organisational change is often a non-linear process. For that reason, while program logic can be a powerful tool for defining intentions, it is most valuable when it is used throughout a program’s life to reflect on program implementation and its intended or unintended consequences. It is not a static document, but rather an ideal roadmap, which needs to be reviewed over time in relation to the reality which is encountered. As the foundational structure for an evaluation framework, a program logic guides the evaluator to assess what occurred at each stage of the process, and the extent to which the intended outcomes were achieved.

The use of a program logic model is especially useful for a complex package such as the ICDP in which a number of independent but interrelated activities are intended to contribute to the same goals. The program logic model, as it has been used here, defines the assumptions behind each individual measure within the Package. However, the program logic for the Package as a whole seeks to integrate the individual measures into one cohesive structure, providing some structure for the Package to be considered holistically. The individual measure program logics each stand on their own in defining the internal logic of the measure; the overall Package logic articulates the expected comprehensive changes – at individual, community, and system levels - which should be seen once all the measures are implemented.

The use of a program logic approach for the ICDP has facilitated:

- a detailed understanding of each of the measures in layers – from the short-term outputs and activities that will be delivered to the results that may be expected should the measures be implemented successfully, and their contribution to the long-term outcomes defined by COAG
- consideration and differentiation between the range of outputs and results expected from measures in the first and second year of implementation, and longer term outcomes
- consideration of the overlapping factors across measures, and how these interact
- development of the Frameworks based on the program logic structure (aims, activities, outputs, early results, medium-term results, long-term and ultimate outcomes) which allow for easy identification of monitoring and evaluation questions, measure indicators and data sources at different stages of implementation.

It should be noted that, in this Framework, the phrase ‘medium-term results’ generally refers (unless otherwise specified) to the impact of the ICDP at the conclusion of the initial four-year implementation period. We have chosen to use the word ‘results’ rather than ‘outcomes’ for the goals sought in the four-year period, as we consider that it will not be possible to see significant health outcome change at a population level by 2013. The word ‘results’ includes benefits which are expected in the system capacity to influence chronic disease risk factors at the individual and community levels, improved clinical outcomes, improved service delivery, and enhanced workforce capacity. Given the staggered implementation plans for some of the measures, substantial changes in chronic disease risk factors may not be apparent by the end of the initial four-year implementation period and can realistically be expected over the late-medium term (5-10 years). However, indicators, evaluation questions and possible data sources are included to monitor any perceptible impact of the Package on the risk factors during and after the four-year implementation period.

Long-term outcomes of the ICDP – reducing chronic disease morbidity and mortality – and the ultimate outcome of the COAG Closing the Gap initiative – reducing the gap in life expectancy – will not be achieved by 2013. Again, the Framework has included a number of indicators, evaluation questions and data sources to facilitate ongoing monitoring and evaluation of ICDP goals beyond 2012/13.
3.2.2 The relationship between the ICDP and individual measure program logics and frameworks

The Monitoring and Evaluation Framework has required the development of Package-wide and individual measure program logics, and monitoring and evaluation questions and indicators. The measures are the individual building blocks to achieving a range of ICDP objectives. In monitoring and evaluating the ICDP, a range of qualitative and quantitative data will be collected and analysed:

- at the Package-wide level (e.g., one or more surveys of the ICDP health workforce; a series of stakeholder consultations about the ICDP at a national, State/Territory, regional and local level)
- at the measure level (e.g., analysis of data specific to that measure such as level of program take-up and utilisation) which are then ‘reported up’ at the Package level.

A matrix has been developed (see Volume 3, Appendix D) which maps the sources of data (Package-wide and measure-specific) that will feed into reporting at the Package level. The final product is a single ICDP Monitoring and Evaluation Report (due in 2012/13), drawing on data collected and/or analysed at both the Package and measure levels.

3.2.3 The issue of attribution

The ICDP is one of a number of initiatives that are seeking to prevent, detect and better manage chronic disease conditions amongst Indigenous Australians. Running parallel to the ICDP over the next three years are various:

- national Indigenous health programs targeting chronic disease and healthy lifestyle choices
- state/territory specific Indigenous health program or initiatives along the same lines
- national (mainstream) strategies targeting chronic disease conditions
- state/territory chronic disease strategies.

Any of these initiatives and activities will potentially impact on the health status of Indigenous Australians with or at risk of chronic disease. Clearly, in this context, the attribution of any improvement at a population level to a specific program such as the ICDP is problematic. However, it would be expected that by 2012/13 the ICDP evaluation will be able to assess the impact of the ICDP at an individual level or community level, as well as at a service and program level. It may be possible to assess attribution at some (local) level based on information on the extent to which various ICDP measures are effectively implemented and taken up in various locations, and the relative ‘results’ in these locations. The evaluation will also elicit information and insights to indicate the extent to which service-providers, stakeholders and others are of the view the ICDP is meeting identified need, complementing existing programs and services, and making a significant contribution towards achieving the desired health and health system goals.

The issue of attribution is also relevant in terms of different components of the ICDP. On the advice of the Reference Group, any results relating to ‘improved health outcomes’ for Indigenous Australians are reported at the Package level only. It is considered impossible to identify or attribute any changes in health outcomes amongst the Indigenous patient population to a specific ICDP measure (e.g., a new worker, improved access to medicines, better trained health professionals). Instead, it will be taken that any improvement in clinical outcomes may have been influenced by the collective impact of the ICDP measures.

3.2.4 Improved service delivery

It is acknowledged that there is no standard definition or agreement on what constitutes improved service delivery or ‘quality of care’ within primary health care services. Neither is there any articulation within the ICDP as to what ‘improved service delivery’ would comprise, although that is what is aspired to. For the purpose of the Framework, a number of improved care indicators or proxies have been utilised. These include for instance:

- patients receiving target levels of care
patients accessing and utilising PBS medicines
patients accessing specialist and allied health services
patients accessing services that exhibit greater cultural awareness
patients accessing professionals who are better trained in Chronic Disease Management (CDM)
increase in Aboriginal Health Assessments, which recent research indicates lead to better health outcomes.

3.2.5 Comparative analysis

The Monitoring and Evaluation Framework makes provision for comparative analysis to the maximum extent possible. The comparative analysis that will be possible will include the following:

- comparison of ICDP program up-take and utilisation, by State/Territory and urban/rural locality
- comparison of implementation at the local level (Sentinel Sites) compared to the national benchmark (administrative and program data sets)
- comparison of contextual issues impacting on implementation and impact of the ICDP at the local (Sentinel Sites) and regional level (ICDP Evaluator)
- comparison of service and program utilisation, take-up and impact, by service type
- comparison of users and non-users of ICDP programs and services to identify barriers and facilitators
- analysis of impacts on risk factors and health outcomes by a range of demographic factors
- comparisons of service/ICDP program uptake across sites that have high and low levels of ICDP workforce resourcing.

3.3 Monitoring and evaluation roles, responsibilities and tasks

3.3.1 Roles and responsibilities

Implementation of the Monitoring and Evaluation Framework will be undertaken by a number of parties. These include:

- DoHA
- one or more independent evaluator/s to evaluate the ICDP as a whole or specific ICDP measures
- the Sentinel Sites contractor
- ICDP program managers.

It was originally envisaged that an independent evaluator would be appointed to conduct the Package-wide evaluation in 2012/13 (Year 4 of the ICDP). However, a need has been identified for an independent evaluator to be appointed at an earlier stage in the ICDP, and it is therefore recommended that this occur.

The principal reasons for this are that the earlier appointment of an independent ICDP evaluator will:

- facilitate the conduct of a formative evaluation at national, State/Territory and regional level to complement the monitoring/early results focus of the Sentinel Sites at the local level
- facilitate the analysis of administrative and ICDP program data, providing an early picture of ICDP implementation and early results at a national level (and where possible at a State/Territory level) to both complement and benchmark the analysis of the same data in the Sentinel Sites
- provide a mechanism for gauging progress of the ICDP in non-Sentinel Sites (in recognition of the fact that the Sentinel Sites are not ‘typical’ in that they may represent relatively well-functioning communities and be influenced by the fact they have increased intervention by reason of being a
Sentinel Site), thus providing valuable information about any major implementation problems or difficulties being experienced in less well-functioning or less established sites.

