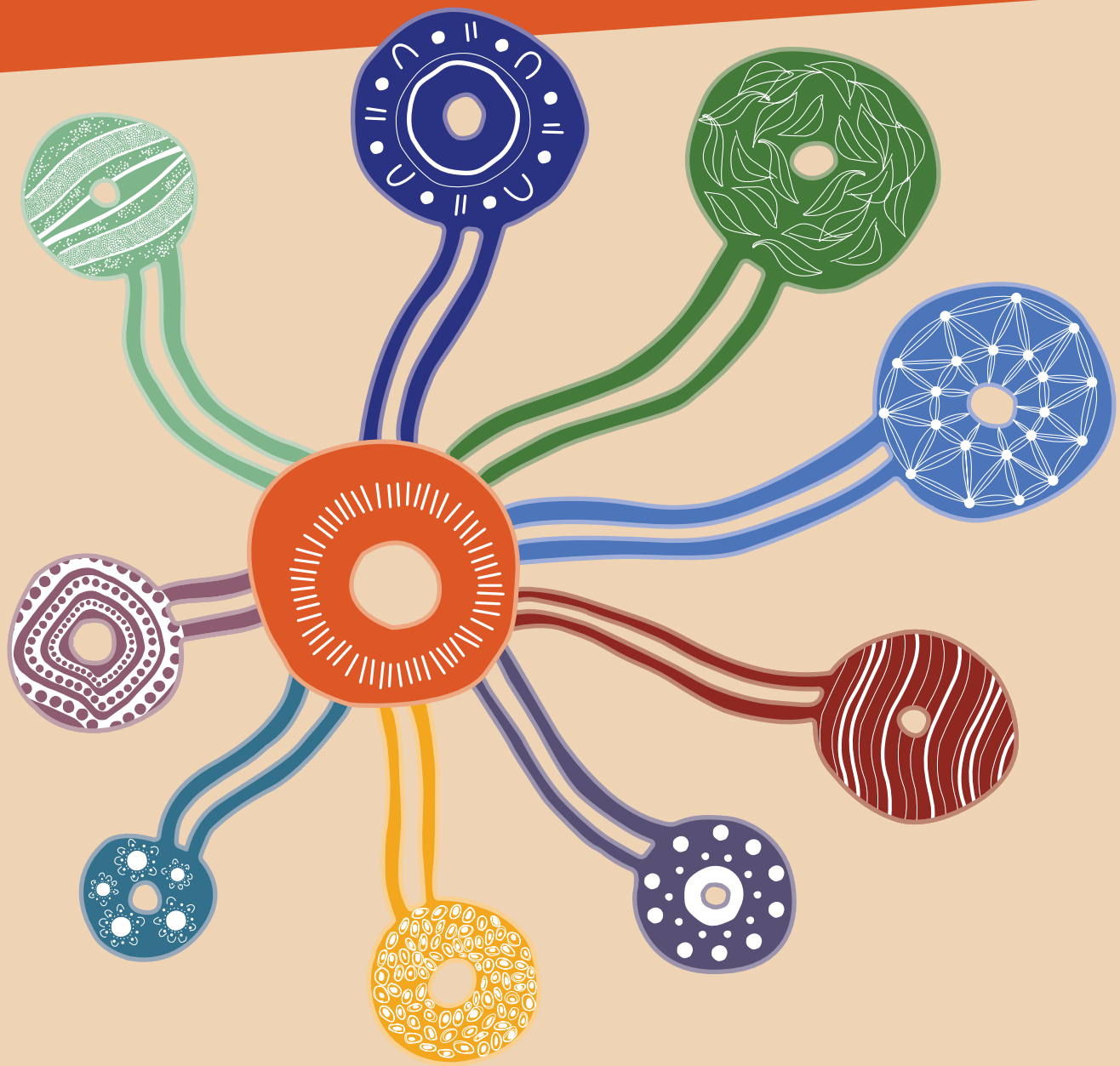
# Aboriginal Community Controlled Health Organisations in practice: Sharing ways of working from the ACCHO sector



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## Acronyms

| | |
|---|---|
| ACAT | Aged Care Assessment Team |
| ACCHS | Aboriginal Community Controlled Health Service |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| ACCO | Aboriginal Community Controlled Organisation |
| AGM | Annual General Meeting |
| AGPAL | Australian General Practice Accreditation Limited |
| AHCSA | Aboriginal Health Council of South Australia |
| AHCWA | Aboriginal Health Council of Western Australia |
| AH&MRC | Aboriginal Health & Medical Research Council (of NSW) |
| AIHW | Australian Institute of Health and Welfare |
| AMS | Aboriginal Medical Service |
| AMSANT | Aboriginal Medical Services Alliance Northern Territory |
| CDC | Client Directed Care |
| CHSP | Commonwealth Home Support Program |
| CPI | Consumer Price Index |
| CQI | Continuous Quality Improvement |
| DOH | Department of Health |
| HCP | Home Care Package |
| MBS | Medicare Benefits Schedule |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NAIDOC | National Aboriginal and Islanders Day Observance Committee |
| NDIS | National Disability Insurance Scheme |
| NGO | Non-government organisation |
| NHMRC | National Health and Medical Research Council |
| nKPI | National Key Performance Indicator |
| ORIC | Office of the Registrar of Indigenous Corporations |
| PHN | Primary Health Network |
| QAIC | Queensland Aboriginal and Islander Health Council |
| QIC | Quality Improvement Council |
| QMS | Quality Management System |
| RACGP | Royal Australian College of General Practitioners |
| RAS | Regional Assessment Service |
| RTO | Registered Training Organisation |
| TIS | Tackling Indigenous Smoking |
| VACCHO | Victorian Aboriginal Community Controlled Health Organisation |
| WHO | World Health Organisation |

# Acknowledgements

## Acknowledgement of Country

The authors of this resource recognise Aboriginal and Torres Strait Islander peoples as the traditional custodians of Country. We respect the spiritual relationship between all Aboriginal and Torres Strait Islander nations and their Country and acknowledge the effects that colonisation has had and continues to have on Australia's First Peoples. We acknowledge the deep feelings of attachment and relationship of Aboriginal and Torres Strait Islander peoples to culture and Country.


## Acknowledgement of Contributors

### CREATE Leadership Group

We acknowledge and thank the Leadership Group of the Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE) for their valuable time, enormous contribution, thoughtful guidance and ongoing support. Members marked with * have since changed roles.

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## Participating Services

We acknowledge and thank the following ACCHOs and peak bodies for contributing to the work of the Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange including informing or providing feedback on the content of this resource.

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Central Australian Aboriginal Congress, NT

Danila Dilba Health Service, NT

Dhauwurd-Wurrung Elderly & Community Health Service Incorporated, VIC

Geraldton Regional Aboriginal Medical Service, WA

Miwatj Health Aboriginal Corporation, NT

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# About this resource

## About this resource

This resource was developed to share the findings of Aboriginal and Torres Strait Islander led research undertaken during 2014 – 2019 by the Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE), Wardliparingga Aboriginal Health Equity, South Australian Health and Medical Research Institute. The aim of the resource is to showcase the work of Aboriginal community controlled health organisations (ACCHOs) in practice in order to strengthen the ACCHO sector nationwide.

## Who is this resource for?

This resource has been developed to support staff working within ACCHOs and other Indigenous primary health care organisations providing services to Aboriginal and Torres Strait Islander communities.

The CREATE team would like to acknowledge that for many ACCHOs, the learnings shared within this resource will be common knowledge and represent long standing practices. The resource highlights the important work of the ACCHO sector in providing essential services to Aboriginal and Torres Strait Islander communities across Australia.

## How to use this resource

This resource may be used to support induction of new staff, workforce capacity building, evaluation of existing programs and service delivery models, strategic planning processes, funding applications and future research endeavours.

It is important to consider the unique characteristics of your ACCHO and community before considering whether some of the recommendations and ways of working included in this resource could be adopted to benefit local Aboriginal and Torres Strait Islander peoples.

There are sand coloured boxes throughout each chapter that describe practical examples of ACCHO ways of working. It will be clear from the description whether the ways of working have been drawn from a *Metro ACCHO*, *Regional ACCHO* or *Remote ACCHO*.

## The development of the resource

The development of this resource was guided by the CREATE Leadership Group that comprised senior representatives from the ACCHO sector. The CREATE Leadership Group identified the following domains as focus areas for the research: health service delivery, governance, workforce, social determinants of health, health promotion, aged care, funding, accreditation, continuous quality improvement and national key performance indicators. These domains were explored through a nationwide series of case studies with ACCHOs in addition to systematic reviews and scoping reviews of the literature. The CREATE Leadership Group reviewed the findings of the case studies and refined the content presented within this resource to represent a broad range of practices accross the ACCHO sector.

## Where did the information for the resource come from?

The start of each chapter identifies where the information is drawn from such as whether it was one or more case studies undertaken with metropolitan, regional or remote ACCHOs, and whether the information is supported by the findings of a literature review. It is important to remember that the content of the chapters has been informed and sanctioned by the CREATE Leadership Group comprising senior representatives from the ACCHO sector nationwide.

Many people and organisations contributed to content presented in this resource. Further information regarding CREATE, the case study process and the ethical approaches to the research project are provided at the back of this resource (see page 194).

## How is the information presented?

There are ten chapters within the resource that each describe ACCHO practices in one domain. Each chapter has a summary and list of contents on the first page. The chapter then provides a detailed description of ACCHO ways of working, outcomes, enablers, challenges and recommendations related to that domain. There is also a brief discussion that describes other relevant research, and a Reflection Tool that summarises key approaches outlined within the chapter.

## Let's have a yarn about language

### Use of the Term ACCHO

The term ACCHO is used through this resource to describe Aboriginal community controlled organisations providing primary health care to Aboriginal and Torres Strait Islander peoples. There are other commonly used terms such as Aboriginal Community Controlled Health Services (ACCHS), Aboriginal Community Controlled Organisations (ACCOs) and Aboriginal Medical Services (AMSs) that could be used interchangeably with ACCHO.

### ACCHO ways of working and Western concepts

The strength of this resource is that it uses both Aboriginal and Torres Strait Islander concepts and Western concepts to describe ACCHO ways of working. It is designed to bridge the language gap between ACCHO and Western terminology. Matching both ACCHO concepts and Western concepts can be of benefit in funding applications and tenders. Below are some examples of ACCHO ways of working, and the Western concepts that these approaches relate to.

| **ACCHO ways of working** | **Western concepts** |
|---|---|
| *We value consensus based decision making founded upon collective cultural values* | ACCHOs value **Cultural Governance** in addition to **Strategic Governance** and **Clinical Governance** |
| *Growing and strengthening our ACCHO mob* | ACCHOs strengthen **Workforce** in relation to both capacity building and leadership roles |
| *We do whatever is necessary to support our mob* | ACCHOs have a **Social Determinants of Health** approach |
| *We listen to community and strive to tailor our programs to community needs* | ACCHOs practice **Continuous Quality Improvement** |

# A Brief Introduction to Aboriginal Community Controlled Health Organisations

## What is Aboriginal community control?

The National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak body for all ACCHOs, defines Aboriginal community control in health services as:

*'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community.[1]'*

## What is the definition of Aboriginal health?

ACCHOs have long adopted a holistic definition of health as defined in the Constitution of the National Aboriginal Community Controlled Health Organisation (NACCHO):

*'"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.[2]'*

## What is an Aboriginal Community Controlled Health Organisation?

An ACCHO is described by NACCHO as:

*'a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.[3]'*

ACCHOs understand the position and role they play in supporting their local Aboriginal Torres Strait Islander communities to live better lives. The ACCHO approach has evolved out of an inherited responsibility to provide flexible and responsive services that are tailored to the needs of local Aboriginal and Torres Strait Islander communities. ACCHOs provide many services over and above their funded activities to ensure their community members gain the services they need. In line with their holistic health approach ACCHOs support the social, emotional, physical and cultural wellbeing of Aboriginal and Torres Strait Islander peoples, families and communities.

## What is the history of ACCHOs?

The first ACCHO was established for local Aboriginal and Torres Strait Islander communities in Redfern in 1971. This was in response to experiences of racism in mainstream health services and an unmet need for culturally safe and accessible primary health care. A national umbrella organisation, the National Aboriginal and Islander Health Organisation, was first established in 1976 and became the National Aboriginal Community Controlled Health Organisation in 1992. There are now more than 140 ACCHOs across Australia with peak representative organisations across all states and territories.

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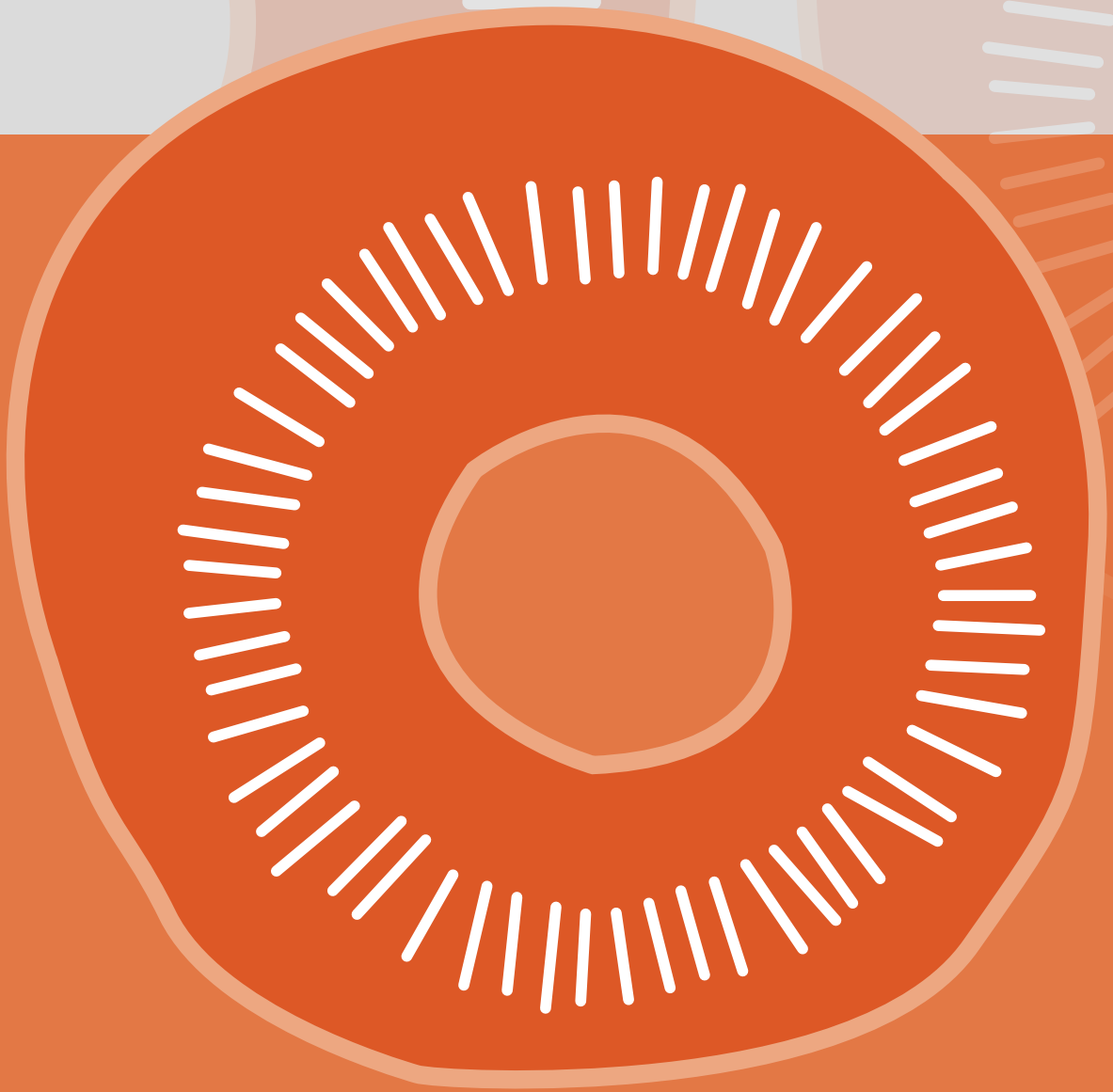
[1]National Aboriginal Community Controlled Health Organisation. (no date). *Community Controlled.* Accessed on January 17, 2020 at: naccho.org.au/about/aboriginal-health/definitions/
[2]National Aboriginal Community Controlled Health Organisation. (no date). *Aboriginal Health*. Accessed on January 17, 2020 at: naccho.org.au/about/aboriginal-health/definitions/
[3]National Aboriginal Community Controlled Health Organisation. (no date). *Aboriginal Community Controlled Health Services (ACCHSs).* Accessed on January 17, 2020 at: naccho.org.au/about/aboriginal-health/definitions/

# Chapter 1

## Characteristics of ACCHO Comprehensive Primary Health Care Service Delivery



# Characteristics of ACCHO Comprehensive Primary Health Care Service Delivery


## Summary

This chapter describes the characteristics of ACCHO comprehensive primary health care service delivery. All ACCHO services are focused upon local communities. While ACCHOs across Australia vary greatly in size and the services they can provide, there are common principles and practices that reflect Aboriginal and Torres Strait Islander ways of working and that are unique to the ACCHO sector. **Culture** is central to all ACCHO service delivery and is related to each of the other nine characteristics that include **self-determination and empowerment, community control and community participation, culturally competent and skilled workforce, holistic health care, accessible health services, flexible and responsive approach to care**, **relationship building and advocacy, comprehensive health promotion** and **continuous quality improvement.** To deliver services, ACCHOs also seek and administer funding from multiple sources and achieve accreditation across multiple national standards. Common best practice outcomes of ACCHO comprehensive primary health care service delivery include tailoring of services to meet community need, increased access to services by community, enhanced integration of services, improved holistic health and social outcomes for community, and the strengthened capacity of the local Aboriginal and Torres Strait Islander workforce.


The content within this chapter was drawn from an international systematic scoping review that was refined for the ACCHO context by the CREATE Leadership Group and strengthened with learnings from multiple CREATE case studies.

## What we cover in this chapter:

## Characteristics of Comprehensive Primary Health Care Service Delivery in ACCHOs

What makes an ACCHO unique?
The characteristics of primary health care service delivery models in ACCHOs include the **values**, **principles** and **components** of service delivery[1] or, more simply put, the principles and practices of service delivery. While ACCHOs across Australia range from small services with limited staff in remote communities to large metropolitan services with hundreds of staff, there are common principles and practices that reflect Aboriginal and Torres Strait Islander ways of working and that are unique to the ACCHO sector.

The characteristics outlined in this chapter were drawn from multiple sources including the findings of a review of the international literature, input from an ACCHO expert panel (the CREATE Leadership Group), and findings from a series of in-depth case studies of ACCHO ways of working. The systematic scoping review examined the international literature to identify the characteristics of Indigenous primary health care service delivery models[1] that included predominantly Australian studies but also studies from Canada, the United States, New Zealand, Papua New Guinea, Mexico and Peru.

The findings were then reviewed and refined by the CREATE Leadership Group to specifically reflect the ACCHO context. Learnings drawn from ACCHO case studies on governance, social determinants of health, health promotion, aged care, workforce and continuous quality improvement were also included to further elaborate the characteristics of ACCHO comprehensive primary health care service delivery.

**Within this chapter the findings of other systematic reviews** undertaken through the CREATE project are included, where relevant, within pale orange text boxes such as this.

## The ACCHO Comprehensive Primary Health Care Service Delivery Model

The proposed model depicted in Image 1 (over page) is focused on tailoring services to meet community need and highlights ten characteristics that include:

- Culture
- Self-determination and empowerment
- Community control and community participation
- Culturally competent and skilled workforce
- Holistic health care
- Accessible health services
- Flexible and responsive approach to care
- Relationship building and advocacy
- Comprehensive health promotion
- Continuous quality improvement

All ACCHO services are focused upon local communities. The characteristics of service provision may differ from one ACCHO to the next, depending on local historical factors, context, governance, resources, needs and priorities.

ACCHOs must also meet national clinical accreditation standards and must negotiate, secure and administer adequate funding to deliver services to their communities. As such, accreditation and funding are essential requirements of ACCHO health service delivery.

[1]Harfield SG, Davy C, McArthur A, Munn Z, Brown A, Brown N. (2018). Characteristics of Indigenous primary health care service delivery models: a systematic scoping review. *Global Health, 14* (1): 12.

**Image 1: The ACCHO Comprehensive Primary Health Care Service Delivery Model**


## Model description

The ACCHO Comprehensive Primary Health Care Service Delivery Model depicts the key characteristics of ACCHO health service delivery, with two surrounding yellow rings representing additional elements (i.e. funding and accreditation) necessary for health service delivery. The model highlights that Aboriginal cultures (in orange) are central to ACCHO health services and the foundation for all other characteristics of service delivery. Many of the other characteristics are inter-related: self-determination and empowerment is a key characteristic but is also an intrinsic principle of both community control and community participation and holistic health care; beyond the relationship building and advocacy characteristic, advocacy activities are fundamental to comprehensive health promotion and holistic health care; and continuous quality improvement relates to all areas of ACCHO service provision, workforce, and governance. All characteristics are focused on community and on responding to local needs and priorities.

This model was developed through the CREATE project, based on the findings of an international systematic scoping review and refined for the ACCHO sector through consultations with the CREATE Leadership Group.

# Culture

Aboriginal and Torres Strait Islander cultures are central to health service delivery within ACCHOs and are the unique characteristic that makes ACCHOs distinct from other primary health care services. Embedding culture within all elements of service delivery is key to creating a culturally safe and comprehensive primary health care service that is oriented to the needs of community.

In line with Aboriginal and Torres Strait Islander cultural practices, ACCHOs focus on the needs of individuals as well as their families and communities and respect the cultural needs of men and women including providing gender-specific programs. The employment of local Aboriginal and Torres Strait Islander peoples within ACCHOs is key to embedding culture throughout service delivery, as is the use of local language and artwork and the incorporation of local customs and traditional practices within services. Cultural safety training and two-way learning between Aboriginal and Torres Strait Islander workforce and non-Indigenous staff is also important in promoting cultural safety within ACCHOs.

The key ways that Aboriginal and Torres Strait Islander cultures are embedded across ACCHO primary health care service delivery models:

- Incorporation of local cultural values, customs, ceremonies, beliefs and spirituality (which may include traditional healing and practices) in all programs and services.
- Focusing on the needs of individuals, families and communities.
- Respecting women's and men's cultural needs.
- Creating welcoming spaces and family-friendly environments.
- Use of local Aboriginal and Torres Strait Islander language, artwork and signage.
- Culturally appropriate prevention and health promotion resources.
- Ensuring the local community is engaged with and in control of the ACCHO.
- Employment of Aboriginal and Torres Strait Islander staff.
- Cultural safety and two-way learning between Aboriginal and Torres Strait Islander and non-Indigenous colleagues.

# Self-Determination and Empowerment

Self-determination and empowerment are fundamental principles of all ACCHO health service delivery. They are embedded within Aboriginal and Torres Strait Islander ways of working, are central to the Aboriginal community controlled model of ACCHO governance, and are reflected in the empowerment of Aboriginal and Torres Strait Islander workforce within the ACCHO. ACCHO staff empower clients and families to make their own decisions and take control of their health.

The principles of self-determination and empowerment underpin the ACCHO governance model (see **Chapter 2**), the ACCHO workforce capacity building and leadership model (see **Chapter 3**), the ACCHO social determinants of health approach (see **Chapter 4**) and the ACCHO comprehensive health promotion approach (see **Chapter 5**).

The principles of self-determination and empowerment in ACCHO health service delivery are demonstrated through:

- Empowering clients to self-manage their health at an individual and family level leading to increased client capacity and resilience.
- Promoting community development through cultural days, camps and reconciliation events leading to increased social connectedness and cultural pride.
- Providing employment and training opportunities to support the development of the local Aboriginal and Torres Strait Islander health workforce.
- Facilitating leadership opportunities for local people to create positive role models.
- The Aboriginal community controlled governance model of the ACCHO which reflects collective self-determination.

# Community Control and Community Participation

Aboriginal community control is a fundamental characteristic of ACCHO service delivery. This encompasses custodianship and management of the service by the community, respect for the role of Elders, and governance provided by the local community including the Board of Directors. It also relates to community participation where the ACCHO engages and consults with community to tailor services to local needs and priorities.

For further information regarding ACCHO governance, see **Chapter 2**. This chapter highlights the three elements of ACCHO governance including cultural governance, strategic governance and clinical governance.

The key features of Aboriginal community control and community participation within ACCHOs:

- Custodianship of the ACCHO by the local Aboriginal and Torres Strait Islander community.
- Governance of the ACCHO by the local Aboriginal and Torres Strait Islander community through the Board of Directors.
- Respecting the role and status of Elders and facilitating their involvement in the work and governance of the ACCHO.
- Community consultation, engagement and collaboration to ensure programs and services are culturally responsive, accessible and tailored to local context and needs.

# Culturally Competent and Skilled Workforce

One of the key ways that culture is centred within ACCHO service delivery is through a culturally competent and skilled workforce. ACCHOs are one of the leading employers of Aboriginal and Torres Strait Islander peoples and recognise the cultural, family and professional obligations and responsibilities of their staff. Aboriginal and Torres Strait Islander staff understand the historical trauma and lived experience of their communities including kinship structures and cultural obligations.This ensures that the needs of ACCHO clients are met according to cultural protocols in addition to clinical standards.

For further information regarding ACCHO workforce see **Chapter 3**. This chapter highlights the four key strategies to strengthen ACCHO workforce: 1) attract and recruit local Aboriginal and Torres Strait Islander peoples; 2) support, value, promote and recognise ACCHO staff; 3) strengthen the capacity of ACCHO staff; 4) nurture emerging Aboriginal and Torres Strait Islander leaders.

ACCHOs promote a culturally competent and skilled workforce through:

- Recruiting and employing a range of skilled local Aboriginal and Torres Strait Islander peoples that deliver culturally competent and safe practices.
- Providing supportive culturally safe environments that recognise the cultural, community and family obligations of staff and where workforce feel supported.
- Investing in local people by providing mentoring, training and development opportunities for non-clinical positions as well as clinical roles (e.g. Aboriginal and Torres Strait Islander Health Workers and Practitioners, nursing, medical and allied health roles).
- Providing ongoing cultural competency training for all staff.
- Recognising the need to build and grow the Aboriginal and Torres Strait Islander workforce through a commitment to Aboriginal-identified positions, long term retention and professional development strategies and clear career pathways.
- Two-way learning between Aboriginal and Torres Strait Islander and non-Indigenous colleagues including cultural mentorship.

**What Aboriginal and Torres Strait Islander clients value about ACCHO care:**
A systematic review of client perceptions of the unique characteristics and value of care provided by ACCHOs[2] identified that the **qualities of ACCHO staff** were highly valued. These qualities include the Aboriginal identity of ACCHO staff and the employment of Aboriginal Health Workers, and respectful behaviour and understanding demonstrated by ACCHO staff. Examples included respectful and non-judgemental behaviour; taking the time to get to know the client and their background; sensitivity, kindness and reassurance; and trustworthiness.

[2]Gomersall J, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, Canuto K, Munn Z, Aromataris E, Brown A. (2017). What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health, 41*: 4.

# Holistic Health Care

ACCHOs provide holistic primary health care in line with NACCHO's definition of health that encompasses social, emotional, mental, physical and cultural wellbeing of individuals and the whole community.[3] ACCHOs strive to provide a diverse range of services and address the social determinants of health. These services are provided across the lifespan, from pre-natal care through to care for Elders.

For further information regarding the holistic health approach of ACCHO health service delivery see **Chapter 4**, which describes the ACCHO Social Determinants of Health model.

In ACCHOs, holistic health care can include:

- Comprehensive primary health care that supports the health and wellbeing of not only the individual but also their family and community and includes mental, emotional, spiritual, physical, social and cultural wellbeing.
- A diverse range of services (e.g. maternal and child health, prevention, disability, pharmacy, chronic disease care, prison health, traditional healing services).
- Education to strengthen health knowledge and understanding.
- Client, family and community advocacy such as with Centrelink, employment services, child protection services, and the justice system.
- Engaging with the social determinants of health such as through supporting clients with housing security, social security payments, food security, education programs and employment services.
- Based on the local context and community needs, ACCHOs may also provide additional services such as environmental health, bush foods, early childhood education and child care centres.

**Ways in which ACCHOs address the social determinates of health:** A document analysis of ACCHO annual reports identified the considerable efforts of the ACCHO sector in addressing the social determinants of health impacting Aboriginal and Torres Strait Islander communities at both the intermediary level and structural levels.[4] Activities were underpinned by culture and had a strong focus on services that strengthened community and cultural connections. This analysis demonstrates that not only do ACCHOs play an essential role in addressing the immediate healthcare needs of their communities but they also undertake extensive efforts to strengthen the cultural determinants of health and address the social determinants of health including the challenging structural factors that create inequity.

**What Aboriginal and Torres Strait Islander clients value about ACCHO care:**
A systematic review of client perceptions of the unique characteristics and value of care provided by ACCHOs[5] identified their **comprehensive, holistic approach** as a key element. Non-clinical services including social services, cultural events and group activities (e.g. bush camps) were valued, with group activities providing opportunities for clients to spend time with people who shared similar experiences and to connect with community and culture.

[3]National Aboriginal and Community Controlled Health Organisation. (no date). *Definitions.* Accessed on January 17, 2020 at: naccho.org.au/about/aboriginal-health/definitions/
[4]Pearson O, Schwartzkopff K, Dawson A, Hagger C, Karagi A, Davy C, Braunack-Mayer A, Brown A on behalf of the Leadership Group guiding the Centre for Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE). (2020). *Ways in which Aboriginal Community Controlled Health Services strive for health equity through influencing the social determinants of health* (under preparation).
[5]Gomersall J, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, Canuto K, Munn Z, Aromataris E, Brown A. (2017). What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health, 41*: 4.

# Accessible Health Services

ACCHOs go to great lengths to provide accessible comprehensive primary health care services for their communities. This includes providing services at no cost* to clients and tailoring services to community need in relation to where and how services are delivered. ACCHOs strive to enhance the acceptability of care (such as in relation to cultural safety and confidentiality) and to promote community awareness of available ACCHO services in order to maximise client engagement and access.

ACCHOs promote accessible health services through:

- Providing affordable health care at no cost* to clients.
- Delivering, where possible, a broad range of services in a variety of locations and settings.
- Providing walk in appointments, transport, increased opening hours, home visits and outreach services that are flexible and responsive to community need.
- Delivering acceptable care that includes trust, privacy, confidentiality, cultural respect, social justice and equality.
- Enhancing community awareness of services through numerous strategies (e.g. brochures, guest speakers during community lunches, referrals across ACCHO teams).
- Engaging with community members who are not clients of the service (e.g. during community events) to understand how to improve services to meet local needs.

**What Aboriginal and Torres Strait Islander clients value about ACCHO care:** A systematic review of client perceptions of the unique characteristics and value of care provided by ACCHOs[6] identified the **accessibility of ACCHO services** as a key element. ACCHO clients identified that transport services, proactive service provision including outreach services, culturally safe care, a range of services and a welcoming environment all contributed to the accessibility of ACCHO primary health care services.

**Access to primary health care services for Indigenous peoples:** A framework synthesis[7] of factors that impacted access to primary health care for Indigenous peoples identified challenges related to the social determinants of health such as poverty which impacted the ability of clients to afford transport and to pay for services. The synthesis also identified that health care access was promoted by Indigenous health services through the provision of transport, through community consultation in identifying and addressing health care needs, and through the provision of affordable health care.

*Note that there may be a minimal out of pocket expense for some ACCHO services, such as pharmaceutical items.

[6]Gomersall J, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, Canuto K, Munn Z, Aromataris E, Brown A. (2017). What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health*, *41*:4.

[7]Davy C, Harfield S, McArthur A, Munn Z, Brown A. (2016). Access to primary health care services for Indigenous peoples: A framework synthesis. *Int J Equity Health, 15* (1): 163.

# Flexible and Responsive Approach to Care

ACCHOs strive to be both flexible and responsive and tailor services to meet the changing needs of their local communities. This may include delivering services outside of the standard health clinic model such as home visits and outreach services (e.g. pop-up clinics and health checks during community events). ACCHO staff work within multi-disciplinary teams and develop partnerships with external agencies to integrate services and support clients with their social, emotional, cultural, mental and physical wellbeing.

ACCHOs provide flexible and responsive services through the following actions:

- Ongoing consultation and engagement with community to understand local needs and priorities and continuously improve the care provided to community.
- Tailoring services to meet the needs of the local community ensuring they are relevant, culturally safe and effective.
- Provision of services that respond to community need such as through outreach services, home visits and service provision during community events.
- Integrating services with a multi-disciplinary team approach including case management and continuity of care.
- Creating partnerships through linking with other services to promote integration and cooperation across sectors and to promote flexible and responsive care in partner services.

**What Aboriginal and Torres Strait Islander clients value about ACCHO care:**
A systematic review of client perceptions of the unique characteristics and value of care provided by ACCHOs[8] identified that ACCHO service delivery was **appropriate and responsive to client needs**. The review identified four elements of care including staff who take the time to know and care for clients, health care that was personalised and tailored to self-perceived need, the provision of information in a way that was understandable (i.e. appropriate communication), and continuity of care over time.

[8]Gomersall J, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, Canuto K, Munn Z, Aromataris E, Brown A. (2017). What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health*, *41*: 4.

# Relationship Building and Advocacy

ACCHOs invest in building relationships and undertaking advocacy with a broad range of partner organisations and funders. Partnerships can be both formal and informal. Partner organisations can include local hospitals, specialist services and rehabilitation services, other ACCHOs within the region and across the state/territory, Aboriginal community controlled peak bodies and national representative bodies, government departments and services (e.g. housing, education, social services, justice, police), and non-government organisations. The development of accountable relationships with partner organisations enables a more coordinated and collaborative local health and social services system that can promote increased client access to other health and social services and the development of culturally safe environments beyond the ACCHO.

ACCHOs also devote considerable time in building and maintaining relationships with their funders including government departments, primary health networks and non-government organisations. They undertake extensive and ongoing advocacy with governments, funders and partner organisations for better policies and funding models for Aboriginal and Torres Strait Islander peoples and to raise awareness about the value system of ACCHOs.

For further information regarding the relationship building and advocacy activities of ACCHOs see **Chapter 4** which describes ACCHO approaches to the Social Determinants of Health and **Chapter 5** which describes the ACCHO Comprehensive Health Promotion Model.

The broad range of relationship building and advocacy activities ACCHOs can undertake include:

- Advocating on behalf of clients such as in relation to health, keeping children and families together, finances, housing, education and employment opportunities (as described under the Holistic Health characteristic).
- Advocating on behalf of Aboriginal and Torres Strait Islander communities at the local, state/territory and national levels to influence the development of healthy public policy that is inclusive, equitable and aligns with the priorities of Aboriginal and Torres Strait Islander peoples.
- Advocating to other services, such as hospitals and specialist services, to adapt (that is, reorient) their models of care to better meet client needs.
- Promoting culturally safe environments in partner organisations through advocating for and delivering cultural safety training.
- Advocating for seamless, integrated and multidisciplinary care for Aboriginal and Torres Strait Islander clients such as through providing cultural mentorship to staff within partner organisations regarding what it means to provide a culturally safe and responsive service for Aboriginal and Torres Strait Islander peoples.
- Advocating for systems change through providing cultural advice, support and direction to government departments, PHNs, partner organisations and research institutes through participation in forums, working groups and research activities.

# Comprehensive Health Promotion

Comprehensive health promotion refers to the approach ACCHOs undertake to tailor services to meet community need, to strengthen and unite communities, to strengthen cultural pride and personal skills, to provide and promote culturally safe spaces (both within the ACCHO and in partner services) and to advocate for equitable public policy. These five action areas of comprehensive health promotion align with and extend the holistic health care model provided by ACCHOs. Health promotion is defined by the World Health Organisation as the *'process of enabling people to increase control over, and to improve, their health'*.[9] Comprehensive health promotion has a focus on prevention and early intervention, raising awareness, building health knowledge and understanding, advocacy, strengthening, empowering and uniting communities.

For further information regarding the ACCHO Comprehensive Health Promotion Model see **Chapter 5**.

The five action areas of comprehensive health promotion in ACCHOs include:

- Orienting primary health care to meet community need: designed by community, for community.
- Providing culturally safe spaces in the ACCHO and promoting culturally safe spaces in mainstream services.
- Strengthening cultural pride and personal skills through role modelling, mentoring and education.
- Strengthening, empowering and uniting Aboriginal and Torres Strait Islander communities.
- Advocating for and driving the development of public policies that achieve equity for Aboriginal and Torres Strait Islander peoples.