The key monitoring and evaluation roles and functions of each are detailed in Table 2.

Table 2 – ICDP key monitoring and evaluation roles

<table>
<thead>
<tr>
<th>Parties</th>
<th>Monitoring and Evaluation Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>DoHA</td>
<td>• Report to COAG under the Commonwealth Implementation Plan</td>
</tr>
<tr>
<td>ICDP Evaluator</td>
<td>• Conduct an independent Package-wide evaluation of the ICDP, drawing on Package-wide and measure-specific data</td>
</tr>
<tr>
<td></td>
<td>• Conduct both formative and summative evaluation components</td>
</tr>
<tr>
<td></td>
<td>• Review and analyse secondary data from a wide range of sources</td>
</tr>
<tr>
<td></td>
<td>• Conduct primary research to complement the monitoring and evaluation data collected from existing data sources and from the Sentinel Sites</td>
</tr>
<tr>
<td>Sentinel Sites</td>
<td>• Monitor the implementation of the ICDP at the local level in 24 Sentinel Sites</td>
</tr>
<tr>
<td></td>
<td>• Monitor baseline data to enable tracking of changes to identify early outcomes in the Sentinel Sites</td>
</tr>
<tr>
<td></td>
<td>• Identify changes resulting from the ICDP, including early outcomes in the Sentinel Sites</td>
</tr>
<tr>
<td></td>
<td>• Provide timely feedback on barriers and enablers impacting implementation</td>
</tr>
<tr>
<td></td>
<td>• Contribute to the overall evaluation of the ICDP</td>
</tr>
<tr>
<td>Measure evaluators</td>
<td>• Evaluate the effectiveness of a specific ICDP measure</td>
</tr>
<tr>
<td></td>
<td>• Contribute to the overall evaluation of the ICDP</td>
</tr>
<tr>
<td>Program (measure) managers</td>
<td>• Collect information and data via program reporting mechanisms</td>
</tr>
<tr>
<td></td>
<td>• Ongoing monitoring of the implementation of their ICDP measure</td>
</tr>
</tbody>
</table>

3.3.2 DoHA

DoHA has responsibility for reporting to COAG under the Commonwealth Implementation Plan. The data to be reported by DoHA has been incorporated into the Monitoring and Evaluation Framework and has been indicated by the use of bold italics in the Framework tables.

3.3.3 The ICDP Evaluator: Key evaluation tasks and timetable

The Monitoring and Evaluation Framework sets out the expected results, evaluation questions, indicators and data sources for the ICDP and its measures. Table 3 summarises the proposed evaluation tasks for the ICDP evaluator – the evaluation methodology – through which these data will be collected and/or analysed.

It will be apparent that the bulk of the evaluation activity by the ICDP evaluator will be conducted in Year 4. However, it is recommended that data from certain key administrative data sets and key implementation data from ICDP program documentation be analysed on an annual basis from 2010/11 onwards. It is also recommended that two rounds of stakeholder and community consultations occur, an initial round in Year 2, followed by a more substantial round in Year 4.

3.3.4 The Sentinel Sites contractor

The precise details of the monitoring and evaluation tasks and reporting to be undertaken by the Sentinel Sites contractor were still being developed at the time of writing, and will depend on negotiations and discussions with funded services and other stakeholders in Sentinel Site locations.

The Monitoring and Evaluation Framework provides guidance to the Sentinel Sites contractor on the range and type of monitoring and evaluation questions, issues and data that could be collected and/or analysed at the Sentinel Sites level.

The precise content and timing of Sentinel Sites activity and reporting (ie whether six monthly or annually) will be agreed over coming months, and may need to be adjusted over time, depending on
staffing priorities, issues and circumstances as the ICDP measures are rolled out. By necessity then, there will need to be some flexibility in how the Framework is applied at the Sentinel Sites level.

Table 3 – Key evaluation tasks to be conducted by the ICDP evaluator

<table>
<thead>
<tr>
<th>Evaluation activity</th>
<th>Timing Year 2 2010/11</th>
<th>Timing Year 3 2011/12</th>
<th>Timing Year 4 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative data set analysis</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• PIP/ PIP IHI</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• MBS</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• PBS</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• OSR</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• GPET</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• APCC</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• NT AHKPI</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Healthy for Life</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• QAHIHC</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• BEACH</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• USOAP</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• MSOAP</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>ICDP Program data/documentation</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Analyse ICDP measure data relating to implementation and early outcome targets (eg recruitment, program participation, training, service utilisation)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Analyse other ICDP program documentation, as available and appropriate (re quality, value etc)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Analysis of national surveys and data collections (based on HPF)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Health workforce survey(s) (ICDP Workforce)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Organisational survey (ICDP-funded services)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Web user survey</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Pre and post survey of healthy lifestyle program participants</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Analysis of ICDP measure evaluation report(s)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Stakeholder/community consultations</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Series of regional forums in each State/Territory (say 10-12 in total) with key service providers and stakeholders</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Consultations with ICDP program managers (National, State/Territory level)</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Consultations with full range of National, State/Territory stakeholders</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Site visits to 8 locations  (non-Sentinel Sites) to consult with full range of local stakeholders</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>• Site visits to 15-20 locations to consult with full range of stakeholders</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>Analysis of Sentinel Sites reports</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
</tbody>
</table>

17 Description of data sets and sources are attached at Volume 3, Appendix E
3.3.5 ICDP program managers

At the time of writing the Monitoring and Evaluation Framework, ICDP program managers were at various stages in considering and/or developing the nature of the information and data they will require funded services and agencies to report. Some program managers were well down the track in defining these and incorporating them into service contracts. Others were still considering what data they want reported. Where data has been clearly defined and articulated, they have been included in the Monitoring and Evaluation Framework. Where they have not, Urbis has (in consultation with program managers) attempted to shape the collection of data by suggesting indicators. Both agreed and suggested data are defined under the term ‘program documentation’ in the Framework.

There are a number of issues that need to be considered in determining the precise nature, content and frequency of reporting by ICDP funded services and organisations:

- finding the right balance between reporting for accountability, monitoring and evaluation purposes whilst not placing too onerous a reporting burden on funded services
- considering the resources available to program managers to collect and/or analyse data from reports
- considering the likely quality, reliability and comparability of data that is reported.

It remains to be seen precisely what program data (‘program documentation’) will be able to be collected and/or reported by program managers. For the purposes of the Framework, however, it is obviously essential that decisions are made, clearly articulated and well-communicated, and that these data are collected from Year 2 onwards. At a later stage, the ICDP evaluator will need to liaise with program managers to determine:

- precisely what data/information has been collected/reported
- the reliability and quality of that data
- the ease with which it can be extracted from reports (eg whether the program managers have collated and/or analysed information to provide to the evaluator).

At that point, a decision will be made as to which data and indicators can be readily and reliably extracted from program documentation for inclusion in the Year 4 ICDP evaluation report.

3.3.6 Measure evaluators

The role of ICDP measure-specific evaluators will be to conduct an in-depth evaluation of the relevant measure, in line with the broad guidance provided within the Framework. Reports from these evaluations will be made available to the ICDP evaluator to analyse and incorporate within the Final ICDP Monitoring and Evaluation Report.