A scoping review[10] of **Aboriginal and Torres Strait Islander health promotion programs for the prevention and management of chronic diseases** found that published programs were not comprehensive in nature and predominantly focused on one risk factor, most commonly nutrition or smoking. The findings of this scoping review are at odds with ACCHO case study findings (see **Chapter 5** of this resource) which describe comprehensive and culturally centred health promotion activities. The authors of the review acknowledged that many health promotion programs delivered by primary health care services (including ACCHOS) were not captured as they are infrequently reported in the research literature. This highlights a lack of support for evaluation of health promotion programs implemented in primary health care services and the need for designated funding to support the sector in sharing learnings to inform future efforts.

[9]World Health Organisation. (1986). *Ottowa Charter for Health Promotion*. World Health Organisation, Geneva. Accessed on January 17, 2020 at: healthpromotion.org.au/images/ottawa_charter_hp.pdf

[10]Canuto, K. J., Aromataris, E., Burgess, T., Davy, C., McKivett, A., Schwartzkopff, K., Canuto, K., Tufanaru, C., Lockwood, C., & Brown, A. (2019). Aboriginal and Torres Strait Islander health promotion programs for the prevention and management of chronic diseases: a scoping review. *Health Promotion Journal of Australia*, *00*: 1–29.

# Continuous Quality Improvement

From the beginning, ACCHOs were established to address an un-met need for culturally safe and comprehensive primary health care for Aboriginal and Torres Strait Islander communities. To this day, ACCHOs continually review their programs and services to improve the way they respond to changing community priorities and needs. Quality improvement processes may differ across ACCHOs but consistently include collecting and analysing relevant data through internal reviews and through engaging with community (both active clients as well as community members who are not clients of the service) to look for ways to improve service delivery to benefit community. Continuous quality improvement (CQI) processes are integrated within all teams and programs within the ACCHO.

For further information regarding ACCHO approaches and processes to CQI, see **Chapter 9**.

Key elements of ACCHO CQI processes include:

- Embedding whole-of-organisation CQI processes that are outwardly focused and centred on community needs and feedback.
- Engaging with disengaged members of the community to enable them to re-engage.
- Undertaking ongoing improvement processes in the delivery of safe and quality patient care.
- Collecting and analysing relevant data to improve health outcomes and enable program evaluation and development.
- Evaluating services such as in relation to economic outcomes, service utilisation, health assessments and chronic disease plans.

## Outcomes of ACCHO health service delivery

Common best practice outcomes of ACCHO health service delivery, drawn from the case studies undertaken on ACCHO programs and practices relating to the social determinants of health, aged care, health promotion and workforce include:

- **Tailoring of services to meet community need** due to strong links with community and effective community engagement.
- **Enhanced integration of services** through ACCHO investment in relationships with external partners.
- **Culturally safe and responsive care** which may include using local language.
- **Client's health needs are met according to both cultural protocols and clinical standards** since ACCHO staff understand the historical trauma and lived experience of their clients including kinship structures and cultural obligations.
- Increased community **access to services.**
- **Improved holistic health outcomes for clients and community** in relation to: social, emotional, physical and cultural wellbeing; cultural identity and connection; confidence to navigate numerous systems and services; educational, employment and housing outcomes; reduced pressures and responsibilities on carers; support for healthy inclusive communities.
- **Strengthened capacity and empowerment of the local Aboriginal and Torres Strait Islander workforce.**

**What Aboriginal and Torres Strait Islander clients value about ACCHO care:** A systematic review of client perceptions of the unique characteristics and value of care provided by ACCHOs[11] identified that ACCHO service delivery was perceived to positively impact client wellbeing, including improved overall health and mental health, increased confidence, enhanced knowledge regarding managing conditions and engaging in decision making, and also pride in being part of the local Aboriginal community and its health service.

## Enablers of ACCHO health service delivery

There are common enablers of ACCHO best practice described across the case studies undertaken on ACCHO approaches to the social determinants of health, aged care, health promotion and workforce. These include:

- **Community consultation and engagement** which enables a two-way process that ensures ACCHO services are client-centred and tailored to local priorities, culture and need.
- Strong Aboriginal and Torres Strait Islander **leadership.**
- **A committed, united, skilled, flexible, caring and culturally safe Aboriginal and Torres Strait Islander and non-Indigenous ACCHO workforce** who align with the values of the organisation.
- **Effective relationships** within and across ACCHO teams including clear communication and referral pathways.
- **Effective governance** by the Board of Directors and operational leadership in relation to creating effective organisational structures and accountable external partnerships.
- Strong **organisational culture and effective operational systems**, policies and procedures including the ability to manage multiple and complex funding streams.
- Investment in respectful and collaborative **partnerships** including with volunteers, other Aboriginal organisations and mainstream services.

[11]Gomersall J, Gibson O, Dwyer J, O'Donnell K, Stephenson M, Carter D, Canuto K, Munn Z, Aromataris E, Brown A. (2017). What Indigenous Australian clients value about primary health care: a systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health, 41*: 4.

## Challenges impacting ACCHO health service delivery

While all ACCHOs strive to deliver services to their communities in line with the characteristics described within this chapter, their capacity to do so can be limited by factors such as the size of the service. For example, smaller services with limited staff may be unable to undertake a comprehensive approach to health promotion. The common challenges facing ACCHO service delivery as identified in ACCHO case studies on the social determinants of health, health promotion, aged care, funding and workforce include the following:

### Funding challenges:

- **Insufficient funding** limiting service provision (e.g. dental) and requiring ACCHOs to deliver services in the absence of funding (e.g. transport, funeral support), short term funding and withdrawal of funding, lack of funding for evaluation of programs and services, staff wage increases not matched by an increase in government funding.
- **Restrictive funding** agreements including programs with pre-determined priorities (reducing the ability to tailor services to community need) or that do not support a comprehensive social determinants of health approach.
- **Considerable time and resources needed to prepare tenders and funding submissions.**
- **Competing for funding** with non-Indigenous organisations.
- **Complexity in coordinating multiple sources of funding** including reporting burden.
- **MBS funding models** may not always match Aboriginal and Torres Strait Islander ways of working.

### Workforce challenges:

- **Aboriginal and Torres Strait Islander workforce supply shortage.**
- **Non-competitive staff salaries** due to inadequate funding of ACCHO programs leading to challenges in recruitment and retention of skilled staff.
- **Challenges in recruiting and retaining staff,** particularly Aboriginal and Torres Strait Islander staff.
- **Staff stress due to 24/7 nature of work** and juggling professional, community and cultural obligations.
- Challenges in **attracting funding for workforce training and capacity building initiatives.**
- Challenges in **identifying and accessing suitable management training** for ACCHO managers.
- **Considerable time and resources** must be invested in capacity strengthening and mentoring staff.
- **Building cultural competency** in staff and an appreciation of the ACCHO sector's role in strengthening capacity of Aboriginal and Torres Strait Islander staff.

### Advocacy and Partnership challenges:

- **Building and maintaining relationships with numerous external partners** (both formal and informal).
- **The constant advocacy that ACCHOs undertake with governments, funders and partners** to raise awareness about the value system of ACCHOs, about the role ACCHOs play, and to advocate for better policies and funding models for Aboriginal and Torres Strait Islander peoples.

### Sector reform challenges:

- **Staff investment required to adopt new systems, processes and terminology** when taking on additional service delivery or experiencing sector reforms (e.g. Aged Care, NDIS and prison health reforms).

### Service delivery challenges:

- **Maintaining ongoing community trust and engagement** and achieving client self-determination and autonomy versus reliance on services.
- **Building genuine relationships** with clients who are from diverse Aboriginal and Torres Strait Islander cultures.

## Policy level actions to strengthen and support ACCHO health service delivery

To provide accessible, quality, culturally safe care to their communities, ACCHOs must be adequately resourced and have the flexibility to adapt programs and services in response to community priorities and feedback. Programs to strengthen the capacity and retain Aboriginal and Torres Strait Islander workforce in remote, rural and metropolitan areas are also needed to deliver quality culturally safe care. Table 1 presents a summary of potential policy level actions that could address common challenges facing ACCHO comprehensive primary health care service delivery models. These challenges were identified through case studies with ACCHOs on the social determinants of health, health promotion, aged care, funding and workforce.

**Table 1: Potential policy actions to address challenges to effective ACCHO health service delivery**

| Domain | Challenge to effective ACCHO health service delivery | Potential policy level actions |
|---|---|---|
| Funding | **Insufficient funding** of ACCHO comprehensive primary health care resulting in unfunded services (e.g. transport, home visits, funeral support), lack of funding for dental health, lack of funding for program evaluation, staff wage increases unmatched by increases in government funding. | Funding agreements to adequately resource the ACCHO comprehensive primary health care model including evaluation of programs and workforce salary increments. |
| | **Restrictive funding** agreements including programs with pre-determined priorities or that do not support a comprehensive social determinants of health approach. | Funding agreements to incorporate flexibility that enables ACCHOs to consult with their communities to identify local priorities and tailor services to local needs. |
| | **Short term funding and de-funding of programs.** | Funding agreements to provide long-term sustainable funding for ACCHO programs and services. |
| | **Considerable time and resources needed to prepare tenders and funding submissions.** | Funding opportunities through tenders and funding submissions to have reasonable timeframes and be promoted to the ACCHO sector. The ACCHO sector would benefit from capacity building in relation to preparing competitive submissions. |
| | **Competing for Aboriginal health funding with non-Indigenous organisations.** | ACCHOs to be recognised as the experts in Aboriginal comprehensive primary health care and the preferred recipient of funding for Aboriginal and Torres Strait Islander initiatives. |
| | **Complexity in coordinating multiple sources of funding including reporting burden.** | The frequency and complexity of reporting to be streamlined to reduce the burden on the ACCHO sector. The sector requires additional resourcing for administration including IT, data, reporting and financial management. |
| | **MBS funding models may not always match Aboriginal ways of working.** | MBS to consult with the ACCHO sector regarding MBS items needed to support cultural ways of working. |

| Domain | Challenge to effective ACCHO health service delivery | Potential policy level actions |
|---|---|---|
| **Workforce** | **Aboriginal and Torres Strait Islander workforce supply shortage.** | The workforce supply shortage to be addressed as an urgent priority through investment in a range of targeted workforce initiatives (e.g. place-based traineeships, scholarships, university places). |
| | **Non-competitive staff salaries** due to inadequate funding of ACCHO programs. | Funding agreements to provide greater resourcing for ACCHO programs so that ACCHO staff can be remunerated fairly and in line with other sectors (e.g. government health services). |
| | **Challenges in recruiting and retaining staff,** particularly Aboriginal and Torres Strait Islander staff. | |
| | **Staff stress due to 24/7 nature of work** and juggling professional, community and cultural obligations. | Wellbeing initiatives for ACCHO health workforce to be considered when implementing strategic documents such as the *'National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023'.* |
| | **Challenges in attracting funding for workforce training and capacity building initiatives** and identifying and accessing **suitable management training for ACCHO managers.** ACCHOs who are registered training organisations (RTOs) find it challenging to secure funding to support training of Aboriginal Health Workers and Aboriginal Health Practitioners. | NACCHO to be funded to provide professional development and capacity building initiatives for ACCHO workforce at all levels. ACCHO RTOs to be directly funded to train Aboriginal Health Workers and Aboriginal Health Practitioners. |
| | **Considerable time and resource investment in capacity strengthening and mentoring staff.** | Funding agreements to recognise (and resource) the significant efforts ACCHOs undertake to mentor and strengthen the capacity of Aboriginal and Torres Strait Islander workforce. |
| | **Building cultural competency** in staff and an appreciation of the ACCHO sector's role in strengthening capacity of Aboriginal and Torres Strait Islander staff. | Funding agreements to recognise and resource the cultural mentoring ACCHOs undertake with non-Indigenous clinicians and workforce regarding cultural ways of working. |
| **Advocacy and Partnerships** | **Building and maintaining relationships with numerous external partners.** | Funding agreements to recognise and resource the considerable relationship building efforts and advocacy activities undertaken by the ACCHO sector. |
| | **The constant advocacy that ACCHOs undertake with governments, funders and partners** to raise awareness about the value system of ACCHOs, about the role ACCHOs play, and to advocate for better policies and funding models for Aboriginal and Torres Strait Islander peoples. | |
| **Sector reforms** | **Staff investment required to adopt new systems, processes and terminology** when taking on additional service delivery or experiencing sector reforms (e.g. Aged Care, NDIS and prison health reforms). | Policy makers consider undertaking an ACCHO Impact Assessment when major initiatives and reforms are being developed that potentially impact the ACCHO sector. Consider and resource the ACCHO sector in the development and dissemination of reform-related information and training. |

## Discussion

The ACCHO Comprehensive Primary Health Care Service Delivery Model was developed drawing upon multiple sources of evidence including a systematic scoping review of Indigenous primary health care service delivery (Harfield et al 2018), expert consultations and in-depth case studies. It was strengthened by further studies including a systematic literature review examining what clients value about ACCHO service delivery (Gomersall et al, 2017), a framework synthesis examining access to services (Davy et al, 2016a), and document analysis of ACCHO approaches to the social determinants of health (Pearson and Schwartzkopff et al, 2020). Engagement with the ACCHO sector through the CREATE Leadership Group and through in-depth case studies ensured this model is grounded in current practice. This in no way suggests ACCHO service delivery is limited to this model. Rather, this model represents a starting point for the conceptualisation of ACCHO service delivery characteristics. It could be used to inform workforce capacity development, program design, program evaluation, and funding submissions.

This model of ACCHO health service delivery is consistent with other frameworks such as the *Core functions of primary health care: a framework for the Northern Territory* (Tilton and Thomas, 2011) that outlines five domains (clinical services; health promotion; corporate services and infrastructure; advocacy, knowledge and research, policy and planning; and community engagement, control and cultural safety). It is also consistent with a wellbeing framework for Aboriginal and Torres Strait Islander peoples living with chronic disease (Davy et al, 2017). The framework outlined four key elements: 1) Wellbeing is supported by locally defined, culturally safe primary healthcare services; 2) Wellbeing is supported by an appropriately skilled and culturally competent healthcare team; 3) Wellbeing is supported by holistic care throughout the lifespan; and 4) Wellbeing is supported by best practice care that addresses the particular needs of a community. Our model is also aligned with findings from a systematic review that identified how primary health care and aged care services can support the wellbeing of older Indigenous peoples (Davy et al, 2016b). The review found that the wellbeing of older Indigenous peoples was enhanced through maintaining Indigenous identity, promoting independence and delivering culturally safe care. These factors are promoted within our model through the key characteristics of culture, self-determination and empowerment, and culturally competent and skilled workforce. A systematic review of qualitative studies that examined client perceptions of the unique characteristics and value of ACCHO care compared to mainstream services identified that the key characteristics included accessibility of care, appropriateness of care (including personalised care tailored to self-perceived need, taking the time to know and care for clients, continuity of care and appropriate communication), culturally safe care provided by ACCHO staff who were valued for their Aboriginal identity and respectful behaviour, and a comprehensive holistic approach to care that included non-clinical care (Gomersall et al, 2017).

Importantly, the development of the model in this chapter identified key challenges impacting ACCHO health service delivery. The primary challenges relate to insufficient funding and the burden and complexity of administering funding from multiple government departments and other funders. These challenges have been highlighted in previous work on Indigenous primary health care services by Silburn et al (2011).The reporting burden of ACCHOs and the complexity associated with administering income across multiple funding sources was highlighted by Dwyer and colleagues a decade ago (Dwyer et al, 2009). A more recent in-depth case study with Rumbala Aboriginal Co-operative in Victoria found ongoing challenges with reporting burden. In the delivery of holistic services in the 2013-14 financial year, Rumbala Aboriginal Co-operative held 48 separate agreements with 12 funding agencies (including state and federal government departments, government-funded not-for-profit agencies other agencies). They were required to provide 409 reports against 46 of these agreements, with reports at monthly, quarterly, half-yearly and annual intervals. In addition to the formal reporting requirements, the service participates in various telephone conversations and committee meetings and other relationship building activities (Silburn et al, 2016). Considered together, these studies highlight the historical and ongoing reporting burden impacting the ACCHO sector.

In addition to considerable reporting burden, ACCHOs also report extensive advocacy and relationship building responsibilities. ACCHOs invest considerable time in the development of respectful relationships with partner organisations including with other health services (e.g. hospitals, other ACCHOs), a range of human and social services (e.g. justice, housing) and with multiple funders (e.g. state and federal government departments, PHNs, non-government organisations). The challenges related to the

development of partnerships between Aboriginal community controlled and mainstream services were explored in a qualitative study that found limited knowledge of partner services, communication challenges, mistrust and tension, different ways of working, referral issues and resource limitations as the most commonly cited concerns by both mainstream and Aboriginal community controlled organisation workforce (Taylor et al, 2013). The findings highlight that sufficient time and funding is required to support the operational and relational dimensions of partnerships, with support for regular meetings and workshops and documentation that clearly outlines the agreed ways of working (Taylor et al, 2013). A prior literature review identified that successful partnerships between Aboriginal and mainstream health were challenged by the legacy of Australia's colonial history, different approaches to servicing clients and resource limitations while positive outcomes included a broadening service capacity and increased cultural security of health services. Recommendations for successful partnerships included leadership, addressing tensions early and building trust (Taylor and Thompson, 2011).

This chapter highlights that through an Aboriginal community controlled model, ACCHOs provide holistic health care for clients and community and empower the local Aboriginal and Torres Strait Islander workforce. Holistic health care includes accessible and integrated services that are culturally safe, responsive and tailored to meet the needs of community in consideration of both cultural protocols and clinical standards. Effective ACCHO leadership and governance are consistent themes enabling ACCHO health service delivery. Strong organisational culture and effective operational systems are further enabling factors. Respected and experienced leaders within ACCHOs and the Board of Directors enable effective relationship building and respectful partnerships that are key to supporting clients with their holistic health needs. Aboriginal and Torres Strait Islander and non-Indigenous workforce that are culturally safe, committed, united and skilled is crucial to the effectiveness of ACCHO health service delivery while community consultation and engagement ensures that services are tailored to local needs.