3.4 Data

3.4.1 Data sources

The Framework utilises a wide range of qualitative and quantitative data drawn from various sources. These include data collected through:

- periodic population-based surveys
- existing administrative data sets (such as the Pharmaceutical Benefits Scheme (PBS) or the Medicare Benefits Schedule (MBS))
- ICDP program/measure management and reporting mechanisms
- evaluation activities undertaken by the ICDP evaluator or one of the measure evaluators
- the Sentinel Sites component of the ICDP.
In developing the Framework, a number of performance measures, benchmarks and indicators were also utilised, drawing on policy documentation and the HPF in particular:

- Health related performance benchmarks and indicators as outlined in the National Indigenous Reform Agreement (Closing the Gap)\(^\text{18}\)
- Agreed data quality improvements as presented in Schedule F of the National Indigenous Reform Agreement (Closing the Gap)\(^\text{19}\)
- Performance benchmarks and indicators as outlined in the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes\(^\text{20}\)
- Data sources and limitations as outlined in the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) 2008\(^\text{21}\)

Guides to the data sources and other terminology in the Monitoring and Evaluation Framework are attached at Volume 3, Appendices E and G.

### 3.4.2 Data gaps and limitations

In considering the various data sources that have been recommended for inclusion in the Monitoring and Evaluation Framework, it is necessary to consider the issue of data gaps and limitations.

All key data limitation/issues relating to data sets included in the Monitoring and Evaluation Framework are detailed in Volume 3, Appendix F.

A number of gaps in data were also identified by Urbis and/or key stakeholders. Most notably these concerned:

- the limited nature of data pertaining to the activity of mainstream general practices in data utilised in the HPF
- the lack of any standard national data collection/reporting mechanism for measuring service activity or clinical outcomes from different types of primary health care services
- some limitations in the ability to disaggregate Medicare data by service type.

These gaps in data present challenges to the evaluation in terms of its ability to analyse certain results across different parts of the primary health care sector, and its ability to identify and report consistent and comparable data relating to short-term clinical outcomes.

### 3.4.3 Data availability and timing

The last column in the Monitoring and Evaluation Framework tables refers to the timing of reporting and analysis by the ICDP evaluator or by the Sentinel Sites contractor.

Wherever reporting is denoted Six monthly/annually – this is the responsibility of the Sentinel Sites contractor. In all other cases, the reporting is the responsibility of the ICDP evaluator (or individual ICDP measure evaluators where specified).

Data collection will of course progress through each year in relation to all ongoing administrative and program data sets and documentation. Some of these data will be analysed on an annual basis by the evaluator; some not until Year 4.

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\(^{19}\) Ibid, p. F-80.


In relation to data from the HPF (mainly population-based surveys and national data sets), it should be noted that the HPF is a biennial publication – it will be published in 2010 and then again in 2012. It is anticipated that the ICDP evaluator will primarily draw on the HPF publication rather than conduct a separate analysis of the primary data sources. Hence, it is the HPF reference that is included in the Monitoring and Evaluation Framework tables. It should nevertheless be noted that there is variation in the timing of the collection and publication of the primary data sources on which the HPF is based. The benchmark year for each data source included in the HPF has been identified in the Framework. The ICDP evaluator may need to go to the primary source of the data in some cases, if the HPF report is not published in time for the 2012/13 ICDP Monitoring and Evaluation Report.

3.4.4 Access to administrative and program data sets

In identifying the administrative and program data sets that could be utilised in the Monitoring and Evaluation Framework, the following should be noted:

- Some data sets are internal and some external to DoHA. Clearly access to external data sets will need to be negotiated between DoHA and the relevant data holder, in the context of all privacy, legislative and ethical provisions and protocols.
- Some data /analysis that has been proposed will be able to be extracted from standard reports. Others will require the writing of specific programs or generation of tailored data reports. It is understood that all proposed reports are technically feasible. However, some will require discussion and negotiation with the data holders, with due consideration of any privacy restrictions.

3.5 Ethical and privacy issues

Identifying and dealing appropriately with ethical issues is an important part of monitoring and evaluation of health services. It will be important to ensure the ethical integrity of the monitoring and evaluation activities undertaken as part of the Monitoring and Evaluation Framework for the ICDP.

It is proposed that DoHA establish a group to provide advice on ethical and privacy issues that may need to be taken into account as part of implementing the Framework. This group will examine proposed monitoring and evaluation activities for consistency with current principles guiding the collection of information from and about Aboriginal and Torres Strait Islander peoples and relevant privacy legislation.

The group will identify any ethical issues that may require attention and recommend the appropriate level of ethical oversight for the issue.

It is intended that this group function to cover the ICDP Monitoring and Evaluation Framework as well as the Sentinel Sites component.
4 References

Australian Bureau of Statistics 2006, National Aboriginal and Torres Strait Islander Health Survey, Australia, 2004-2005, Cat.no. 4715.0. ABS, Canberra.


5 Package Program Logic and Monitoring and Evaluation Framework

5.1 Program logic

The diagram on page 21 sets out the program logic for the Package as a whole.
<table>
<thead>
<tr>
<th>Closing the Gap Ultimate outcome</th>
<th>• The gap in life expectancy between Indigenous and non-Indigenous Australians is closed within a generation.</th>
</tr>
</thead>
</table>
| ICDP Long term outcome (year10+) | • The rates of chronic disease morbidity and mortality among Indigenous Australians are reduced.  
• The disparities in chronic disease morbidity and mortality between Indigenous and non-Indigenous Australians are reduced.  
• There is continuing reduction in the incidence of preventable chronic disease risk factors among Indigenous Australians. |
| Medium term results | • There is a reduction in the incidence of preventable chronic disease risk factors among Indigenous Australians.  
• Smoking rates amongst Indigenous Australians are reduced.  
• More Indigenous Australians with or at risk of chronic disease adopt healthy lifestyle choices relating to smoking, nutrition and exercise.  
• ICDP-funded health care services deliver a comprehensive and coordinated approach to chronic disease management, including increased and earlier access to primary health care, specialist and allied health services, affordable care and medicines.  
• More Indigenous Australians with or at risk of chronic disease actively participate in their own health care.  
• Health outcomes are improved amongst Indigenous Australians with or at risk of chronic disease who participate in ICDP measures.  
• More health care providers are equipped to assist Indigenous Australians with or at risk of chronic disease to make healthy lifestyle choices and to manage their condition.  
• More health care providers are accessed by and provide quality care to Indigenous Australians with or at risk of chronic disease.  
• There is an increase in the workforce providing primary health care and other health services to Indigenous Australians. |
| Early results (years 2-4)        | • Resources for designing and delivering health promotion campaigns for Indigenous Australians with or at risk of chronic disease are accessible, effective and evidence-based.  
• Indigenous Australians who have had contact with the ICDP have a better knowledge and understanding of the impact of preventable chronic disease risk factors on their wellbeing.  
• Indigenous Australians who have had contact with the ICDP are more aware of and utilise (accoring to their need) the expanded range of health services and supports available to them to adopt healthy lifestyle choices and reduce smoking.  
• Indigenous Australians who have had contact with the ICDP make positive decisions about their health and lifestyle.  
• ICDP-funded health system supports, incentives and subsidies are operating to facilitate the provision of quality primary health care for Indigenous Australians with chronic disease.  
• Financial and other barriers to accessing health care and medicines are reduced.  
• Health services funded under the ICDP demonstrate cultural awareness and commitment.  
• Care coordination within ICDP-funded services is improved for Indigenous Australians with or at risk of chronic disease.  
• Indigenous Australians with chronic disease or associated risk factors have more services and supports available to help them manage their condition.  
• The number of Indigenous Australians with or at risk of chronic disease who access primary health care services is increased.  
• Indigenous Australians in contact with ICDP measures value the enhanced services.  
• The number of Indigenous Australians with or at risk of chronic disease who access specialist and multi-disciplinary follow-up care is increased.  
• Health care providers demonstrate increased knowledge and improved practice in relation to the prevention, early identification and management of chronic disease for Indigenous Australians.  
• The ICDP workforce is retained and developed within funded services.  
• Marketing, training and recruitment strategies are successful in encouraging more people to work in primary health care and other services available to Indigenous Australians. |
| Outputs (year 1 and ongoing)     | • The workforce required to implement the ICDP is recruited, oriented and trained.  
• Package measures are implemented in accordance with agreed guidelines and timelines.  
• Monitoring and reporting requirements are met.  
• Internal and external stakeholders, Sentinel Sites and service-providers consider the implementation of the Package to be addressing identified needs and enhancing the existing service system.  
• To reduce preventable chronic disease risk factors among Indigenous Australians.  
• To improve chronic disease management and follow-up care for Indigenous Australians.  
• To increase the size and capacity of the primary care workforce in Indigenous and mainstream health services in... |
5.2 Key indicators

The diagram on page 23 describes key outcome indicators for the package as a whole. The data sources for these key resources are detailed in Volume 3, Appendix H.

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22The key indicators chart was originally developed by Urbis Pty Ltd. as part of the Framework. Some changes were made to the chart in view of the staggered implementation plans for some of the ICDP measures.
ICDP MONITORING AND EVALUATION FRAMEWORK: KEY INDICATORS

The gap in life expectancy between Indigenous and non-Indigenous Australians is closed within a generation

- Closing the gap in chronic disease-related mortality between Indigenous and non-Indigenous Australians
- Closing the gap in the prevalence of chronic disease between Indigenous and non-Indigenous Australians

- Reduction in chronic disease-related mortality amongst Indigenous Australians
- Reduction in the prevalence of chronic disease amongst Indigenous Australians

- Reduction in the proportion of Indigenous Australians who smoke regularly
- Improved dietary behaviour of Indigenous Australians
- Reduced proportion of overweight and obese Indigenous Australians
- Increased levels of physical activity amongst Indigenous Australians

ICDP
Years 1-4

- Increased awareness of preventable chronic disease risk factors
  - More resources for delivering health promotion services to Indigenous Australians with or at risk of chronic disease
  - Improved awareness of the impact of preventable chronic disease risk factors
  - Increased awareness, and utilisation of, the expanded range of health services supporting adoption of healthy lifestyle choices

- Improved chronic disease management and follow-up care
  - Earlier detection and treatment of chronic disease
  - More comprehensive and coordinated approach to chronic disease management and care
  - Increased access to PBS medication
  - Improved self-management of chronic disease conditions
  - Improved clinical indicators of health - HbA1C, blood pressure, cholesterol, BMI, etc.

- Expanded and more skilled workforce for Indigenous Australians
  - Expanded workforce delivering health services to Indigenous Australians
  - More people are choosing to work (and stay working) in Indigenous health services or positions
  - More skilled workforce: - Chronic disease prevention, detection and management - Cultural awareness
  - Increased utilisation of primary care services by Indigenous Australians
5.3 ICDP Monitoring and Evaluation Framework: Package Level

The tables beginning on page 25 set out the key evaluation questions, indicators, data sources and data collection/analysis timing for each of the outcomes and results defined in the Program Logic.
### Closing the Gap Ultimate Outcome

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The gap in life expectancy between Indigenous and non-Indigenous Australians is closed within a generation.</td>
<td>Life expectancy at birth</td>
<td>HPF #1.17</td>
<td>Data collected 5 yearly: Baseline 2005-2007</td>
</tr>
<tr>
<td></td>
<td>To what extent is there a reduction in the gap in life expectancy between Indigenous and non-Indigenous Australians? What trends are established?</td>
<td>All-cause mortality</td>
<td>HPF #1.22</td>
<td>Data collected annually: Baseline 2004-2008</td>
</tr>
</tbody>
</table>

### ICDP Long-term outcomes

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The rates of chronic disease morbidity and mortality among Indigenous Australians are reduced.</td>
<td>Circulatory disease: Indigenous Australians reporting heart and circulatory conditions (by age, sex and remoteness) crude rate</td>
<td>HPF #1.05</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td>Are there reductions in rates of chronic disease in the Indigenous Australian population? Where are the reductions observed?</td>
<td>Diabetes: Prevalence of diabetes for Indigenous Australians – by age, sex, remoteness population characteristics and particular health conditions, crude rate</td>
<td>HPF #1.08</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>End-stage renal disease: Incidence of end-stage renal disease by remoteness, crude rate, incidence of mortality related to end-stage renal disease, crude rate</td>
<td>HPF #1.09</td>
<td>Data collected annually: Baseline 2006-2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High blood pressure: self-reported prevalence of high blood pressure among Indigenous Australians (by age) crude rate; information about GP encounters in relation to hypertension</td>
<td>HPF #1.07</td>
<td>Self reported data collected 6 yearly: Baseline 2004-05</td>
</tr>
</tbody>
</table>

Data sources 23 For references to data sources please see Volume 3, Appendix E.

Data Collection 24 In some cases, although the data is collected annually, a rolling average over several years is used to produce a ‘current period figure’.

Data Collection 25 For references to data sources please see Volume 3, Appendix E.

Data Collection 26 In some cases, although the data is collected annually, a rolling average over several years is used to produce a ‘current period figure’.
### ICDP Long-term outcomes

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
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<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there reductions in chronic disease-related mortalities? Where are the reductions observed?</td>
<td>Chronic disease mortality crude rates</td>
<td>Portfolio Budget Statements (AIHW 2006 National Morbidity Database)</td>
<td>Data collected annually: Baseline 2004-2008</td>
<td></td>
</tr>
<tr>
<td>Leading causes of mortality (by Indigenous status); crude rate, longer term mortality trend data (only available in three jurisdictions) – including respiratory, diabetes, renal and circulatory diseases</td>
<td>HPF #1.23</td>
<td>Data collected annually: Baseline 2004-2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The disparities in chronic disease morbidity and mortality between Indigenous and non-Indigenous Australians are reduced.</td>
<td>Chronic disease mortality by Indigenous status, age standardised rate, rate ratio and rate differences, time series</td>
<td>Portfolio Budget Statements</td>
<td>Data collected annually: Baseline 2004-2008</td>
<td></td>
</tr>
<tr>
<td>Leading causes of mortality (by Indigenous status); age standardised rates, rate ratios and rate differences; longer term mortality trend data (only available in three jurisdictions) – including respiratory, diabetes, renal and circulatory diseases</td>
<td>HPF #1.23</td>
<td>Data collected annually: Baseline 2004-2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most common reasons for hospitalisation: Hospital admissions for the leading ICD-10-AM categories by Indigenous status expressed as a percentage, age-standardised rate, rate ratio and rate differences</td>
<td>HPF #1.02</td>
<td>Data collected annually: Baseline 2006-2008</td>
<td></td>
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</tr>
<tr>
<td>Circulatory disease: persons reporting heart and circulatory conditions by Indigenous status, age standardised rate, rate ratio and rate differences, time series</td>
<td>HPF #1.05</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes: persons reporting diabetes by Indigenous status, age standardised rate, rate ratio and rate differences, time series</td>
<td>HPF #1.08</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-stage renal disease: Incidence of end-stage renal disease by Indigenous status, age standardised rate, rate ratio and rate differences, time series</td>
<td>HPF #1.09</td>
<td>Data collected annually: Baseline 2006-2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure: persons reporting high blood pressure by Indigenous status, age standardised rate, rate ratio and rate differences, time series</td>
<td>HPF #1.07</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ICDP Long-term outcomes

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What impact has the ICDP had on Indigenous Australians’ social and emotional well-being?</td>
<td>Perceived health status: self-assessed health status (by Indigenous status, age and sex)</td>
<td>HPF #1.15</td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social and emotional wellbeing: Levels of psychological distress Indigenous status, age standardised rate, rate ratio and rate differences.</td>
<td>HPF #1.16</td>
<td>Data collected 3 yearly: Baseline 2008</td>
</tr>
<tr>
<td>Chronic disease risk factors:</td>
<td>There are sustained and continuing reductions in the incidence of preventable chronic disease risk factors among Indigenous Australians.</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
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<tr>
<td></td>
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<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
</tr>
<tr>
<td></td>
<td>There are sustained and continuing reductions in smoking rates among Indigenous Australians.</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
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<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
</tr>
<tr>
<td></td>
<td>There are sustained and continuing improvements in health lifestyle relating to smoking, nutrition and exercise among Indigenous Australians at risk of chronic disease.</td>
<td>As specified in Medium-term result below</td>
<td>As specified in Medium-term results below</td>
<td>As specified in Medium-term results below</td>
</tr>
</tbody>
</table>
### Late-medium term results (years 5-10)