The proposed ACCHO Comprehensive Primary Health Care Service Delivery Model is based on available evidence drawn from the literature, ACCHO experts and ACCHO case studies though the characteristics of health service delivery may differ from one ACCHO to the next, depending on historical factors, local context, local governance, community needs and priorities. For ACCHOs to be successful in meeting the needs of their local communities, the fundamental challenges that must be addressed relate to funding, workforce and the development of respectful and effective partnerships. There is an Aboriginal and Torres Strait Islander workforce supply shortage across multiple clinical and professional roles and ACCHOs experience a drain on their human and financial resources due to capacity development of Aboriginal and Torres Strait Islander and non-Indigenous staff in relation to both professional skills and cultural competency. Funding that is insufficient, short term or insecure can lead to staff turnover and lost corporate knowledge and community connections. Funding that is prescriptive and/or restrictive means that ACCHOs cannot respond to and tailor services to community needs. Other challenges impacting ACCHOs include a lack of recognition by funders of the value of ACCHO service delivery grounded in Aboriginal cultures and founded upon community connections; competing for Aboriginal health funding with mainstream organisations (that have greater financial and human resources); and the complexity of managing multiple income streams and reporting burdens. ACCHOs require funding that is sufficient, flexible and secure and that can enable the sector to address complex workforce challenges in relation to the recruitment, retention and capacity development of ACCHO staff. Once the fundamental challenges impacting the sector are addressed, ACCHOs will be in a stronger position to achieve improved holistic health outcomes for their communities.

## Further Reading

It may be useful to review other documents related to the core functions and corporate services of ACCHOs, such as:

- Tilton E and Thomas D. (2011). *Core functions of primary health care: a framework for the Northern Territory.* Northern Territory Aboriginal Health Forum, Darwin.
- Silburn K, Thorpe A and Anderson I. (2011). *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services – Overview Report,* The Lowitja Institute, Melbourne.

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Tilton E and Thomas D. (2011). *Core functions of primary health care: a framework for the Northern Territory.* Northern Territory Aboriginal Health Forum, Darwin.

# ACCHO Comprehensive Primary Health Care Service Delivery: Reflection Tool

While ACCHOs across Australia vary greatly in size and the services they can provide, there are common principles and practices that reflect Aboriginal and Torres Strait Islander ways of working and that are unique to the ACCHO sector. This Reflection Tool is designed to assist ACCHOs to reflect on the ten characteristics of ACCHO Primary Health Care Service Delivery Models.

The ACCHO Health Service Delivery Model depicts ten characteristics of ACCHO health service delivery with two surrounding yellow rings representing additional elements (i.e. funding and accreditation) that are necessary for health service delivery. The Model highlights that culture (in orange) is central to ACCHO health service delivery and is the foundation for all other characteristics. It is what sets ACCHOs apart from mainstream health services.

## The ACCHO Comprehensive Primary Health Care Service Delivery Model

**Step 1. Consider the activities your ACCHO currently practises across the ten characteristics.**

**Step 2. What other activities could your ACCHO consider in the future and what partnerships and resources will be needed to achieve this?**

## Culture

- [ ] We incorporate local cultural values, customs and beliefs as well as traditional healing and practices in all programs and services.
- [ ] We focus on the needs of individuals, families and communities.
- [ ] We respect women's and men's cultural needs.
- [ ] We create welcoming spaces and family-friendly environments.
- [ ] We use local Aboriginal and Torres Strait Islander language, artwork and signage.
- [ ] We have culturally appropriate prevention and health promotion resources.
- [ ] We engage with the local community and they are in control of the ACCHO.
- [ ] We employ Aboriginal and Torres Strait Islander staff.
- [ ] We provide cultural safety training to promote culturally safe services.

## Self-Determination and Empowerment

- [ ] We empower clients to self-manage their health at an individual and family level.
- [ ] We promote community development through cultural days, camps and reconciliation events.
- [ ] We provide employment and training opportunities to support the development of the local Aboriginal and Torres Strait Islander health workforce.
- [ ] We facilitate leadership opportunities for local people to create positive role models.
- [ ] We embrace the Aboriginal community controlled governance model of the ACCHO which reflects collective self-determination.

## Community Control and Community Participation

- [ ] The local Aboriginal and Torres Strait Islander community are the custodians of the ACCHO.
- [ ] We are governed by our local Aboriginal and Torres Strait Islander community through the Board of Directors.
- [ ] We respect the role and status of Elders and facilitate their involvement in the work and governance of the ACCHO.
- [ ] We consult, engage and collaborate with our communities to ensure programs and services are culturally responsive, accessible and tailored to local context and needs.

## Culturally Competent and Skilled Workforce

- [ ] We recruit and employ a range of skilled local Aboriginal and Torres Strait Islander peoples.
- [ ] We provide supportive culturally safe environments that recognise the cultural, community and family obligations of staff.
- [ ] We invest in our staff by providing training and development opportunities.
- [ ] We provide ongoing cultural competency training for all staff.
- [ ] We recognise the need to build and grow the Aboriginal and Torres Strait Islander workforce through long term retention and professional development strategies.
- [ ] We provide opportunities for two-way learning between Aboriginal and Torres Strait Islander and non-Indigenous colleagues including cultural mentorship.

## Holistic Health Care

- [ ] We provide comprehensive primary health care that supports the health and wellbeing of not only the individual but also their family and community and includes mental, emotional, spiritual, physical, social and cultural wellbeing.
- [ ] We deliver a diverse range of services (e.g. maternal and child health, prevention, disability, pharmacy, chronic disease care).
- [ ] We provide traditional healing services.
- [ ] We support clients to improve health knowledge and understanding.
- [ ] We advocate on behalf of our clients such as with Centrelink, employment services, child protection services, and the justice system.
- [ ] We support clients to address the social determinants of health impacting their lives, such as housing security, financial security, food security, education and employment.
- [ ] We provide additional holistic services such as environmental health (water quality), bush foods, early childhood education and child care centres.

## Accessible Health Services

- [ ] We provide affordable health care at low cost or no cost to clients.
- [ ] Where possible, we deliver a broad range of services in a variety of locations and settings.
- [ ] We provide walk in appointments, transport, increased opening hours, home visits and outreach services that are flexible and responsive to community need.
- [ ] We deliver acceptable care that considers trustworthiness, privacy, confidentiality, cultural respect, social justice and equality.
- [ ] We enhance community awareness of services through numerous strategies (e.g. brochures, guest speakers during community lunches, referrals across ACCHO teams).
- [ ] We engage with community members who are not clients of the service (e.g. during community events) to understand how to improve services to meet local needs.

## Flexible and Responsive Approach to Care

- [ ] We continuously engage and consult with community to understand local needs and priorities and continuously improve the care provided to our communities.
- [ ] We tailor services to meet the needs of our local communities ensuring they are relevant, culturally responsive and effective.
- [ ] We provide services that are flexible and responsive to community need such as outreach services, home visits and providing services at community events.
- [ ] We integrate health care services within a multi-disciplinary team approach including case management and continuity of care.
- [ ] We create partnerships by linking with other services to promote integration and cooperation across sectors and to promote flexible and responsive care in partner organisations.

## Relationship Building and Advocacy

- [ ] We build relationships with partner organisations and provide cultural advice, support and direction through staff participation in case management meetings and through numerous committees and working groups.
- [ ] We advocate on behalf of clients such as in relation to finances, housing, keeping children and families together, justice, education and employment opportunities.
- [ ] We promote culturally safe environments in partner organisations through advocating for and delivering cultural safety training.
- [ ] We advocate to other services, such as hospitals and specialist services, to adapt (that is, reorient) their models of care to better meet client needs.
- [ ] We advocate for seamless, integrated and multidisciplinary care for Aboriginal and Torres Strait Islander clients such as through providing cultural mentorship to staff within partner organisations regarding culturally responsive service for Aboriginal and Torres Strait Islander peoples.
- [ ] We advocate on behalf of Aboriginal and Torres Strait Islander communities at the local, state/territory and national levels to influence the development of healthy public policy that is inclusive, equitable and aligns with the priorities of Aboriginal and Torres Strait Islander peoples.

## Continuous Quality Improvement

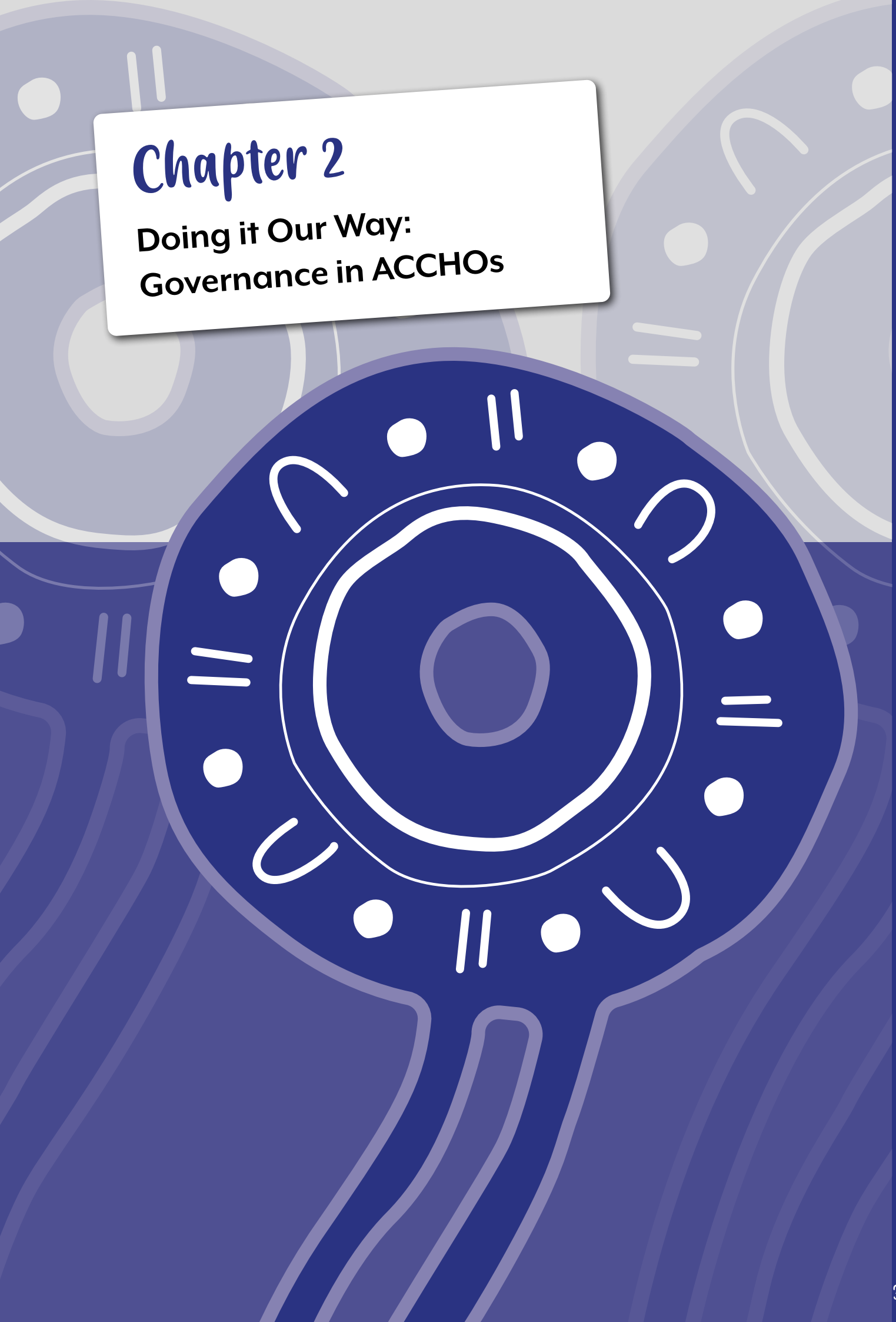
- [ ] We have embedded whole-of-organisation CQI processes that are outwardly focused and centred on community needs and feedback.
- [ ] We engage with disengaged members of the community to enable them to re-engage with our services.
- [ ] We collect and analyse relevant data to improve health outcomes and enable program evaluation and development.
- [ ] We evaluate services such as in relation to economic outcomes, service utilisation, health assessments and chronic disease plans.

## Comprehensive Health Promotion

- [ ] We design our services to meet community need: designed by community, for community.
- [ ] We provide culturally safe spaces in the ACCHO and promote culturally safe spaces in mainstream services.
- [ ] We strengthen cultural pride and personal skills through role modelling, mentoring and education.
- [ ] We strengthen and unite Aboriginal and Torres Strait Islander communities.
- [ ] We advocate for and drive the development of public policies that achieve equity for Aboriginal and Torres Strait Islander peoples.

# Chapter 2

## Doing it Our Way: Governance in ACCHOs



# Doing it Our Way: Governance in ACCHOs


## Summary

Governance in the ACCHO sector is about Aboriginal and Torres Strait Islander peoples' health and welfare being in the hands of Aboriginal and Torres Strait Islander peoples. ACCHOs do not have just one governance model, but rather different models that reflect local needs and protocols. Within an ACCHO, governance has several components including cultural governance, strategic governance and clinical governance. **Cultural governance** refers to the cultural guidance provided by Aboriginal and Torres Strait Islander community members, staff and Board of Directors to ensure the organisation follows cultural protocols and provides culturally-centred care. **Strategic governance** refers to guidance and direction given to determine and achieve the long-term or overall aims and interests of the ACCHO. It comes from the Board of Directors who have a duty to ensure the ACCHOs long-term strategic vision aligns with community priorities and to monitor the organisation's financial management, risk management and legal responsibilities. **Clinical governance** refers to the systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHO programs and services. Clinicians, administrators, program coordinators and managers have a shared responsibility for providing clinical governance within ACCHOs. These three components of governance ensure that local Aboriginal and Torres Strait Islander communities are actively involved in guiding the ACCHO in the provision of culturally-tailored programs and services.


The content within this chapter was drawn from a rapid review of the literature and meta-synthesis of ACCHO case studies. This was refined through consultation with a newly established ACCHO and collective input from the CREATE Leadership Group to include perspectives from the ACCHO sector nationwide.

### What we cover in this chapter:

## What is Aboriginal community control?

The national peak body for all ACCHOs, the National Aboriginal Community Controlled Health Organisation (NACCHO), defines Aboriginal community control in health services as:

*'a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community'.*[1]

An ACCHO is an incorporated or corporated Aboriginal and Torres Strait Islander health organisation controlled by local Aboriginal and Torres Strait Islander communities. ACCHOs are governed by an Aboriginal and Torres Strait Islander Board of Directors which is elected by members of the ACCHO.

## What is governance?

Governance refers to:

*'the system by which an organisation is controlled and operates, and the mechanisms by which it, and its people, are held to account. Ethics, risk management, compliance and administration are all elements of governance'.*[2]

NACCHO describe good governance and leadership by ACCHO Boards as: the implementation of community control, a clear understanding of role, ensuring the delivery of organisational objectives, effective team and individual work, exercising effective control, behaving with integrity and being open and accountable.[3]

The objective of effective ACCHO governance is to ensure the ACCHO can provide sustainable high quality culturally responsive health services to community that leads to improvements in the health and social outcomes for the community it serves.

## What are the different types of governance?

ACCHO governance comprises three elements:

### Cultural governance

The cultural guidance provided by Aboriginal and Torres Strait Islander community members, staff and the Board of Directors to ensure the organisation follows cultural protocols and provides culturally-centred care.

### Strategic governance

Guidance and direction given to determine and achieve the long-term or overall aims and interests of the ACCHO. Strategic governance comes from the Board of Directors who have a duty to ensure the long-term strategic vision of the ACCHO aligns with community priorities and who monitor the organisation's financial management, risk management and legal responsibilities.

### Clinical governance

The systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHO programs and services. Clinicians, administrators, program coordinators and managers have a shared responsibility for providing clinical governance within ACCHO programs and services.

The ACCHO Governance Model is depicted in Image 2 (over page).

Operational Leadership, undertaken by the ACCHOs CEO and Senior Management, play a role in linking the ACCHOs' Strategic governance and the Clinical governance, to ensure the strategic directions set by the Board of Directors are enacted in service delivery.

ACCHO governance is influenced by NACCHO, peak bodies (e.g. AMSANT, AH&MRC, VACCHO), government departments and accreditation Standards.

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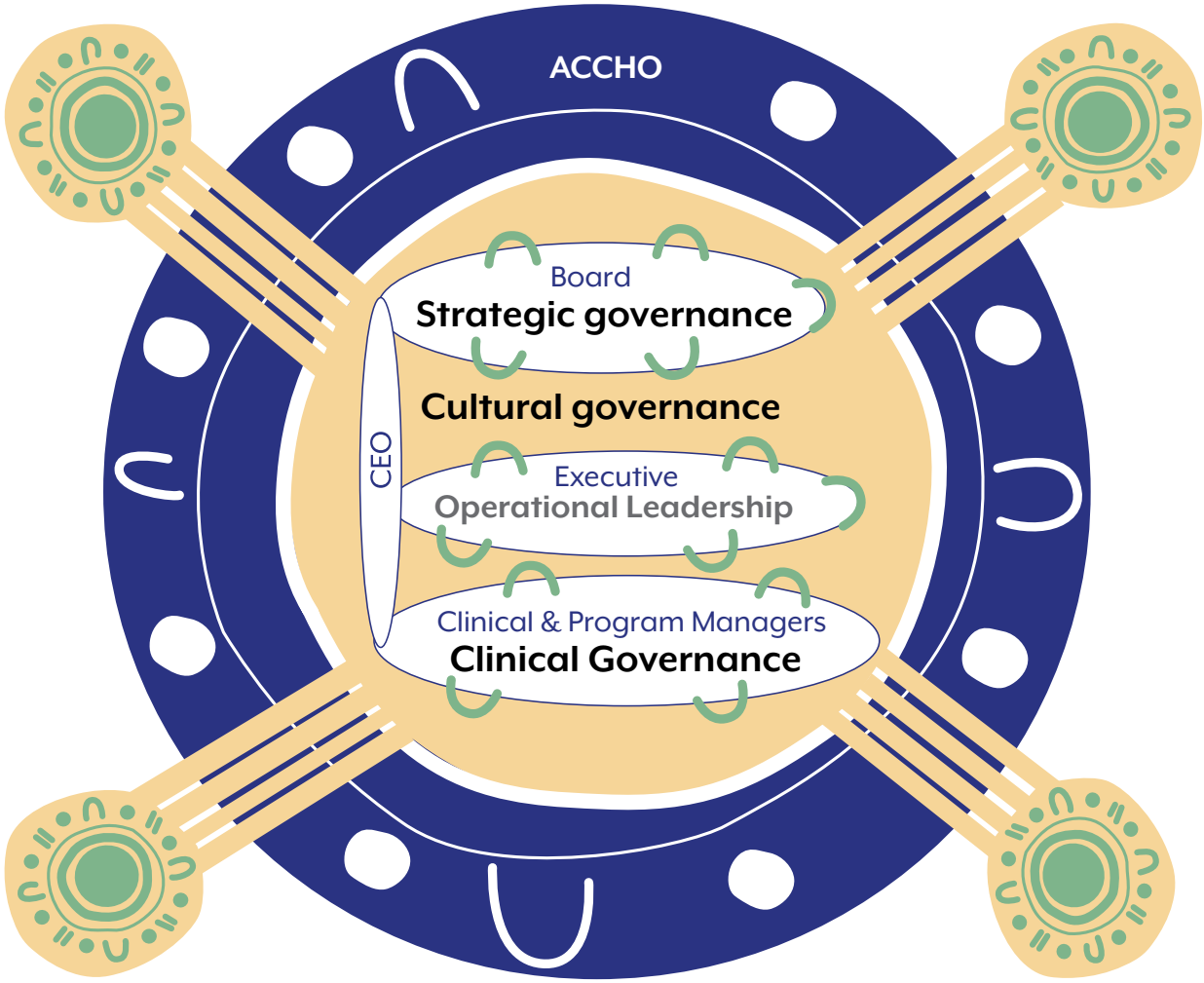
[1]National Aboriginal Community Controlled Health Organisation. (no date). *Community Controlled*. Accessed on January 17, 2020 at: naccho.org.au/about/aboriginal-health/definitions/
[2]Governance Institute of Australia. (no date). *What is Governance?*. Accessed on January 17, 2020 at: governanceinstitute.com.au/resources/what-is-governance/
[3]Aboriginal Health Council of South Australia Ltd. (2012). *NACCHO Governance Code: National Principles and Guidelines for Good Governance*. Accessed January 17, 2020 at: ahcsa.org.au/app/uploads/mp/files/resources/files/final-naccho-npgs-for-good-governance-endorsed-by-board-31-august-2012.pdf

**Image 2: The ACCHO Governance Model**




### Model description

The image above shows how different forms of governance and leadership are enacted within the ACCHO.

The green symbols represent Aboriginal and Torres Strait Islander peoples within local community settings and at the heart of the ACCHO.

This symbol represents the community.

Cultural governance guides, overarches and underpins the organisation and is represented by the yellow areas.

**Cultural governance** is provided by Aboriginal and Torres Strait Islander peoples who may be community members, clients of the service, staff or members of the ACCHO leadership, including the Board of Directors. **Strategic governance** is provided by the Board of Directors and is the guidance and direction given to determine and achieve the long-term or overall aims and interests of the ACCHO. **Clinical governance** is provided by clinical and program managers and is the systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHO programs and services. The CEO interacts with all levels of governance and leadership. Strategic governance is separated from other forms of governance as the Board of Directors maintains separation from operational and clinical governance functions.

This model was developed through the CREATE project based on case studies with the ACCHO sector and consultations with the CREATE Leadership Group.

## Cultural governance

Cultural governance is at the heart of ACCHOs and is defined as the cultural guidance and decision making that ensures the organisation follows cultural protocols and provides culturally-centred care. Cultural governance operates differently to strategic governance in that it is less structured and enables cultural guidance to enter through numerous entry points with respect given to all community members and leaders. It reflects and promotes community self-determination and the promotion and maintenance of culture.

Cultural governance is provided by local Aboriginal and Torres Strait Islander peoples. These may include Board members, ACCHO members, CEOs and other staff, clients and community members. Aboriginal and Torres Strait Islander ACCHO staff contribute to cultural governance through advising the CEO, managers and health practitioners on cultural matters. ACCHO cultural governance is also indirectly influenced by other local, state and national Aboriginal organisations, peak bodies and research institutes who provide additional cultural guidance, support and resources.

Members of an ACCHO are local Aboriginal and Torres Strait Islander peoples who register to be a Member of the ACCHO. Member roles and responsibilities include casting votes in relation to ACCHO Board of Directors, the ACCHO Constitution, and any other proposals put forward at the Annual General Meeting.

Cultural governance is obtained both through formal and informal methods. Formal methods include cultural guidance from the Board of Directors, ACCHO members, client/consumer sub-committees, Aboriginal and Torres Strait Islander specific advisory groups and staff committees. Informal methods include yarns between community members, staff and Board members such as during community events.

At *Regional ACCHO* cultural governance is guided by local cultural and traditional knowledge. It is provided formally and informally through continuous feedback from local Aboriginal and Torres Strait Islander peoples who are community members, ACCHO members, clients, staff and Board members. Local community members and clients providing feedback through meetings, evaluation forms and yarns with staff. Staff and Board members provide cultural guidance and leadership during meetings. *Regional ACCHO* also receive cultural guidance from their peak body and NACCHO, though cultural guidance from the local community takes a priority for true 'community control'.

## Strategic governance

Strategic governance refers to guidance and direction given to determine and achieve the long-term or overall aims and interests of the ACCHO. Strategic governance comes from the Board of Directors who have a duty to ensure the ACCHOs long-term strategic vision aligns with community priorities and to monitor the organisation's financial management, risk management and legal responsibilities.

### ACCHO Boards of Directors

The Boards of Directors (the Board) is generally elected by ACCHO Members during an Annual General Meeting. The Board has a duty to ensure it is functioning effectively and is meeting its legal obligations. In some states/territories, the peak body determines that all ACCHO Board members must be Aboriginal or Torres Strait Islander peoples and in other jurisdictions it is possible to establish skill-based Boards that include non-Indigenous Board members. There may also be specific requirements regarding gender balance and representation on the Board (e.g. having a youth representative). The ACCHOs Constitution clearly outlines who can be elected to the Board, how long Board members can serve, and whether they are voluntary or paid positions. Board members may have specific roles such as the Chairperson or Secretary. The connection between the Board and the CEO facilitates strategic governance as the CEO provides updates on how the organisation is functioning (e.g. through financial reports) and seeks guidance and direction from the Board.

Some ACCHOs establish Subcommittees to provide expert advice to the Board. A Subcommittee can include Board members and non-elected professionals with specific expertise and experience (e.g. legal, financial, risk management). These 'ex officio' (non-voting) subcommittee members provide professional advice to ensure business, management and administrative functions are considered together with cultural knowledge to provide the best possible service for community

### What is the Board guided by?

The Board is guided by community priorities, cultural governance, legal responsibilities, the Constitution (also called the Rule Book), the peak body (i.e. state/territory community-controlled organisation) and NACCHO. The Board must be aware of and respond to government department and funding changes, accreditation standards, reporting requirements and agreed key performance indicators.

At *Metro ACCHO* the Board often seeks advice from external experts for legal and financial matters. These people are involved as a Subcommittee of the Board. The Subcommittee supports growth and sustainability and is valuable to the business model of the ACCHO.

Importantly, the Board needs to be aware of their legal responsibilities. These should be clearly outlined in the Constitution or Rule Book. The Board is guided by National Acts and Legislations for Organisations including the Corporations (Aboriginal and Torres Strait Islander) Act 2006. The Australian Institute for Company Directors can provide information about the legal responsibilities of ACCHO Boards. Peak bodies may also provide support including governance training.

### The Chairperson

The Board elects a representative Chairperson who contributes to the organisational culture of the ACCHO, sets the standard for performance and monitors the Board's overall performance. They also review and approve Board meeting agendas and papers. The Chairperson may also support the CEO in delegated discussions and negotiations with government, ministerial staff, departmental personnel, non-government organisations and community organisations which relate to the aims and objectives of the ACCHO.

### Board Executive

The ACCHO Board may have a Board Executive. A Board Executive is a smaller group of Board members (often including the Chairperson or those with office bearing roles) who meet with the CEO in between Board meetings to progress non-operational matters requiring a specific strategic lens particularly when time-critical decisions must be made. This group keeps the strategic elements of the ACCHO running between Board meetings.

### What is the Board responsible for?

The Board responsibilities are set out in their Constitution and can include:

1. Determining the strategic directions of the ACCHO.
2. Approving and adapting the ACCHOs strategic directions.
3. Overseeing and supporting the CEO (hiring, monitoring performance, mentoring).
4. Monitoring the ACCHOs performance as an organisation including financial and legal obligations.
5. Risk, compliance and strategy management.
6. Representing the ACCHO regarding strategic matters with various stakeholders.
7. Communicating with community and other external stakeholder groups.

The *Regional ACCHO* found that it helped to have an **Executive Officer to the Board.** This person can assist with compliance to reporting requirements and protocols as outlined in the Constitution (e.g. preparing agendas, taking minutes, and other administration and communication duties).

### What is the Board NOT responsible for?

Board members are generally not involved in the day to day operation of the ACCHO. The daily operation of the ACCHO is the responsibility of the CEO, executive and senior management under Operational Leadership. ACCHOs separate Strategic Governance and Operational Leadership. The CEO is the link between the Board and all other staff in the organisation. The CEO enacts the Board's directions and reports accurate details regarding how the organisation is functioning during monthly meetings, or as constituted.

At *Regional ACCHO* the Board members do not go directly to ACCHO staff with instructions regarding the day to day operation of the organisation. They indirectly provide direction to staff through the Operational Leadership (CEO, Executive and Senior Management) of the organisation. Similarly, staff do not go directly to Board members with concerns, instead they use reporting and risk identification processes that the CEO presents to the Board.

## Clinical governance

Clinical governance refers to the systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHO programs and services. It is a mechanism through which ACCHOs are accountable to the community to improve service quality. Clinicians, administrators, program coordinators and managers have a shared responsibility for providing clinical governance within ACCHOs to identify near misses and adverse events and implement and evaluate improvements. Cultural governance processes also contribute to clinical governance to ensure that services are tailored to the cultural needs of the local community.

Clinical governance processes must be in place in order to gain accreditation under the Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition). Specifically, Clinical governance is described within *'QI Standard 3, Criterion QI3.1 – Managing clinical risks'* of the Standards and is defined as a 'framework through which clinicians and health service managers are jointly accountable for patient safety and quality care' (p168)[4].

At *Metro ACCHO* the Clinic and Program Managers arrange regular team meetings, planning activities (often every 6 months), team and individual reporting. They ensure team activities meet the strategic directions set out by the Board and meet accreditation standards, policies and guidelines. They seek formal and informal community and staff feedback and regularly adapt programs to better meet local community needs (as much as is possible within their budget, strategic directions and scope of practice).

[4]The Royal Australian College of General Practitioners. (2017). *Standards for general practices*. 5th edn. East Melbourne, Victoria: RACGP.

## Operational Leadership

Operational Leadership (undertaken by the ACCHOs CEO and Senior Management) is not a type of governance but plays a role in linking the ACCHOs Strategic governance and Clinical governance, to ensure the strategic directions set by the Board of Management are enacted in service delivery.

The CEO manages the ACCHO and makes day to day decisions about how the organisation functions. The CEO is appointed, monitored and mentored by the Board. The CEO puts the Board's strategy and directions into action and links the Board with the ACCHO executive, managers and staff. The CEO is guided by the Board's strategic direction, the ACCHO Constitution, and state and national Acts and Legislations for Organisations.

The Executive or Senior Management Group includes the CEO and senior staff such as Practice Manager, Community Programs Manager and Corporate Hub Managers (Human Resources, Payroll, Finance). They work to ensure that each team within the organisation is meeting the strategic directions set by the Board, legal and registration standards, compliance and accreditation standards. They generate reports to provide to the Board during monthly meetings.

At *Metro ACCHO* the Senior Management Group are responsible for and participate in regular scheduled meetings, organisation planning and review, team planning and reporting, staff feedback and performance reviews, accreditation and compliance.

## The wider context of governance: what influences ACCHO governance?

ACCHO governance takes place within a wider context, with Board members, CEO, executive and managers striving to meet the organisations strategic direction by working with multiple organisations, both Aboriginal and mainstream, outside of the ACCHO. These include state/territory and federal governments, other ACCHOS and peak bodies, other Aboriginal services (e.g. Land Councils), other health services (e.g. PHNs, hospitals, GP clinics), other services (e.g. Justice, legal) and governance bodies (e.g. Office of the Registrar of Indigenous Corporations (ORIC)).

There are a range of ways that ACCHOs across Australia have responded to community needs and resources, and the need to function in a complex government funding and health care environment. Some ACCHOs work together to share resources and strategies to be in a better position to provide services for their community and to reduce costs and duplication. For example, some ACCHOs have negotiated shared agreements for technology, transport or a co-funded workforce.

Table 2 describes the range of individuals, groups and organisations that are involved in the cultural, strategic and clinical governance functions of ACCHOs. The involvement may be both direct (highlighted in green) and indirect (highlighted in yellow). Common functions and contributions to ACCHO governance are listed though these will differ greatly across states and territories and from one ACCHO to another.

## What to do if things go wrong

ACCHOs operate across dynamic and diverse environments balancing community expectations and operational requirements. There are times when governance within ACCHOs is challenged, such as in relation to the turnover of Board members, the capacity of Board members, communication and conflict (internal and external). Indicators of governance challenges can include program being defunded, accreditation challenges, staff turnover, lack of Board meetings, or staff and community complaints. At these times it can help to seek out external supports, both formal and informal, such as through other ACCHOs, peak bodies, the ORIC, mediators and private consultants.

**Table 2: Governance within an ACCHO: who, how and which element of governance?**

| Role in the ACCHO | Role in Governance | Element of ACCHO governance | | |
|---|---|---|---|---|
| | | *Cultural governance** | *Strategic governance* | *Clinical governance* |
| Local Aboriginal and Torres Strait Islander peoples | Provide feedback on programs and services and provide cultural guidance to the ACCHO. | | | |
| ACCHO Board of Directors | Set the strategic direction for the ACCHO, monitor the performance of the ACCHO and provide cultural guidance on behalf of local communities. | | | |
| ACCHO Members | Provide cultural guidance, provide feedback on programs (which contributes to clinical governance) and may vote on the strategic direction of the ACCHO during Annual General Meetings (e.g. Constitution). | | | |
| CEO | Provides cultural guidance, works with the Board to set the strategic direction, and works with Clinical and Program Coordinators to ensure ACCHO services are tailored to community needs. | | | |
| ACCHO Clinical and Program Coordinators | Undertake decision making relating to ACCHO clinical services and programs to ensure all ACCHO services are tailored to community needs. Provide cultural guidance to colleagues. | | | |
| ACCHO Staff | Provide cultural guidance, and contribute to collective decision making to ensure all ACCHO services are tailored to community needs. | | | |
| NACCHO | Indirectly influence ACCHO governance through setting the national strategic direction and through providing resources and support. | | | |
| Peak bodies (e.g. QAIC, AHCSA, AHCWA, AH&MRC, AMSANT) | Indirectly influence ACCHO governance through setting the state/territory strategic directions and through providing resources, training and support. | | | |
| Local Aboriginal organisations (e.g. Land Councils, cultural centres) | Indirectly influence ACCHO cultural governance through informal yarns and through partnerships and collaborations. | | | |

Note: Green boxes indicate direct involvement and yellow boxes indicate indirect involvement in governance. The ACCHO roles are not listed in any order of hierarchy.

*Cultural governance is provided only by Aboriginal and Torres Strait Islander peoples

## Establishing governance in a new ACCHO

When *Regional ACCHO* first began, the organisation and Board was built from the ground up. An experienced Aboriginal person was appointed as an interim CEO to engage with the community, grow staff and lead managers through the process of establishing the service.

At the very beginning, a community meeting was held with local Aboriginal and Torres Strait Islander peoples encouraged to join the ACCHO as members. During this meeting, the ACCHO members elected an interim Board of Directors to guide the organisation while it was being established.

In the early stages the CEO provided a lot of guidance and direction to the interim Board, but as the Board members became more experienced, they took an increasingly strong governing and strategic directions role, which the CEO encouraged and welcomed. The *Regional ACCHO* sought assistance with governance training for the Board members, some of whom had no previous experience. It was hard to get adequate training and advice about Board roles, responsibilities and obligations under the various Acts and legislation.

As a new ACCHO and a not-for-profit organisation, the Board determined how best to position and govern the service and ensure it operated within guidelines set out by Charities Australia. They hired a consultant and lawyer to help them through the process. The journey the Board undertook, and experience gained through the transition process, broadened their knowledge and expertise. They developed clear roles and responsibilities, an agreed code of conduct and a Constitution that was approved by the members.

At the next annual general meeting, ACCHO members self-nominated for Board positions giving a brief account of what they could bring to the service. Board members were then elected from different family groups and locations, genders and ages, representing diversity within the community.

## Benefits of effective governance

- The Board provides a platform to enable a collective community voice that ensures local priorities are identified and addressed, that there are clear strategic directions, and transparency in decision making.
- The ACCHO Board enact self-determination through their leadership role within the ACCHO which empowers their communities. It is an example of communities self-determining their own health needs.
- Local Elders act as knowledge holders and role models for ACCHO staff and younger Board members.
- Community trust in the organisation is strengthened by effective governance.
- Strong connections between cultural governance and strategic governance allows for ACCHOs to provide the best quality service to community.
- Effective governance is essential to gain accreditation under the Quality Improvement Council's Standards.

## Enablers of Governance

While no one size fits all, there are principles of good practice that have been observed and discussed across studies of ACCHO governance across Australia[5].

### The appointment of Boards:

- In a transparent and community approved process.
- That are demographically representative of their communities (e.g. older, younger, men, women, different family groups).
- That have an appropriate knowledge and skill mix (e.g. cultural, health care, organisations).
- That have strong links back to their communities and mechanisms to engage with the communities.

### Involvement of community members:

- Through self determination to improve health service delivery.
- With strong local leadership.

### Board members:

- That understand their roles and responsibilities.
- That have two- or three-year staggered terms to facilitate a balance between continuity and Board renewal.
- Who develop long term visions for their services which are understood and shared by management and the community.
- Who appoint the CEO and monitor performance.
- Who undertake training and opportunities to build their capacity.
- With appropriate succession planning.
- Who take on specific roles, such as Chairperson or Executive Board membership.

### Strong CEOs:

- Who are effective communicators
- Who work respectfully with (and are respected by) the Board, local community members, executive and staff.

### Organisations that:

- Have mechanisms in place to monitor performance and to ensure internal accountability.
- Are engaged in strategic planning and monitoring activities linked to Board meeting processes and planning cycles.
- Have a good understanding of government processes and how the ACCHO can best work with them (and when not to).
- Have effective change management processes when transforming from one kind of organisation to another or from one leader to another.
- Work creatively to meet local needs.
- Focus on providing holistic care that responds to cultural and social determinants of health.



[5]These enablers are drawn from the resources in Table 3 and the following publications (see References on page 49): Carroll, V., et al., (2015); Champion, S., C. Franks, and J. Taylor, (2008); Collard, K.S., et al., (2005); Coombe, L.L., (2008); Coombe, L.L., M.R. Haswell-Elkins, and P.S. Hill, (2008); Freeman, T., et al., (2016a); Freeman, T., et al., (2016b); Gajjar, D., et al., (2014); Reeve, C., et al., (2015).