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic disease risk factors:</td>
<td>To what extent has there been a reduction in the incidence of chronic disease risk factors among Indigenous Australians? Where have the greatest reductions been achieved?</td>
<td>Proportion of adults who smoke regularly, aged 15 or more: smoking status (by age, sex, state/territory, remoteness, selected population characteristics and trends over time)</td>
<td>HPF #2.18</td>
<td>Year 4&lt;br&gt;Data collected 3 yearly: Baseline 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of women smoking in pregnancy: whether the mother smoked at all during pregnancy, and if so, the frequency – average no. cigarettes per day - in the second half of the pregnancy (by Indigenous status, state/territory, and maternal characteristics)</td>
<td>HPF #2.19</td>
<td>Year 4&lt;br&gt;Data collected annually: Baseline 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental tobacco smoke: children 0-14 yrs who live in a household with a smoker: Proportion of Indigenous children living in a household with a regular smoker, and proportion that live with someone who smokes indoors (by state/territory and remoteness)</td>
<td>HPF #2.03</td>
<td>Year 4&lt;br&gt;Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevalence of overweight and obesity: prevalence of overweight and obesity among Indigenous Australian adults and children (though note no data currently available on children) (by Indigenous status, age, sex, risk factors, selected health outcomes and selected population characteristics)</td>
<td>HPF #2.26</td>
<td>Year 4&lt;br&gt;Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community reports of increased healthy lifestyle behaviours, perceptions of well-being, increased knowledge and confidence in lifestyle and chronic disease self-management</td>
<td>Community members consultation</td>
<td>Year 4&lt;br&gt;Six monthly/Annually</td>
</tr>
</tbody>
</table>

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27 For references to data sources please see Volume 3, Appendix E.

28 In some cases, although the data is collected annually, a rolling average over several years is used to produce a ‘current period figure’. 

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### Late-medium term results (years 5-10)

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Smoking rates amongst Indigenous Australians are reduced.</td>
<td>To what extent have smoking rates amongst Indigenous Australians been reduced as a result of ICDP activities?</td>
<td>Crude rates of current daily smokers</td>
<td>NATSIHS/NATSISS</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data collected in 2011: Baseline 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-reported smoking behaviour and impact of ICDP activities</td>
<td>A1 and A3 measure evaluations</td>
<td>To be determined</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community members consultation</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>• More Indigenous Australians with or at risk of chronic disease adopt healthy lifestyle choices relating to smoking, nutrition and exercise.</td>
<td>What evidence is there that Indigenous young people at risk of taking up smoking are postponing the decision to smoke?</td>
<td>Indigenous community perceptions of impact of smoking campaigns on community understanding and acceptance of smoking, especially among young people</td>
<td>A1 and A3 measure evaluations</td>
<td>To be determined</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community members consultation</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-reported behaviour change eg increased levels of physical activity</td>
<td>Pre and post survey of healthy life-style program participants</td>
<td>Years 3 and 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level of physical activity: proportion of Indigenous Australian adult population classified as having moderate or high physical activity levels (classifications are sedentary, low, moderate and high), (by age, sex, state/territory, remoteness).</td>
<td>HPF #2.22</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dietary behaviour: dietary habits of Indigenous Australians.</td>
<td>HPF #2.23</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tobacco use by Indigenous status, age standardised rates, rate ratios and rate differences.</td>
<td>HPF #2.18</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical activity by Indigenous status, age standardised rates, rate ratios and rate differences</td>
<td>HPF #2.22</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data collected 6 yearly: Baseline 2004-05</td>
</tr>
</tbody>
</table>
## Medium-term results

### Late-medium term results (years 5-10)

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dietary behaviour by Indigenous status, age standardised rates, rate ratios and rate differences</td>
<td>HPF #2.23</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevalence of overweight and obesity by Indigenous status, age standardised rates, rate ratios and rate differences</td>
<td>HPF #2.26</td>
<td>Year 4</td>
</tr>
</tbody>
</table>

### Early-medium term results (year 4+)

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More Indigenous Australians with or at risk of chronic disease adopt healthy lifestyle choices relating to smoking, nutrition and exercise.</td>
<td>Identification of barriers and enablers to programs/behaviour change</td>
<td>Consultation with primary health care services, community members and other stakeholders</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td>ICDP-funded health care services deliver a comprehensive and coordinated approach to chronic disease management, including increased and earlier access to primary health care, specialist and allied health services, affordable care and medicines.</td>
<td>To what extent are health services more accessible to Indigenous Australians?</td>
<td>Self reported access to health services and change over time</td>
<td>Year 4</td>
</tr>
</tbody>
</table>

---

27 For references to data sources please see Volume 3, Appendix E.

28 In some cases, although the data is collected annually, a rolling average over several years is used to produce a ‘current period figure’.

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<table>
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<tr>
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<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To what extent has the uptake of MBS items related to health assessments and early detection by Indigenous Australians increased?</td>
<td>Early detection and early treatment: MBS Health Assessment and follow-up items for Aboriginal and Torres Strait Islander People (15-54 years) and Chronic Disease Management Plans (CDMP) and follow-up services</td>
<td>Year 4</td>
<td>Data collected monthly: Baseline 2010</td>
</tr>
<tr>
<td></td>
<td>To what extent has the PIP incentive increased the number of Indigenous Australians receiving the target level of care?</td>
<td>Number of registered Indigenous Australians receiving target level of care (# of annual PIP payments) (by service type, geography, age, gender)</td>
<td>Year 4</td>
<td>Data collected 6 monthly: Baseline 2010</td>
</tr>
<tr>
<td></td>
<td>How does service participation in the ICDP improve the quality of care provided to Indigenous Australians with a chronic disease?</td>
<td>Proportion of Indigenous Australians with a chronic disease to have had relevant tests (eg HbA1c, cholesterol, spirometry/peak flow, blood pressure)</td>
<td>Year 4</td>
<td>To be determined (sentinel sites)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of Indigenous Australians with Type 2 diabetes to receive recommended care</td>
<td>HPF #3.06</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical information systems and/or quality improvement systems in primary health care services</td>
<td>To be determined (sentinel sites)</td>
<td></td>
</tr>
</tbody>
</table>
## Early-medium term results (year 4+)