## Challenges to Governance

### Building a strong Board

Appointing the Board of Directors with a good balance of skills, experience, and community credibility can be a challenge for ACCHOs. ACCHOs seek out a Board of Directors with knowledge and experience and who can work together in the best interests of the community and the ACCHO. In the Rule Book there are guidelines about who can sit on the Board which may include having a young person represented.

### Positioning the ACCHO

One challenge for ACCHOs is deciding how best to position the organisation to provide the best services for their community. This includes how to adapt to funding, legislation and peak body changes, which services to partner with, and how to set up their Boards. For example, some ACCHOs include non-Indigenous people on their Boards who may bring a specific skill set, but some states and peak bodies require ACCHOs to have all Aboriginal and Torres Strait Islander Directors on their Boards.

### Payment of Board members

There are also decisions to be made about whether Board members should be paid or unpaid. This can be a philosophical and pragmatic discussion, that includes consideration of competition from other organisations who pay Board members.

### Blurring of roles and responsibilities

It is not recommended for Board members to become involved in the day to day decision making in an organisation as it crosses the line between goveranace and operations. It is the role of the Board to provide strategic governance and the role of the CEO to provide operational leadership through managing the organisation and staff. A strong relationship between the Chairperson and the CEO allows for clear communication and understanding between governance and operations. It is a critical element of good governance.

### Changing government, legal and financial processes

It can be difficult for Boards to keep up with ongoing reforms in government departments and programs, legal bodies and funders.

### Deciding how best to structure the ACCHO as an organisation

The Board must decide how best to establish the ACCHO in relation to whether they are corporated under the national *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act) or incorporated under state or territory Acts (e.g. the South Australian 'Associations Incorporation Act 1985')[6]. There are different considerations and requirements for corporated and incorporated organisations and ACCHO Boards must undertake due diligence to determine the best path forward. ACCHOs that are corporated under the CATSI Act must become members of the ORIC.

ORIC is a regulatory body that enacts the CATSI Act that establishes the role of the Registrar of Indigenous Corporations and allows Aboriginal and Torres Strait Islander groups to form corporations. ORIC describes the CATSI Act as follows:

> *The CATSI Act delivers modern corporate governance standards but still provides measures to suit the needs of Aboriginal and Torres Strait Islander people. Examples of this are the requirements for the majority of directors and the majority of members to be Aboriginal and Torres Strait Islander people. This means corporations will always be owned and controlled by Aboriginal and Torres Strait Islander people*[7].

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[6]See the ORIC 'Comparative table of Commonwealth, state and territory incorporation legislation' for further information at: oric.gov.au/sites/default/files/documents/06_2013/ORIC_Snapshot-comparative-table_v1-0_Mar08.pdf

[7]Office of the Registrar of Indigenous Corporations. (no date). *About the CATSI Act.* Accessed on January 17, 2020 at: oric.gov.au/catsi-act/about-catsi-act

## Recommendations

### Recommendations for ACCHOs

- Provide governance training and resources for new Board members so that they can develop a clear understanding of their roles, responsibilities and obligations.
- Undertake succession planning and mentoring for new Board members, in particular those who have not previously sat on Boards, so they understand their legal and ethical obligations.
- Identify and maintain a clear strategic governance role for Board members and a management role for the CEO.
- Choose an appropriate governance framework that best aligns with local community priorities.
- Prioritise the importance of a trained, committed and stable Board that is drawn from local Aboriginal and Torres Strait Islander communities and is strongly connected with communities to inform strategic planning and priority setting.
- When needed, connect with the state/territory peak body for advice and support related to goverance.

### Recommendations for Peak Bodies

- Provide ongoing governance training and support for member services.

### Recommendations for Policy Makers

- Increase support strategies to include training, financial and legal advice for new ACCHOs who are establishing their Boards.
- Provide specific and adequate funding and resources to enable ACCHOs to train and support new Board members.
- When requested, ACCHOs could benefit from timely and effective support from the Office of the Registrar of Indigenous Corporations (ORIC).

## Discussion

This chapter describes an ACCHO governance model that was developed following a rapid review of the literature and consultation with the ACCHO sector. The model includes three distinct elements of ACCHO governance each with unique functions: cultural governance, strategic governance and clinical governance. More work is needed to clarify the model of ACCHO governance and to understand the outcomes, enablers and challenges of the different elements.

An international review of the characteristics of Indigenous primary health care models of service delivery identified community participation – that included Indigenous ownership and governance - as one of eight key characteristics (Harfield et al, 2018). ACCHOs have been described as having a model of 'community governance' (Panaretto et al, 2014). Local decision making performed by the elected Board of Directors of ACCHOs represents a reclaiming of Indigenous authority following the erosive impacts of colonialism, racism and exclusion and ensures service provision is responsive to local needs (Khoury et al, 2015). The ACCHO community controlled governance model has been linked to an ability to sustainably address health inequity compared with state government primary health care services (Freeman et al, 2016c) and is conceptualised as one of the pathways (alongside employment and training, knowledge and expertise, and clinical services and health promotion) through which ACCHOs contribute to improving the health and wellbeing of Aboriginal peoples (Campbell et al, 2017).

It is unknown how different governance elements impact frontline ACCHO staff. Aboriginal Health Workers, for example, participate in and are guided by both cultural governance and clinical governance processes. They use cultural ways of working (that are informed by cultural governance processes) while also providing clinical care in line with clinical guidelines and quality Standards. Cultural governance has traditional origins and represents collective and shared decision-making while clinical governance has Western biomedical foundations reflecting top-down processes and adherence to prescribed Standards. There is potential for the guidance and direction provided to workforce through cultural governance and clinical governance processes to be at odds. This is reflected in a qualitative systematic review undertaken by Topp and colleagues (2018) that found that Aboriginal Health Workers must balance cultural obligations with the expectations of non-Indigenous colleagues that are underpinned by clinical governance models.

The model of ACCHO governance proposed in this chapter highlights that Board members participate in both strategic and cultural governance processes. The core principles of effective governance proposed by Dodson and Smith (2003) include cultural 'match' or 'fit' that relates to the degree of connection between the governing structures and procedures and local culturally-based values and systems of authority. Achieving cultural match, then, relates to 'developing strategic and realistic connections between extant cultural values and standards, and those required by the world of business and administration' (Dodson and Smith 2003, p.19). ACCHO Boards must seek to enact governance through a balance of strategic and cultural governance structures and processes.

There is increasing evidence that effective governance enables effective service delivery. A case study by Kelaher and colleagues (2014) suggests that increased equity in governance, through the participation of Aboriginal organisations in regional planning, resulted in increased equity in access to health services. It is not surprising that increased access is achieved through increased participation by community in the governance, design and delivery of services. A qualitative evaluation of the 'Strong Women, Strong Babies, Strong Culture Program' suggests that inclusion of cultural knowledge and practice supported the sustainability of the program over two decades. Enabling factors included effective intercultural collaborative practice of health staff as well as community participation and control supported through effective governance and organisational commitment (Lowell et al, 2015).

It is evident that ACCHOs have complex governance processes and mechanisms that balance cultural values and cultural governance processes with strategic and clinical governance processes founded in Western concepts. Effective governance supports good practice and is an enabler of effective health service delivery in ACCHOs. Further work is needed to elaborate the nuances of ACCHO governance and explore the capacity strengthening activities and resources that could better facilitate effective and sustainable governance in the sector. The Appendix on page 50 provides further reading and available resources related to governance.

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## Appendix: Further reading and available resources

There are a range of different resources to assist ACCHOs with governance, as described in Table 3. Some are Aboriginal and Torres Strait Islander specific, some are health specific, and some are both Aboriginal and Torres Strait Islander specific and health focused.

**Table 3: Governance resources**

| Resource | Description |
|---|---|
| NACCHO Governance Code: National Principles and Guidelines for Good Governance<br>*Aboriginal and Torres Strait Islander health specific* | This 13-page document outlines and explains 7 principles for good governance and leadership by ACCHO Boards including: implementing community control; understanding their role; ensuring delivery of the organisation's objectives; working effectively both as individuals and as a team; exercising effective control; behaving with integrity and being open and accountable. Each principle is described (what), explained (why), and strategies for implementation given (how).<br><br>ahcsa.org.au/app/uploads/mp/files/resources/files/final-naccho-npgs-for-good-governance-endorsed-by-board-31-august-2012.pdf |
| The Indigenous Governance Toolkit a free, public-access document<br>*Indigenous specific but not health specific* | This is an online resource developed for Indigenous nations, communities, individuals and organisations searching for information to build their governance. It covers all the basics – the rules, values, culture, membership, leadership, and decision making, and has many examples of ideas that work from other groups, tools to help you get started, and useful guidance to sustain your efforts.<br>It includes the Institute for Urban Indigenous Health (IUIH) discussing the importance of Indigenous Governance. The Toolkit can be used in many ways, depending on circumstances and needs. It can be used individually or as a group.<br><br>toolkit.aigi.com.au/ |
| ORIC – Office of the Registrar of Indigenous Corporations<br>*Indigenous specific but not health specific* | ORIC is an independent statutory office holder who administers the Corporations (Aboriginal and Torres Strait Islander) Act 2006. The Registrar's office both supports and regulates corporations by:<br>• Advising on how to incorporate<br>• Training directors, members and key staff in good governance<br>• Ensuring compliance with the law<br>• Intervening when needed.<br><br>According to their website, ORIC:<br>• Is Indigenous specific, recognises conflict tensions that exist within communities, within and between families and in relation to native title<br>• Provide a range of fact sheets, which they also use when investigating an issue<br>• Assists with start-up and ongoing support<br>• Provide introductory and two-day Governance workshops in urban, rural and remote locations.<br><br>ORIC holds both a support and regulatory role. The ORIC website has a range of resources available for a range of different literacy levels. They also provide governance training, but organisations need to join ORIC in order to receive this training.<br><br>oric.gov.au/ |
| Clinical Governance, Safety and Quality Policy Framework<br>*Not Aboriginal and Torres Strait Islander health-specific* | This policy framework was development by the Department of Health, Government of Western Australia. It provides clear definitions of clinical governance, clinical governance structures and clinical governance processes.<br><br>ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality |

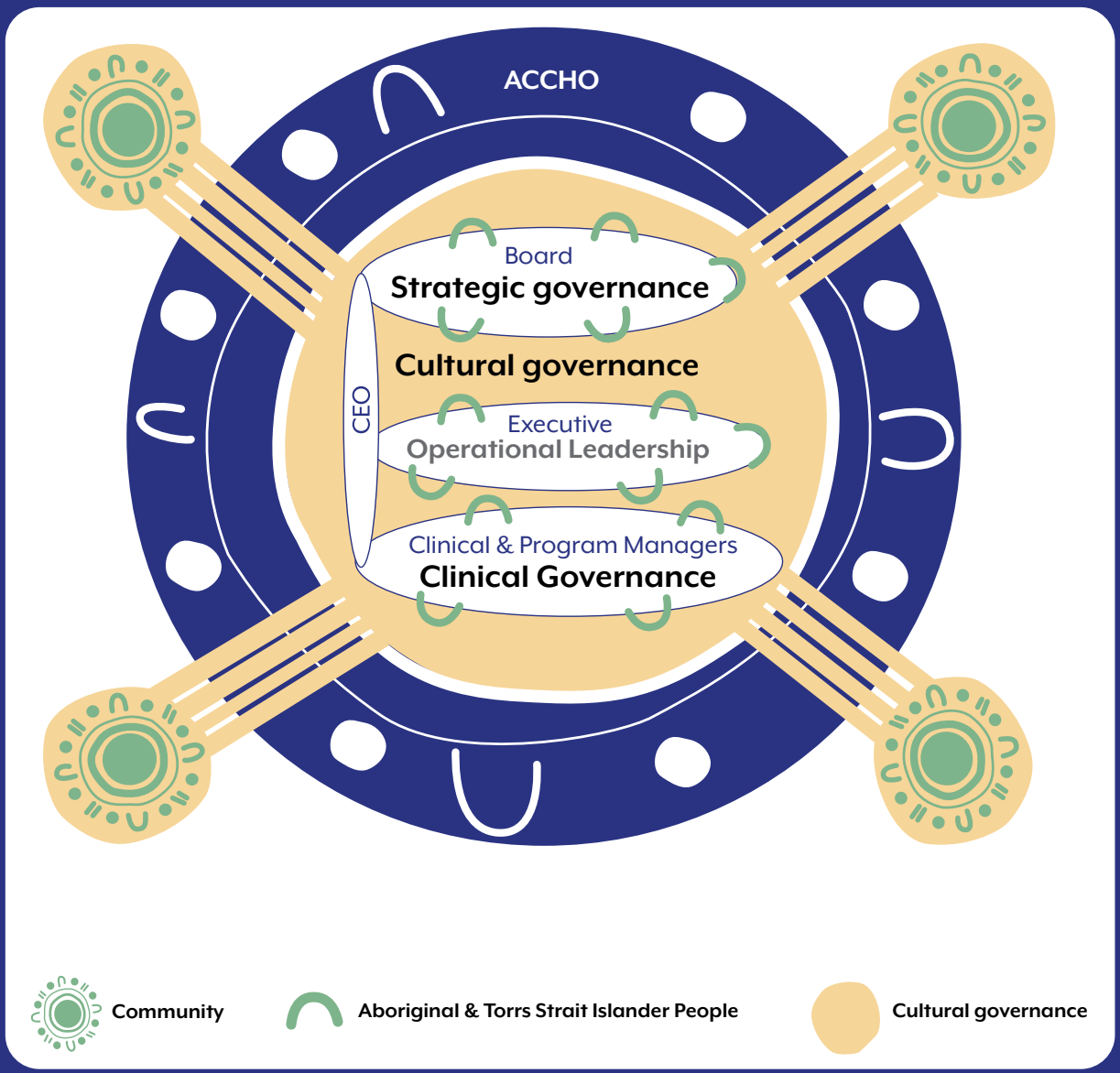
| Resource | Description |
|---|---|
| Everything Goes Great Until There's a Problem – Operational Governance in Aboriginal Community Controlled Health Services in NSW: The Theory and The Practice by Kirsty McEwin<br>*Aboriginal and Torres Strait Islander health specific, NSW focused* | The Aboriginal Health and Medical Research Council of NSW (AH&MRC) Corporate Governance Project was funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) to examine governance arrangements in different models of Aboriginal Community Controlled Health Services (ACCHSs) in NSW. Five ACCHSs from across NSW and with different corporate structures participated in the project and representatives from many other services and organisations were also consulted. The objectives of the project were: to build on the corporate governance capacities of the participating ACCHSs; to enable the AH&MRC to further engage in the area of corporate governance support as part of its broader member services support role; and to encourage the exploration of opportunities to further develop the corporate governance models for the Aboriginal Community Controlled Health Sector in NSW.<br><br>This project found that while no one size fits all, there are principles of good practice that can be observed in the services that have the most effective governance arrangements.<br><br>ahcsa.org.au/app/uploads/mp/files/resources/files/governance-everthing-until-report-201105.pdf |
| The FAR Project – Lowitja Institute and Flinders University<br>*Aboriginal and Torres Strait Islander health specific* | The Funding, Accountability and Results (FAR) project studied reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory and Cape York, Queensland between 2006 and 2014. Five reports outline different governance structures in ACCHOs and describe how and why they were developed and what they achieved. These are discussed in relation to self-determination, authority and decision making and the government environment ACCHOs work within. There is also a policy brief and video from the 2015 Lowitja institute knowledge translation forum, including Mr Cleveland Fagan, CEO, Apunipima Aboriginal Health Service, talking about this project.<br><br>lowitja.org.au/page/research/research-categories/health-policy-and-systems/governance/completed-projects/far |
| Taking Care of Business: Corporate services for Indigenous primary health care services – Overview Report<br>*Indigenous health specific* | This project looked at a range of ways ACCHOs obtain support for corporate functions where necessary. In many cases organisations get direct support from one or more providers (such as accountants, lawyers etc). However, the main focus of the work is on how ACCHOs have moved beyond one-on-one arrangements and developed ways to obtain corporate support for multiple functions in organised or structured ways. There is a small section on what support ACCHOs might need in relation to Governance. This includes; criteria for election of Board members, Board processes, accessing support to assist the Board in skills areas that they do not currently have (such as financial and legal) roles and responsibilities of the Board and CEO, balancing community and corporate priorities, and training and capacity building opportunity for community members to enable them to take up Board positions.<br><br>lowitja.org.au/page/services/resources/health-policy-and-systems/governance/Taking-Care-of-Business-overview-report |
| General practice management toolkit: Clinical governance.<br>*Not Aboriginal and Torres Strait Islander health-specific* | This resource provides a detailed description of clinical governance in relation to general practice. There are five sections that include: 1) creating a supportive organisational culture, 2) appointing strong clinical leaders, 3) assigning clear accountabilities, 4) performance measurement (clinical audit, risk assessment, patient consultation) and 5) quality and safety improvement (plan, do, study, act).<br><br>www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Management%20toolkit/Clinical-governance.pdf |

# ACCHO Governance: Reflection Tool

Within an ACCHO, governance has several components including cultural governance, strategic governance and clinical governance. This Reflection Tool is designed to assist ACCHOs to reflect on these three components of governance.

The ACCHO Governance Model shows how different forms of governance and leadership are enacted. The green symbols represent Aboriginal and Torres Strait Islander peoples within local community settings and at the heart of the ACCHO. **Cultural governance** is represented by the yellow areas. It guides, overarches and underpins the organisation and is provided by Aboriginal and Torres Strait Islander peoples who may be community members, clients of the service, staff, or Board members. **Strategic governance** is the guidance and direction given to determine and achieve the long-term or overall aims and interests of the ACCHO. It comes from the Board of Directors who have a duty to monitor the organisation's financial management, risk management and legal responsibilities. **Clinical governance** is the systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHO programs and services. The CEO interacts with all levels of governance and leadership. Strategic governance is separated from operational leadership and clinical governance as the Board of Directors maintains separation from operational, clinical and program duties within the ACCHO.

## The ACCHO Governance Model



**Step 1. Consider the activities your ACCHO currently practises under the three areas of governance.**

**Step 2. What other governance focused activities could your ACCHO consider in the future and what partnerships will be needed to achieve this?**

## Cultural Governance

- ☐ Aboriginal and Torres Strait Islander peoples are represented at all levels of our ACCHO including within the ACCHO Board, staff and clients.
- ☐ Our ACCHO members are local Aboriginal and Torres Strait Islander peoples that represent the diverse family groups, language groups, age groups and gender profile of the local community.
- ☐ We provide continuous opportunities to receive cultural governance through meetings, evaluation forms and yarning with community and staff.
- ☐ We use cultural governance to inform decision making that ensures the organisation follows cultural protocols and provides culturally-centred care.