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<tbody>
<tr>
<td>▪ More Indigenous Australians with or at risk of chronic disease actively participate in their own healthcare.</td>
<td>To what extent has the ICDP increased utilisation of PBS by Indigenous Australians?</td>
<td>PBS utilisation of participants (before and after measure, vs ≤100, vs all Australians)</td>
<td>PBS</td>
<td>Annually</td>
</tr>
<tr>
<td>▪ How has the CCSS measure increased access to/use of support services?</td>
<td>PBS utilisation of Indigenous Australians before and after measure (using all VII PBS dispense records)</td>
<td>PBS</td>
<td>PBS</td>
<td>Annually</td>
</tr>
<tr>
<td>▪ More Indigenous Australians with or at risk of chronic disease feel that the ICDP measures are assisting them to participate in their own healthcare?</td>
<td>Medication adherence (Closing the Gap prescription repeats)</td>
<td>PBS</td>
<td>PBS</td>
<td>Annually</td>
</tr>
<tr>
<td>▪ ▪ To what extent have the USOAP and MSOAP-ICD increased the number of Indigenous Australians accessing specialist and multi-disciplinary care?</td>
<td>Number and type of support services provided by CCSS</td>
<td>Program documentation</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ How has the CCSS measure increased access to/use of support services?</td>
<td>Number of occasions of service provided through USOAP</td>
<td>Program documentation</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ More Indigenous Australians with or at risk of chronic disease actively participate in their own healthcare.</td>
<td>Number of visits being provided to a location and the number of patients in total over a reporting period through MSOAP-ICD</td>
<td>Program documentation</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ To what extent have the USOAP and MSOAP-ICD increased the number of Indigenous Australians accessing specialist and multi-disciplinary care?</td>
<td>Number of occasions of service provided through USOAP</td>
<td>Program documentation</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ ▪ To what extent has self-management increased among Indigenous Australians with chronic disease who have been in contact with ICDP measures?</td>
<td>Perceptions of Indigenous community members regarding the value of the ICDP services and activities in assisting them to participate in their own healthcare</td>
<td>Community members consultation</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ ▪ ▪ To what extent has the ICDP increased utilisation of PBS by Indigenous Australians?</td>
<td>Key results from ICDP measure data, especially B4, B3a, B3b</td>
<td>MBS</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>▪ ▪ ▪ ▪ ▪ To what extent have the USOAP and MSOAP-ICD increased the number of Indigenous Australians accessing specialist and multi-disciplinary care?</td>
<td>Evidence of improved indicators for HbA1c, blood pressure, cholesterol, smoking, nutrition, physical exercise, weight, waist circumference, Body Mass Index etc</td>
<td>APCC, H4L, NT AHKPI, QAIHC Core Indicators</td>
<td>Year 4</td>
<td>(Negotiated in Year 2)</td>
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31 Note that the PBS data set does not generally support an analysis of dispensing of repeat prescriptions but could be developed.
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<th>Data Collection</th>
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<tbody>
<tr>
<td>Workforce expansion and support:</td>
<td>▪ More health care providers are equipped to assist Indigenous Australians with or at risk of chronic disease to make healthy lifestyle choices and to manage their condition.</td>
<td>▪ What impact have the training and resources provided through the ICDP had on the ability of Indigenous health services and general practice to provide better quality care for Indigenous Australians with or at risk of chronic disease?</td>
<td>Reported impact of training and resources on capacity of health services and personnel to support and assist Indigenous Australians with or at risk of chronic disease</td>
<td>Health workforce survey</td>
<td>Year 4</td>
</tr>
<tr>
<td>▪ More health care providers are accessed by and provide quality care to Indigenous Australians with or at risk of chronic disease.</td>
<td>▪ How have individual Indigenous Australians made use of the primary health care services? What impact has there been on the local community of the enhanced service provision?</td>
<td>Experiences and perceptions of Indigenous Australians who have used primary health care services</td>
<td>Community members consultation</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>▪ To what extent has access to allied health and specialists been increased?</td>
<td>Number and occasions of services provided by CCSS and USOAP. Number of visits being provided to a location and the number of patients in total over a reporting period through MSOAP-ICD</td>
<td>Program documentation</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ What do Indigenous Australians who access the participating services value in the enhanced services?</td>
<td>Experiences and perceptions of Indigenous Australians who have used the enhanced services</td>
<td>Community members consultation</td>
<td>Year 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ There is an increase in the workforce providing primary health care and other health services to Indigenous Australians.</td>
<td>▪ How are ATSIOWs, RTCs, ITACs, HLLWs, IHPOs deployed? To what extent do they complement existing services?</td>
<td>Roles played by new workers, perceived value and effectiveness of these roles</td>
<td>Health workforce survey</td>
<td>Year 4</td>
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Data collected annually: Baseline 2008-09

Data Collection:
- Year 4
- Six monthly/annually
- As available
### Early-medium term results (year 4+)

#### Package Outcomes Hierarchy

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<th>Data sources[^29]</th>
<th>Data Collection[^10]</th>
</tr>
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<tbody>
<tr>
<td>To what extent has the ICDP increased the overall size of the health workforce serving Indigenous Australians?</td>
<td>Increase in workforce in GP Divisions focused on Indigenous chronic disease</td>
<td>(Proposed AGPN workforce survey)</td>
<td>Years 2, 4</td>
</tr>
<tr>
<td>Number of people employed in the ICDP</td>
<td></td>
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<td>Annually</td>
</tr>
<tr>
<td>Total size of ACCHS workforce</td>
<td>HPF #3.20</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Extent of retention in positions recruited</td>
<td>Organisational survey</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Number of Indigenous people in the health workforce (noting that they will not all be serving Indigenous Australians and that there are non-Indigenous Australians working in Indigenous health)</td>
<td>HPF #3.10</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>Enrolments (Indigenous Australians) in health-related higher education courses/VET courses</td>
<td>HPF #3.18</td>
<td>Year 4</td>
<td></td>
</tr>
<tr>
<td>To what extent has the increase in workforce in general practice lead to an increase in delivery of care to Indigenous Australians?</td>
<td>Evidence of increased use of general practice by Indigenous Australians</td>
<td>APCC, BEACH</td>
<td>Year 4</td>
</tr>
<tr>
<td>Identification of barriers and enablers to increased delivery of care to Indigenous Australians through general practice</td>
<td>Consultations with primary health care services, community members and other stakeholders</td>
<td>Year 4</td>
<td></td>
</tr>
</tbody>
</table>

[^29]: care services NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice
[^10]: Six monthly/annually; Year 4; Year 4; Years 2, 4; Year 4; Year 4; Year 4; Year 4; Year 4; Year 4
### Early results (years 2-4)

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<tbody>
<tr>
<td>Chronic disease risk factors:</td>
<td>• Resources for designing and delivering health promotion campaigns for Indigenous Australians with or at risk of chronic disease are accessible, effective and evidence-based.</td>
<td>• What resources were developed and how?</td>
<td>Program documentation</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What is the evidence base from which resources were developed?</td>
<td>Program documentation</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How accessible are the resources?</td>
<td>Consultations with key stakeholders</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A3 measure evaluation</td>
<td>To be determined</td>
</tr>
<tr>
<td></td>
<td>• Indigenous Australians who have had contact with the ICDP have a better knowledge and understanding of the impact of preventable chronic disease risk factors on their wellbeing.</td>
<td>• What education programs have been most effective and influential in getting their message across, according to participants?</td>
<td>Pre and post survey of healthy lifestyle program participants</td>
<td>Years 3 and 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which social marketing and media campaigns have been most effective and influential in getting their message across, according to participants?</td>
<td>Community members consultation</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A3 measure evaluation</td>
<td>Six monthly/annually</td>
</tr>
<tr>
<td></td>
<td>• Indigenous Australians who have had contact with the ICDP are more aware of and utilise (according to their need) the expanded range of health services and supports available to them to adopt healthy lifestyle choices and reduce smoking.</td>
<td>• To what degree did resources and promotions encourage access to primary health care services? What was most effective?</td>
<td>Community members consultation</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PIP IHI</td>
<td>Six monthly/annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What types of services are being accessed?</td>
<td>MBS</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>• Indigenous Australians who have had contact with the ICDP make</td>
<td>• What enablers or barriers have been identified which have</td>
<td>Community members consultation</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
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32 For references to data sources please see Volume 3, Appendix E.

33 In some cases, although the data is collected annually, a rolling average over several years is used to produce a ‘current period figure’.
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<td>Early-medium term results (year 4+)</td>
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<td></td>
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**Package Outcomes Hierarchy**

- Positive decisions about their health and lifestyle.
- Chronic disease management and follow-up care:
  - ICDP-funded health system supports, incentives and subsidies are operating to facilitate the provision of quality primary health care for Indigenous Australians with chronic disease.