## Clinical Governance

- ☐ Our Clinic and Program Managers work effectively with the Senior Management Team in relation to the day-to-day delivery of ACCHO programs and services that provide best quality patient care.
- ☐ Our clinic and program activities meet the strategic directions set out by the Board and meet accreditation standards, policies and guidelines.
- ☐ As much as possible, we seek formal and informal community and staff feedback and adapt programs, as needed, to better meet local community needs.
- ☐ We have a contingency plan for adverse and unexpected events such as sudden absence of clinical staff, pandemic diseases or natural disasters.

## Strategic Governance

- ☐ There is a strong relationship and effective communication between the Board and the CEO.
- ☐ Where needed, our Board engages with external professionals with specific expertise and experience.
- ☐ We ensure business, management and administrative functions are considered together with cultural knowledge to provide the best possible service for community.
- ☐ Our Board is aware of and responds to government department and funding changes, accreditation standards, reporting requirements and agreed Key Performance Indicators.
- ☐ Our Board is guided by community priorities, cultural governance, legal responsibilities, our Constitution, our peak body (i.e. state/territory Aboriginal community controlled organisation) and NACCHO.

# Chapter 3

## Strengthening ACCHO Workforce

# Strengthening ACCHO workforce


## Summary

ACCHOs are one of the largest employers of Aboriginal and Torres Strait Islander peoples across Australia. Aboriginal and Torres Strait Islander staff are critical to the foundational principles and operations of ACCHOs since they bring lived experience and community knowledge, community connection and engagement, and capacity across a range of professional disciplines and leadership roles. The ways in which ACCHO workforce can be strengthened is through targeted recruitment strategies, valuing and support, training and capacity building, and leadership pathways.

Programs to promote wellbeing, respect, team building, connection and equal opportunity also create a harmonious workforce and ACCHO environment. These strategies benefit the ACCHO (e.g. staff retention, maintained organisational culture and knowledge), the community (e.g. holistic health needs are met according to both cultural protocols and clinical standards), and the workforce (e.g. employment and capacity building opportunities, culturally safe working environments). ACCHOs face a range of challenges in relation to growing their workforce, particularly in relation to time, resources and funding.


The content within this chapter was drawn from two in-depth case studies including with a large remote ACCHO and a small regional ACCHO. The content was refined by collective input from the CREATE Leadership Group to include perspectives from the ACCHO sector nationwide.

### What we cover in this chapter:

## Introduction to ACCHO workforce

ACCHOs are a leading employer of Aboriginal and Torres Strait Islander peoples. They strive to strengthen their Aboriginal and Torres Strait Islander workforce and also respect and value their non-Indigenous staff who play an important role in providing services to their Aboriginal and Torres Strait Islander communities. ACCHOs aim to provide a safe working environment for everyone and to provide opportunities for ongoing employment, training and development.

A strong ACCHO workforce includes the following elements:

- Aboriginal and Torres Strait Islander staff members with lived experience and community connection and also those with strong cultural knowledge coupled with an understanding of Western systems (i.e. ability to walk in two worlds). These elements are protective factors that enable resilience within the workforce.
- Non-Indigenous staff members with cultural understanding and competence who are passionate about Aboriginal and Torres Strait Islander health and are prepared to learn, listen, support and engage with communities.
- Stability (i.e. long-term retention of workforce).
- Staff with multi-disciplinary skills and capacity across roles (e.g. clinical, community programs, administration, leadership).
- Respectful relationships between ACCHO staff and clients, and between ACCHO staff and partner organisations (e.g. professional networks).

## Values and principles underpinning ACCHO workforce strategies

### For community, by community

ACCHOs recognise that no one can serve their communities as well as local Aboriginal and Torres Strait Islander peoples who understand the historical context and its impact in contemporary life. This enables them to understand the lived experiences of their clients. ACCHOs value local Aboriginal and Torres Strait Islander staff for both their cultural and professional knowledge and understand the benefits they bring to the organisation in increasing the cultural safety of programs and services. Many ACCHOs find that their Aboriginal and Torres Strait Islander workforce increase engagement with community leading to increased uptake of services (e.g. health checks, immunisation rates).

### Social transformation through self-determination and empowerment

ACCHOs strive to provide targeted employment and capacity building opportunities to empower local peoples. These include providing local Aboriginal and Torres Strait Islander peoples the opportunity to gain employment, to grow and develop, to make decisions about their career pathways and to be empowered in their professional and personal lives. ACCHOs further support their local workforce through trust, respect, valuing, acknowledgement and investment. In this way, social transformation is achieved through empowerment and self-determination.

## Strategies that strengthen ACCHO workforce

There are four key strategies that enable a strong Aboriginal and Torres Strait Islander ACCHO workforce to be achieved; as depicted in Image 3.

**Image 3: The ACCHO Workforce Capacity Building and Leadership Model**


This model was developed through the CREATE project based on case studies with the ACCHO sector and consultations with the CREATE Leadership Group.

### 1. Attract and recruit local Aboriginal and Torres Strait Islander peoples

ACCHOs attract and recruit local people through numerous strategies including engaging with local schools and employment agencies. ACCHOs provide work experience opportunities and traineeships to expose local people to ACCHOs and the range of careers available. Work experience programs are a good way of getting young people in the door and interested in working in health. Offering traineeships within the ACCHO also enables recruitment of local Aboriginal and Torres Strait Islander peoples to the service.

At *Remote ACCHO* they start the recruiting process early. This involves going to schools and talking to students about the benefits of completing their education and the opportunities that are available to them within the ACCHO and other local businesses. Students are offered work experience and traineeship opportunities which can provide skills that are essential to develop both personally and professionally in any career.

### 2. Support, value, promote and recognise ACCHO staff

The social, physical, emotional and cultural wellbeing of Aboriginal and Torres Strait Islander staff is important to ACCHOs. Strategies to support staff include debriefing opportunities, mentoring and buddy programs, flexible working arrangements, cultural leave policies, employee assistance programs, team building activities and salary sacrifice opportunities.

At *Remote ACCHO* new staff are assigned a cultural mentor to work with. Staff relationships are strengthened through team building events, strategic planning days and staff lunches. The service also has a wellbeing program to promote respectful relationships between staff.

Programs to promote wellbeing, respect, team building, connection and equal opportunity create a harmonious workforce and ACCHO environment. ACCHOs support and value their staff by encouraging them to attend community events. At these events, staff engage with community to promote programs and services (e.g. health checks) and also promote the organisation's employment opportunities (e.g. traineeships, work experience and placements).

ACCHOs recognise the important role of Aboriginal and Torres Strait Islander staff in all health roles as they bring cultural and community expertise including an understanding of local communities, families and kinship relationships. ACCHOs value and promote the scope of practice and vital contribution of Aboriginal Health Practitioners and Aboriginal Health Workers who have wide ranging responsibilities.

At *Metro ACCHO* the CEO speaks with non-Indigenous staff about the important role of Aboriginal Health Practitioners and Aboriginal Health Workers who are valued for their cultural ways of working and are recognised for both their clinical and cultural expertise.

### 3. Strengthen the capacity of ACCHO staff

ACCHOs strive to support the growth of ACCHO workforce at all levels of the organisation through professional development courses, core competency training (e.g. cultural safety training, First Aid training) and mentorship. Staff mentoring can play a significant role in increasing sustainability and retention of Aboriginal and Torres Strait Islander staff. It can also help to minimise staff turnover and loss of corporate and cultural knowledge. For an ACCHO to be successful in developing its workforce every staff member should be offered the opportunity to progress in the organisation and develop both personally and professionally.

The *Remote ACCHO* believes in growing their workforce. If a local person comes in to the organisation and has the desire to better themselves they will be supported to train and gain professional qualifications so they can progress in the organisation.

The *Regional ACCHO* has a 'Shut Down week' where they limit clinical service provision and concentrate on training and development of staff and organisational improvement. A range of team building activities and training is provided to staff to connect, learn and share. This provides staff with time to refresh their knowledge and skills and reflect with one another about their learnings. The cultural safety of the organisation is also promoted through cultural awareness training sessions.

### 4. Nurture emerging Aboriginal and Torres Strait Islander leaders

ACCHOs recognise the crucial skills, experiences and cultural knowledge local Aboriginal and Torres Strait Islander workforce bring to the service and the important role of Aboriginal and Torres Strait Islander leaders. ACCHOs actively encourage and nurture the members of their workforce who are aspiring to be leaders via mentoring and long-term succession planning. Mentoring programs link junior and experienced staff together to transfer knowledge and provide junior staff with support. Careful succession planning is undertaken where less experienced staff work alongside leaders to gain knowledge and skills to take over management roles in the future. Aspiring staff can be rotated through various roles within the organisation, with senior members of the team acting as mentors along the way. This is also supported by professional training opportunities in management and leadership skills.

The *Remote ACCHO* provides a supportive and culturally safe learning environment where local Aboriginal and Torres Strait Islander peoples can work with and be supported by other community members through formal and informal mentoring. The organisation has established succession planning for key leadership positions and periodically rotate staff members between various roles within the organisation to provide staff with a holistic understanding of how effective leadership is achieved.

## Benefits of workforce capacity building and leadership strategies

**For the ACCHO:**

- Staff retention leading to maintained organisational culture and knowledge.
- Cost savings in relation to recruiting and training new workforce.
- Competent workforce with a diversity of skills and capacity.

The *Remote ACCHO* has a targeted strategy to employ and develop local people. This has created a stable workforce where the organisations' corporate and cultural knowledge is maintained, and quality culturally safe care is provided to community. This results in cost-savings in relation to recruiting and training new staff and providing travel and housing for fly-in fly-out staff.

- Strong links with community can lead to increased community engagement which further benefits the organisation through increased MBS income.
- ACCHO staff who are also community members provide valuable feedback to the service to ensure improvements are made to tailor service delivery to better meet community needs.
- Training and capacity building of staff supports continuous quality improvement in relation to policies, procedures and practices.
- Stronger engagement by community through attendance at AGMs and by providing informal feedback to ACCHO staff (which then positively influences the tailoring of programs and services).

The *Remote ACCHO* found that increased employment of local Aboriginal and Torres Strait Islander peoples increased their communities' engagement with the service. The more the service was known for employing and supporting local people, the more the community trusted and engaged with the service.

**For community:**

- ACCHO staff understand the historical trauma and lived experience of their clients, including kinship structures and cultural obligations, and the expectations from their communities.
- Client's health needs are met according to both cultural protocols and clinical standards.
- Staff provide culturally safe and responsive care to community which may extend to using local language.

A strong Aboriginal and Torres Strait Islander workforce enables the ACCHO to be a safe space for community where they can receive culturally safe care. At *Remote ACCHO,* some services are provided in local language. Staff act as translators between cultural ways of knowing and doing and biomedical ways of knowing and doing. Aboriginal and Torres Strait Islander staff also provide cultural mentorship to non-Indigenous staff which strengthens their knowledge about cultural ways of working and increases the cultural safety of care provided to community by all ACCHO staff.

- Community members are confident to attend the service leading to increased health checks, GP Management Plans, immunisations and support to navigate other services and systems.
- Community are more likely to act on the advice of Aboriginal and Torres Strait Islander workforce.
- Community self-determination through empowerment of local Aboriginal and Torres Strait Islander staff.
- Improved health outcomes.

The *Remote ACCHO* found that upskilling and investing in Aboriginal and Torres Strait Islander staff within the ACCHO led to increased engagement from clients and improved cultural safety and service delivery. This, in turn, resulted in improved health outcomes, such as increasing immunisation rates within the local community.

**For workforce:**

- Opportunities to gain secure employment within the ACCHO.
- Opportunities to expand skills and knowledge leading to further career progression.
- The wellbeing and mentoring programs promote respectful relationships between colleagues.
- The lived experiences of staff are well understood by the organisation and staff are supported to fulfil both their work and cultural obligations.
- Aboriginal and Torres Strait Islander workforce feel their cultural knowledge is valued and respected and the responsibility to advise on cultural matters is shared across the organisation.
- Two-way learning between Aboriginal and Torres Strait Islander staff and non-Indigenous staff provides opportunities to strengthen both cultural and professional knowledge in the ACCHO workforce.

At *Regional ACCHO* Aboriginal and Torres Strait Islander and non-Indigenous staff benefit from spending time together for training and development. This provides opportunities for two-way learning, particularly in relation to increasing cultural understanding. Staff also co-develop policies and procedures around respectful relationships which further strengthens knowledge, respectful behaviours and equitable relationships across the ACCHO.

## Enablers of workforce capacity building and leadership strategies

### Effective cultural governance and strategic governance

A strong ACCHO workforce is supported by effective cultural governance and strategic governance which means that the service is led by community, for community (for information on ACCHO Governance, see **Chapter 2**). This includes representation of different family groups on the ACCHO Board so that there are strong connections to the local community. This representation gives local people confidence to apply for jobs within the ACCHO as they feel they will be given a fair chance at gaining employment within the organisation. If an ACCHOs Board has a Rule Book that is followed and abided by, it instils confidence in the organisation and the workforce. Some Boards are involved in the selection and appointment of ACCHO staff.

### Supportive organisational culture

ACCHOs establish practical initiatives which provide for the physical, emotional and cultural wellbeing of Aboriginal and Torres Strait Islander staff. Such initiatives include special leave to fulfil cultural obligations, organised debriefing sessions in safe environments to promote peer support, and activities to rejuvenate the spirit and culture of Aboriginal and Torres Strait Islander staff (e.g. smoking and healing ceremonies, reconnecting with Country, yarning sessions, workshops).

### Clear and supportive policies and procedures

ACCHOs benefit from clear policies around duty of care, flexible working arrangements, cultural leave, professional development opportunities, mentorship opportunities, performance reviews and career planning. These policies provide safe and equitable working conditions and opportunities for all staff in the ACCHO.

### Funding for capacity building and professional development

Funding is essential for formally and informally developing ACCHO workforce capacity. This includes funding for traineeships, mentoring programs, professional development courses, vocational training and pathways to university. It is also beneficial, especially in larger organisations, to have a designated person that supports staff to undertake career planning and identify pathways and opportunities for gaining qualifications (e.g. scholarships).

### Strong partnerships with schools, peak bodies, registered training organisations and universities

ACCHOs engage with schools to identify students with an interest in working in the ACCHO sector, and to provide work experience opportunities. ACCHOs also develop partnerships with their state/territory peak body and registered training organisations to identify opportunities for building staff capacity. Some ACCHOs can also develop relationships with universities to look for pathways for their staff to gain clinical and management qualifications.

### Use of culturally appropriate recruitment and interview processes

Western styles of recruitment do not align with the cultural values of many Aboriginal and Torres Strait Islander societies. Where possible and appropriate, ACCHOs are flexible in their approach to recruitment to identify Aboriginal and Torres Strait Islander peoples who have the lived experience and knowledge to work with community and bring value to the organisation. Examples include having an informal approach to interviews, having language speakers on panels so that interviews can be conducted in language, and seeking multiple referees in order to gain an understanding of the lived experience and capacity of applicants.

## Challenges to workforce capacity building and leadership strategies

### Building an awareness of the need for targeted capacity strengthening

There can be misunderstandings about the opportunities provided to Aboriginal and Torres Strait Islander staff. It is critical that ACCHO management are transparent about the key role that ACCHOs play in building Aboriginal and Torres Strait Islander workforce capacity including growing emerging leaders. Non-Indigenous staff have an obligation to support and share their knowledge with Aboriginal and Torres Strait Islander staff within the ACCHO. Managers can encourage all staff to support the appointment of emerging leaders with cultural strengths and experience.

### Attracting funding for workforce training and capacity building initiatives

It is challenging for ACCHOs to resource workforce initiatives and to allocate dedicated personnel to:

1) identify workforce initiatives,

2) develop relationships with potential funders (e.g. government departments, universities, peak bodies, PHN's, private industry and philanthropic organisations),

3) prepare funding submissions for cadetships, traineeships and student placements through available programs.

Resourcing training and capacity building is particularly challenging in regional and remote locations where travel is required. In some jurisdictions, ACCHOs who are registered training organisations find it challenging to secure funding to support training of Aboriginal Health Workers and Aboriginal Health Practioners.

### Lack of training for ACCHO managers

ACCHO managers often face barriers to identifying and accessing suitable management training.

### Inadequate funding of ACCHO programs resulting in non-competitive staff salaries

Government funding agreements that do not reflect the real costs of comprehensive service delivery force ACCHOs to make sacrifices. These sacrifices can include non-competitive salaries for ACCHO workforce.

### The ACCHO sector is insufficiently funded for workforce capacity strengthening and mentoring activities

ACCHOs invest considerable time and resources in capacity strengthening and mentoring staff. Succession planning and mentoring programs take time to establish and sustain which creates an additional burden for ACCHO staff, especially if they are the mentors. The sector needs adequate resourcing for capacity building, succession planning and mentoring activities.

### Aboriginal and Torres Strait Islander workforce supply shortage

Due to a workforce supply shortage, ACCHOs can find it difficult to recruit and retain Aboriginal and Torres Strait Islander workforce in roles such as clinical positions (e.g. GPs, registered nurses) and specialist roles. The shortage of trained Aboriginal and Torres Strait Islander counsellors and psychologists limits the professional support ACCHOs can provide to their staff. This is a key challenge in providing culturally safe counselling services to support staff to manage the stresses of their roles.

### Workforce stress including the 24/7 nature of work

Staff are members of both the organisation and the community. In many Aboriginal and Torres Strait Islander communities everyone is linked through families connections or kinship structures. As a result of these close connections there is little, if any, downtime for Aboriginal and Torres Strait Islander ACCHO workforce who are juggling family and work commitments and cultural obligations. There are expectations placed on ACCHO staff that they are available to community 24/7 and that they are seen to "practice what they preach". This can lead to workforce stress and burn out, if staff aren't adequately supported.