### Evaluation questions

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<th>Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent do participants and health providers impact the capacity of individuals and communities to make healthy lifestyle decisions?</td>
<td>Program participants and health providers</td>
<td>Consultation with primary health care services</td>
<td>Six monthly/annually</td>
</tr>
<tr>
<td>To what extent do the available incentives and supports encourage participation?</td>
<td>Experiences and perceptions of primary health care services and other stakeholders</td>
<td>Consultation with primary health care services NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Year 4</td>
</tr>
<tr>
<td>Uptake of PIP by Indigenous health services and general practice</td>
<td>PIP IHI</td>
<td></td>
<td>Annually</td>
</tr>
<tr>
<td>To what extent does participation in the ICDP translate to an enhanced level of care for Indigenous Australians with or at risk of chronic disease?</td>
<td>Experiences and perceptions of primary health care services</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Year 4</td>
</tr>
<tr>
<td>Number of chronic disease patients recruited to PIP by Indigenous health services and general practice</td>
<td>PIP IHI</td>
<td></td>
<td>Annually</td>
</tr>
<tr>
<td>Number of registered clients receiving target level of care (# of annual PIP payments) (by service type, geography, age, gender)</td>
<td>PIP IHI</td>
<td></td>
<td>Annually</td>
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<tr>
<td>Experiences and perceptions of Indigenous community members</td>
<td>Community members consultation</td>
<td></td>
<td>Year 4</td>
</tr>
<tr>
<td>Did the incentives help to extend the number of services providing quality care for Indigenous Australians?</td>
<td>Experiences and perceptions of primary health care services</td>
<td>Consultation with primary health care services NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Year 4</td>
</tr>
<tr>
<td>Financial and other barriers to accessing health care and To what extent do participating general practices and Indigenous</td>
<td>Number of PIP IHI registered practices facilitating copayment relief</td>
<td>PIP IHI</td>
<td>Annually</td>
</tr>
<tr>
<td>Package Outcomes Hierarchy</td>
<td>Evaluation questions</td>
<td>Indicators</td>
<td>Data sources</td>
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</tr>
<tr>
<td>Early-medium term results (year 4+)</td>
<td>health services facilitate access to copayment relief for PBS medicines?</td>
<td>Number of Indigenous Australians recruited (consented) for PBS copayment relief</td>
<td>MBS</td>
</tr>
<tr>
<td>▪ Are the eligibility criteria for PIP and copayment relief appropriate and workable? How do health services and professionals interpret the criteria? What other criteria do they apply?</td>
<td>Experiences and perceptions of primary health care services and pharmacists</td>
<td>Health workforce survey</td>
<td>Year 4</td>
</tr>
<tr>
<td>▪ Were there any further barriers to participation? What impact did these have on access for Indigenous Australians?</td>
<td>Experiences and perceptions of barriers to accessing health care and medicines</td>
<td>Community members consultation Consultation with primary health care services and pharmacists</td>
<td>Year 4</td>
</tr>
<tr>
<td>▪ Health services funded under the ICDP demonstrate cultural awareness and commitment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Was cultural awareness training undertaken? Was it effective?</td>
<td>Extent of participation by health care providers and other staff in cultural awareness training</td>
<td>Health workforce survey</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td>Perceived appropriateness and effectiveness of training undertaken</td>
<td>Consultation with primary health care services NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training participant feedback</td>
<td>Year 4</td>
</tr>
<tr>
<td>▪ Did the requirement for cultural awareness training present a barrier to participation by mainstream general practices?</td>
<td>Perceptions of program managers and general practice staff</td>
<td>Consultation with general practice staff, SBOs, Divisions of General Practice, AGPN and program managers</td>
<td>Year 4</td>
</tr>
<tr>
<td>▪ Care coordination within ICDP-funded services is improved for Indigenous Australians with or at risk of chronic disease.</td>
<td>To what extent has care coordination been improved? What changes have occurred?</td>
<td>Number and type of Medicare services provided pre and post the measure (for PIP registered participants) (ACCHS and general practice)</td>
<td>Program documentation MBS</td>
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### Early-medium term results (year 4+)

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<tr>
<td></td>
<td></td>
<td>Experiences and perceptions of health care services, other relevant health professionals and patients</td>
<td>Health workforce survey</td>
<td>Year 4</td>
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<tr>
<td></td>
<td></td>
<td>Evidence of an increased range of services available as a result of ICDP</td>
<td>Consultation with primary health care services NACCHO and Affiliates, state and territory health, AGPN, SBOs, Divisions of General Practice and other relevant health professionals</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community members consultation</td>
<td>Six monthly/annually</td>
</tr>
<tr>
<td>• Indigenous Australians with chronic disease or associated risk factors have more services and supports available to help them manage their condition.</td>
<td>What range and types of services are now available to Indigenous Australians with chronic disease as a result of ICDP?</td>
<td>Evidence of an increased range of services available as a result of ICDP</td>
<td>Program documentation</td>
<td>Year 4</td>
</tr>
<tr>
<td>• The number of Indigenous Australians with or at risk of chronic disease who access primary health care services is increased.</td>
<td>What are the factors which encourage or inhibit increased access?</td>
<td>Experiences and perceptions of communities and services regarding factors which encourage or inhibit access</td>
<td>Consultation with primary health care services</td>
<td>Year 4</td>
</tr>
<tr>
<td>• Indigenous Australians in contact with ICDP measures value the enhanced services.</td>
<td>Do Indigenous Australians value the additional services and supports? Did they notice any difference in the amount and appropriateness of services on offer?</td>
<td>Extent of satisfaction with quality and appropriateness of services</td>
<td>Community members consultation</td>
<td>Year 4</td>
</tr>
<tr>
<td>• The number of Indigenous Australians with or at risk of chronic disease who access specialist and multi-disciplinary follow-up care is increased.</td>
<td>How many eligible Indigenous Australians accessed the services provided through USOAP or MSOAP-ICD?</td>
<td>Number and type of USOAP occasions of care</td>
<td>Program documentation</td>
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<tr>
<td></td>
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<td>Number of visits being provided to a location and the number of patients in total over a reporting period through MSOAP-ICD</td>
<td>Program documentation</td>
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<tr>
<td></td>
<td></td>
<td>To what extent were the additional allied and specialist health services used? What additional supports</td>
<td>Extent and increase over time of participation by specialists and allied health professionals in USOAP and MSOAP-ICD</td>
<td>Program documentation</td>
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### Early-medium term results (year 4+)

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<tr>
<td>were required to encourage participation of health care services? What enablers facilitated access for Indigenous Australians?</td>
<td>Reported success factors in the implementation of USOAP and MSOAP-ICD</td>
<td>Consultation with fund holders, outreach services, participating health care providers</td>
<td>Year 4</td>
</tr>
</tbody>
</table>
| **Workforce expansion and support:**  
  • Health care providers demonstrate increased knowledge and improved practice in relation to the prevention, early identification and management of chronic disease for Indigenous Australians. | Feedback on cultural awareness training undertaken  
  Evidence of increased knowledge and improved practice as a result of ICDP activities.  
  Evidence of any continuing barriers/limitations | Program documentation  
  Health workforce survey  
  Organisational survey | Year 4  
  Year 4  
  Year 4 |
| • What has been the impact of ICDP cultural awareness training and initiatives on general practitioner awareness of good practice in the prevention and treatment of chronic disease in Indigenous Australians? | Evidence from community members of improved service and treatment from general practices (and any barriers/limitations) | Community members consultation  
  Patient feedback via GPs | Year 4 |
| • To what extent do health care providers feel they have enhanced their capacity to provide quality health care for Indigenous Australians? | Perceptions of health care providers regarding impact of ICDP-funded activities on capacity to provide quality health care for Indigenous Australians | Organisational survey | Year 4 |
| • The ICDP workforce is retained and developed within funded services. | Extent of retention  
  Evidence of training and development opportunities provided for the ICDP workforce | Organisational survey  
  Consultation with primary health care services | Year 4  
  Year 4 |
| • Marketing, training and recruitment strategies are successful in encouraging more people to work in primary health care and other services available | Feedback from C4 activities regarding Indigenous secondary school students’ intentions | Program documentation | Year 4 |
### Early-medium term results (year 4+)

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<tr>
<td></td>
<td>• Has there been an increase in health professionals working in Indigenous primary health care and other services?</td>
<td>Total size of ACCHS workforce</td>
<td>HPF #3.20</td>
<td>Year 4</td>
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<tr>
<td></td>
<td>• Number of Indigenous people in health workforce (noting that they will not all be serving Indigenous Australians and that there are non-Indigenous Australians working in Indigenous health)</td>
<td>Number of Indigenous people in health workforce</td>
<td>HPF #3.10</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td>• Were the strategies considered effective, appropriate, sound and evidence-based by key stakeholders and potential employees?</td>
<td>Extent of key stakeholder support for strategies</td>
<td>Consultation with key stakeholders</td>
<td>Year 4</td>
</tr>
<tr>
<td></td>
<td>• Extent to which these strategies were cited as influential in career decisions</td>
<td>Health workforce survey</td>
<td>Year 4</td>
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### Outputs (year one and ongoing)

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<tr>
<td></td>
<td>• The workforce required to implement the ICDP is recruited, oriented and trained.</td>
<td>Extent of recruitment of Regional Tobacco Workers (57), Tobacco Workers (170), Healthy Lifestyle Workers (105), Chronic Disease Care Coordinators, Aboriginal and Torres Strait Islander Outreach Workers (166), ACCHS practice managers (43), ACCHS health professionals (33), Indigenous Health Project Officers (80)</td>
<td>Program documentation</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>• What barriers or enablers have been identified which have impacted on the recruitment of particular positions or in particular locations?</td>
<td>Experience and perceptions of program managers and health services regarding recruitment barriers and enablers</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Years 2, 4</td>
</tr>
</tbody>
</table>

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34 For references to data sources please see Volume 3, Appendix E.

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## Outputs (year one and ongoing)

<table>
<thead>
<tr>
<th>Package Outcomes Hierarchy</th>
<th>Evaluation questions</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Data Collection</th>
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<tbody>
<tr>
<td>▪ What impact, if any, has ICDP workforce recruitment had on the workforce in other health services serving Indigenous Australians?</td>
<td>Experiences and perceptions of primary health care and other health services</td>
<td>Consultations with primary health care and other relevant health services</td>
<td>Years 2, 4</td>
<td></td>
</tr>
<tr>
<td>▪ Have newly recruited health workers been provided with orientation, training and early support?</td>
<td>Demonstration of orientation, training and support provided to new workers, and number of people trained</td>
<td>Program documentation</td>
<td>Years 2, 4</td>
<td></td>
</tr>
<tr>
<td>▪ What are the occupancy rates for the ICDP funded positions?</td>
<td>Number of positions filled</td>
<td>Consultation with health care and other relevant services</td>
<td>Six monthly/ annually</td>
<td></td>
</tr>
<tr>
<td>▪ Package measures are implemented in accordance with agreed guidelines and timelines.</td>
<td>Extent to which each measure was implemented according to plan, and documentation of when and why plans may have changed from original intention</td>
<td>Program documentation</td>
<td>Years 2, 4</td>
<td></td>
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<td>▪ What were the enablers and barriers to implementation (at a national, state/territory and local level)?</td>
<td>Description and extent of enablers and barriers to implementation, and how these barriers were overcome</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs, and Divisions of General Practice, program managers</td>
<td>Years 2, 4</td>
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<td>▪ Where and in what circumstances was the ICDP implemented most effectively?</td>
<td>Identification of circumstances/contexts in which implementation has worked well, and where problems have occurred</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice, program managers</td>
<td>Year 4</td>
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<td>▪ What regional variations are there in the uptake of the universal ICDP measures?</td>
<td>Extent of consistent uptake of the ICDP services across regions</td>
<td>Program documentation and administrative data sets</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>▪ Comparison of level of uptake of universal ICDP services, by Sentinel Sites with low and high levels of ICDP resourcing</td>
<td>Program documentation and administrative data sets</td>
<td>Six monthly/ annually</td>
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<td></td>
<td>Are there any inefficiencies in the implementation of the ICDP that need to be addressed?</td>
<td>Evidence of any inefficiencies</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice</td>
<td>Years 2, 4</td>
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<tr>
<td></td>
<td>Monitoring and reporting requirements are met.</td>
<td></td>
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<tr>
<td></td>
<td>Were funds released/used according to plan?</td>
<td>Extent to which actual use of funds differed from the original plan</td>
<td>Program documentation</td>
<td>Year 4</td>
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<td></td>
<td>Have all reporting and contractual requirements been established and agreed?</td>
<td>Evidence of reporting and contractual requirements</td>
<td>Program documentation</td>
<td>Years 2, 4</td>
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<td></td>
<td>Has the implementation of the ICDP resulted in the anticipated MBS and PBS utilisation rates?</td>
<td>Level of uptake of funding allocated for the utilisation of MBS and PBS items, compared to initial forecast</td>
<td>MBS, PBS</td>
<td>Annually</td>
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<td></td>
<td>Internal and external stakeholders, Sentinel Sites and service providers consider the implementation of the Package to be addressing identified needs and enhancing the existing service system.</td>
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<td></td>
<td>Are stakeholders supportive of the measures and their implementation strategies? Are they considered to be addressing identified needs? How are stakeholder concerns addressed?</td>
<td>Extent to which stakeholders participate in and actively support the implementation of the ICDP</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice program managers</td>
<td>Years 2, 4</td>
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<td>To what extent do key stakeholders agree that the ICDP content and priorities are appropriate and designed to address identified needs and priority areas?</td>
<td>Extent of agreement among key stakeholders regarding the content and priorities of the ICDP</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs and Divisions of General Practice program managers</td>
<td>Years 2, 4</td>
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<td>To what extent has the design and implementation of the ICDP involved external integration building on and leveraging existing programs at the national, regional and local levels?</td>
<td>Evidence of building on and leveraging existing programs</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs, and Divisions of General Practice, program managers</td>
<td>Years 2, 4</td>
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<td>To what extent has the design and implementation of the ICDP involved internal integration re coordinated actions across measures at the national, regional and local levels?</td>
<td>Evidence of enhanced internal integration and coordination</td>
<td>Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs, and Divisions of General Practice, program managers</td>
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*SIX MONTHLY/ANNUALLY (LOCAL LEVEL)*

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<td>To what extent do measures complement each other and facilitate a common purpose? Are there ways in which any ICDP measure conflicts with or impedes the operations of another?</td>
<td>Extent of complement/conflict</td>
<td>Program documentation Consultation with primary health care services, NACCHO and Affiliates, state and territory health, AGPN, SBOs, Divisions of General Practice, program managers</td>
<td>Years 2, 4</td>
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<td>To what extent have the service delivery principles been demonstrated in the design and implementation of the ICDP?</td>
<td>Evidence of the service delivery principles in the design and implementation of the Package measures</td>
<td>Program documentation</td>
<td>Year 4</td>
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<td>Extent of stakeholder satisfaction that the service delivery principles have been demonstrated within the ICDP</td>
<td>Consultation with program managers, NACCHO and Affiliates, AGPN, SBOs, primary health care services, community members</td>
<td>Year 4</td>
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### Activities

**Chronic disease risk factors:** A1, A2, A3  
**Chronic disease management and follow-up care:** B1, B2, B3, B4, B5, B6  
**Workforce expansion and support:** C1, C2, C3, C4, C5

### Aims

- Chronic disease risk factors: To reduce preventable chronic disease risk factors among Indigenous Australians  
- Chronic disease management and follow-up care: To improve chronic disease management and follow-up care for Indigenous Australians  
- Workforce expansion and support: To increase the size and capacity of the primary care workforce in Indigenous and mainstream health services in order to increase the uptake of health services by Indigenous Australians with or at risk of chronic disease