## Recommendations

### Recommendations for ACCHOs

- For some ACCHOs, a good representation of family groups within the Board and workforce can promote connection with community and a welcoming work environment.
- Consider an annual skills audit that identifies the training needs of all staff, with a focus on local Aboriginal and Torres Strait Islander staff.
- Seek opportunities to demonstrate value and support for staff including a supportive Employee Assistance Program with Aboriginal and Torres Strait Islander counsellors and/or psychologists. Allocate funding for workforce capacity development and training from your core funding or MBS income, where possible. Look for subsidised opportunities for cadetships and workforce capacity building (e.g. through state/territory peak bodies, PHNs and government departments).
- Formalise policies and procedures for succession planning for key leadership positions including developing structures for reviewing potential leadership candidates.
- Ensure all workforce within the ACCHO have a commitment to strengthening the capacity of Aboriginal and Torres Strait Islander staff. This can be enabled by listing 'Commitment to developing Aboriginal and Torres Strait Islander peoples within the organisation' within the Job Description (and related performance agreement) and by asking applicants to describe their approach during interviews.
- When recruiting Aboriginal and Torres Strait Islander peoples into the ACCHO, culturally responsive processes should be used. These may include informal interview approaches (e.g. bringing a mentor or advocate to the interview, a gender balance and language speakers in the interview panel) and using referees to gain an understanding of the applicant's lived experience and capacity.
- Establish professional mentoring and cultural mentoring programs within the organisation.
- Develop and maintain strong partnerships with schools to attract and recruit young local people to the organisation.
- Develop and maintain strong partnerships with registered training organisations and universities to identify opportunities for formal studies for your staff (e.g. diplomas, university degrees).

### Recommendations for policy makers

- The Commonwealth Government recognise the key role ACCHOs play in developing the capacity of Aboriginal and Torres Strait Islander workforce.
- The ACCHO sector requires long-term sustainable funding for culturally-centred training of the Aboriginal Health Practitioner workforce through an in-service traineeship model. This model ensures that graduates are equipped with both theoretical knowledge and practice-based skills in ACCHO ways of working.
- The Commonwealth Government could support training organisations (including registered training organisations and universities) to develop and deliver regionalised courses which strengthen the capacity of local Aboriginal and Torres Strait Islander staff working in ACCHOs.
- The Commonwealth Government could provide greater investment to strengthen the capacity of Aboriginal and Torres Strait Islander workforce across disciplines and particularly those with critical workforce shortages (e.g. counsellors, psychologists) which impacts the culturally responsive support services that can be provided by ACCHOs.
- The Commonwealth Government could provide long term funding to enable ACCHOs to strengthen the capacity of local Aboriginal and Torres Strait Islander staff to take on leadership roles within ACCHOs.
- The Commonwealth Government could develop a locum service that ensures appropriately skilled staff are available to backfill local Aboriginal and Torres Strait Islander staff attending professional development activities external to the ACCHO.

## Discussion

ACCHOs have positively influenced the employment and retention of Aboriginal and Torres Strait Islander workforce over many decades. They have intentionally increased the number of local Aboriginal and Torres Strait Islander staff employed within services as well as provided formal pathways to support staff to take on the leadership of clinical and community programs and the management of services. Aboriginal health services employ over 7,000 full-time equivalent staff. Just over half of these staff identify as an Aboriginal and/or Torres Strait Islander person (Australian Institute of Health and Welfare 2016, p.118). A significant number (13%) of Aboriginal and Torres Strait Islander staff are employed as Aboriginal Health Workers or Aboriginal Health Practitioners (Australian Institute of Health and Welfare, 2016). These staff bring a significant amount of cultural knowledge to the health care service in addition to their clinical skills and knowledge.

Employing Aboriginal and Torres Strait Islander peoples in these services has several benefits. Aboriginal and Torres Strait Islander staff are often able to identify the community's health needs (including those that are associated with the social determinants of health) and may speak the local language (Freeman, Edwards et al, 2014). They are valued by Aboriginal clients for their Aboriginal identity, respectful and non-judgemental behaviour, and trustworthiness (Gomersall et al, 2017). Aboriginal and Torres Strait Islander Health Workers also provide an important link between the health service and community (Kelly and Luxford 2007, Poroch and Service 2007, Freeman, Edwards et al, 2014), ensuring a high level of community engagement that may not be achieved by non-Indigenous staff (Taylor, Dollard et al., 2001) thereby increasing community members' access to health care services (Murphy and Best 2012, Freeman, Edwards et al, 2014).

In recognition of the value of Aboriginal and Torres Strait Islander workforce, ACCHO leadership pathways enable local peoples to develop into leaders within organisations that recognise the crucial skills, experiences and cultural understandings they bring to the service. This is particularly important as Aboriginal and Torres Strait Islander health providers often face unique challenges in carrying out these roles. When employed within mainstream services, they are more likely to face issues relating to racism and isolation (Gwynne and Lincoln, 2016). Other challenges for Aboriginal and Torres Strait Islander staff include a lack of defined career pathways and insufficient opportunities to develop skills and qualifications needed to progress into leadership positions (Roche, Duraisingam et al, 2013). ACCHO leadership models overcome these challenges by providing supportive employment and training environments whereby local peoples can work with and be supported by other community members.

In summary, ACCHOs are one of the largest employers of Aboriginal and Torres Strait Islander peoples across Australia. A strong ACCHO workforce includes strength across a range of attributes including strength in numbers, strength in cultural knowledge and cultural identity, strength in cultural safety, strength in capacity across a range of disciplines and roles, and strength in community connection and engagement. A strong workforce is important because when ACCHO staff are predominantly local Aboriginal and Torres Strait Islander peoples, community members are more confident to attend the service since they trust that they will be respected, and their health needs will be met according to both cultural and professional clinical standards. The ways in which a strong ACCHO workforce can be achieved is through targeted recruitment strategies to attract local Aboriginal and Torres Strait Islander peoples, support for and valuing of Aboriginal and Torres Strait Islander workforce, capacity building, and leadership pathways including mentoring programs and succession planning. These programs have wide-ranging benefit for Aboriginal and Torres Strait Islander workforce, the ACCHO and the community it serves. A strong ACCHO workforce is enabled by strong cultural governance and strategic governance, supportive organisational culture, clear and supportive policies and procedures, funding for capacity building and professional development, and strong partnerships with schools, peak bodies, registered training organisations and universities. To achieve a strong Aboriginal and Torres Strait Islander workforce, ACCHOs must overcome challenges such as in relation to funding workforce training and capacity building activities, investing time and resources in mentoring staff, recruiting Aboriginal and Torres Strait Islander workforce in specialist roles and managing workforce stress.

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# Strengthening ACCHO Workforce: Reflection Tool

ACCHOs are a leading employer of Aboriginal and Torres Strait Islander peoples. The Aboriginal and Torres Strait Islander workforce is critical to the success and operation of ACCHOs since they bring lived experience, community knowledge, community connection and community engagement. ACCHOs recognise that no one can serve their communities as well as local Aboriginal and Torres Strait Islander peoples who understand the lived experience of clients.

ACCHOs strive to provide targeted employment and capacity strengthening opportunities to empower local peoples. There are four key strategies that can build, support and grow a strong Aboriginal and Torres Strait Islander ACCHO workforce. This Reflection Tool is designed to assist ACCHOs to reflect on these four key strategies.

**Step 1. Consider the activities your ACCHO currently practises under the four key strategies.**

**Step 2. What other workforce focused activities could your ACCHO consider in the future and what partnerships will be needed to achieve this?**

## The ACCHO Workforce Capacity Building and Leadership Model

## Attract and recruit local Aboriginal and Torres Strait Islander peoples

- [ ] We engage and build relationships with local schools and employment agencies to create pathways in to the organisation.
- [ ] We provide work experience and traineeships to expose local people to the range of careers available in ACCHOs.
- [ ] We promote employment opportunities within the ACCHO at local community events.
- [ ] We use culturally responsive processes for recruitment (e.g. including language speakers and a gender balance on interview panels, enabling interviewees to bring a mentor to support them during interviews).

## Support, value, promote and recognise ACCHO staff

- [ ] We recognise the important role of Aboriginal Health Practitioners and Aboriginal Health workers.
- [ ] We value the cultural and community expertise (including an understanding of local communities, families and kinship relationships) that Aboriginal and Torres Strait Islander workforce bring to the service.
- [ ] We promote staff wellbeing with cultural mentoring, buddy programs, debriefing sessions, flexible working arrangements, cultural leave policies and an Employee Assistance Program (with Aboriginal and Torres Strait Islander counsellors and/or psychologists where possible).
- [ ] We host team building sessions and encourage staff to attend community events where staff can engage with community and promote the organisation's employment opportunities.
- [ ] We ensure all staff recruited to the ACCHO have a commitment to strengthening the capacity of Aboriginal and Torres Strait Islander peoples.

## Strengthen the capacity of ACCHO staff

- [ ] We conduct an annual skills audit to identify the training needs of all staff, including a focus on Aboriginal and Torres Strait Islander staff.
- [ ] We develop and maintain partnerships with registered training organisations and universities to identify opportunities for staff to gain formal qualifications (e.g. diplomas, university degrees).
- [ ] We allocate funding for workforce capacity development and training where possible.
- [ ] We seek subsidised professional development and training opportunities and look for cadetships and other government-funded workforce capacity strengthening initiatives.
- [ ] We provide core competency training (e.g. cultural safety training, first aid training, occupational health and safety training).
- [ ] We offer professional development courses so that every staff member can progress in the organisation.
- [ ] We ensure professional mentoring opportunities are provided for staff to share professional and clinical skills.

## Nuture emerging Aboriginal and Torres Strait Islander leaders

- [ ] We recognise the crucial skills, experience and cultural understandings of local Aboriginal and Torres Strait Islander workforce and the important role of leaders with the organisation.
- [ ] We encourage and nurture Aboriginal and Torres Strait Islander staff who are aspiring to be leaders via mentoring programs that link junior and experienced staff and provide opportunities to share knowledge.
- [ ] We provide long-term succession planning opportunities where aspiring staff are rotated through various roles within the ACCHO to work alongside senior managers and gain relevant knowledge and skills for effective leadership.
- [ ] We have policies and procedures for succession planning including structures for reviewing potential leadership candidates.
- [ ] We seek out professional development opportunities for staff in management and leadership skills.

# Chapter 4

## Addressing the Social Determinants of Health: ACCHO practices and principles

# Addressing the Social Determinants of Health: ACCHO practices and principles


## Summary

ACCHOs support clients with their social, emotional and cultural wellbeing as well as physical health needs. Embedded within this holistic approach is the work ACCHOs undertake to tackle the social determinants of health – these are the conditions in which we are born, grow, work, live and age. The social determinants of health explain why and how there are differences in health and social outcomes between people. They include features of the society we live in (governance, policies, culture and societal values), our place in society (social class, income, education, employment, ethnicity), and our life experiences (who we are, how we live, our relationships and social connections, and the health system we can access).

ACCHOs do whatever is necessary to address the social determinants of health and meet the needs of their communities. ACCHOs strive to create an accessible and culturally safe health service and employ a multidisciplinary workforce that walk side by side with clients to link them across sectors such as housing, employment, education, and family services. They work to combat racism through cultural awareness training and mentoring and undertake extensive advocacy efforts to address inequitable features of the society we live in. The work of ACCHOs to address the social determinants of health is enabled by community consultation and engagement, a highly skilled workforce, and respectful partnerships with external organisations.


The content within this chapter was drawn from an in-depth case study with a Regional ACCHO that was reviewed and refined by the CREATE Leadership Group and strengthened with learnings and perspectives from the ACCHO sector nationwide.

### What we cover in this chapter:

## An introduction to the Social Determinants of Health

Health is complex. Health is influenced by a range of factors related to our life experiences (who we are, how we live, who we connect with, and the health system we can access). These life experiences are influenced by our place in society and features of the society itself. These factors are broadly known as the **social determinants of health**.

The social determinants of health are commonly and more simply described as *'the conditions in which we are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life.'*[1] These forces and systems include factors such as socioeconomic position, societal values, racism and social policies. These influence the health of individuals and communities and explain why there are health differences between populations.

### Our life experiences

Our health is determined by who we are including our biology and our behaviours (things such as diet, physical activity, and whether we drink or smoke). How we live, including the environments we live and work in and the quality of food available to us, also play a role (these are our material circumstances). Our relationships, social supports and whether we experience stressful life circumstances (collectively known as our psychosocial factors) also influence our health as does our connection to others (social cohesion) and ability to share and exchange resources within our networks (social capital). The quality and accessibility of the health system available to us also influences our health.

### Our place in society

Our life experiences are influenced by our place in society (our socioeconomic position) which include the opportunities we have for education, income and employment. Our ethnicity (and whether we experience racism), gender and social class also impact our life experiences including how we are treated when accessing health and social services.

### Features of society

Our place in society is influenced by features of the society we live in including social, public and economic policies, governance, culture and societal values.

A practical model of the Social Determinants of Health is presented in Image 4. It is based on the World Health Organisation's 'Conceptual Framework for Action on the Social Determinants of Health'[2] (see further information on Page 80). The image depicts the three levels of the social determinants of health: features of the society we live in, our place in society, and our life experiences. The society we live in and our place in it are known as structural determinants, and our life experiences are known as intermediary determinants of health.

**Image 4: A practical model of the Social Determinants of Health**


[1]World Health Organisation (2018). *Social determinants of health*. Accessed on January 17, 2020 at: who.int/social_determinants/en/
[2]Solar O, Irwin A. (2010). *A conceptual framework for action on the social determinants of health*. World Health Organisation's Social Determinants of Health Discussion Paper 2 (Policy and Practice).

## Principles guiding the ACCHO Social Determinants of Health approach

ACCHOs describe four overarching principles that guide their efforts to tackle the Social Determinants of Health:

- ACCHOs safeguard **client self-determination** and support clients to make their own decisions about the services they receive.

At the *Regional ACCHO*, case managers support their clients to make decisions about the health care they want to receive. Intensive support is provided during times of great need and this support is gradually reduced over time. Staff are there to support and provide information to help clients make decisions.

- ACCHOs do **whatever is necessary** to directly address, or facilitate services that address, the social determinants of health that impact clients.

In many instances an ACCHO can be the first point of contact for local Aboriginal and Torres Strait Islander communities to gain support and guidance on addressing a broad range of holistic health needs and living circumstances. The *Regional ACCHO* staff do whatever is necessary to support clients with their needs. This extends the work of ACCHOs far beyond the health system and calls on staff to work flexibly across teams and programs and with partner organisations.

- ACCHOs provide **culturally safe care** for Aboriginal and Torres Strait Islander clients and promote cultural safety in associated social services and partner organisations.

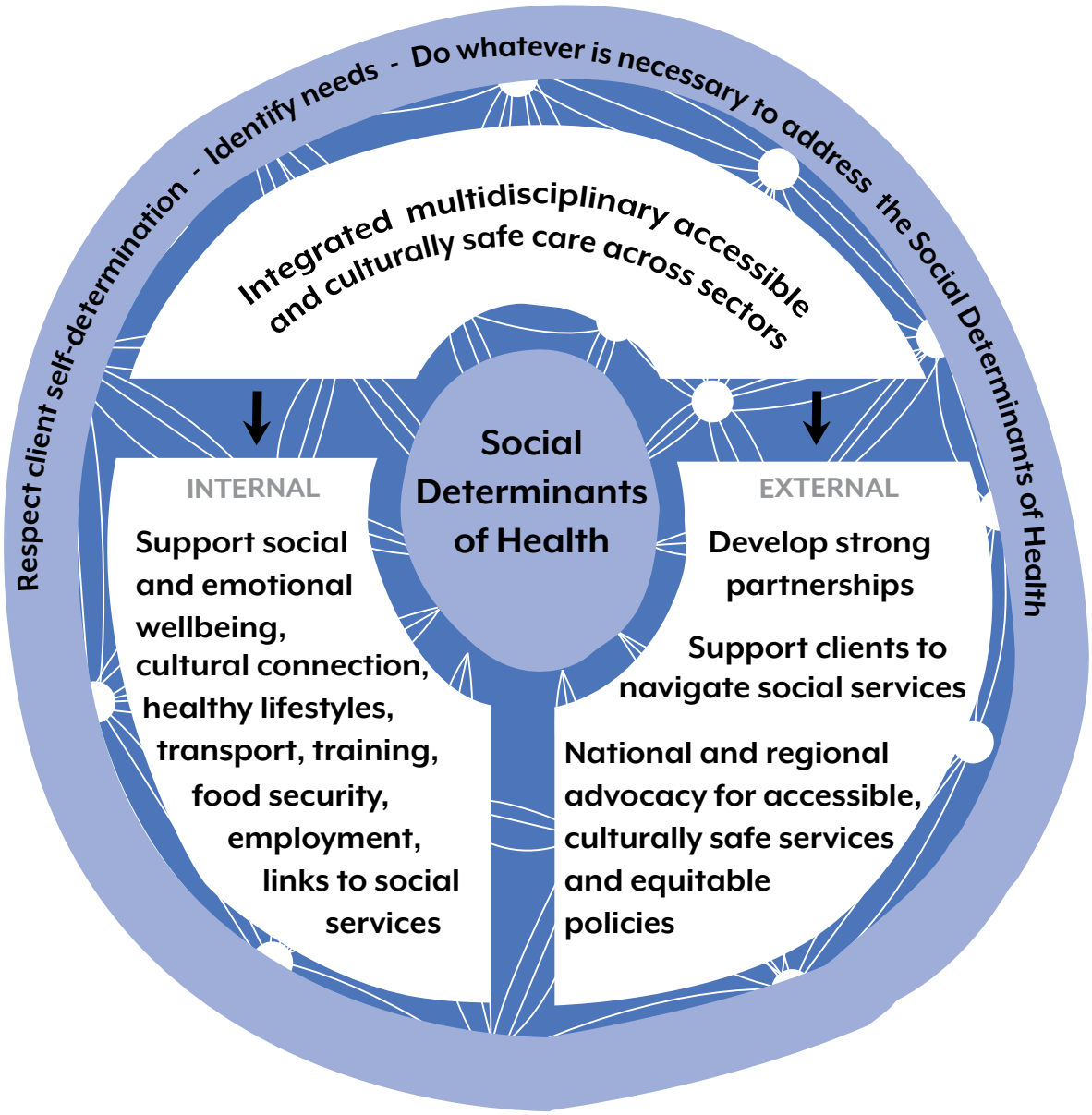
The *Regional ACCHO* is committed to providing culturally safe care and advocating for safe care in partner organisations. This includes a Cultural Awareness induction program for all staff including visiting specialists and registrars, and the use of local language in programs and resources. Local Aboriginal and Torres Strait Islander staff have been charged with the responsibility of working as a cultural mentor to guide other ACCHO staff and those employed by partner organisations in what it means to provide an acceptable service for Aboriginal and Torres Strait Islander peoples. This helps to create an accessible, acceptable and appropriate health service for Aboriginal and Torres Strait Islander communities including culturally safe connections to other mainstream services.

- ACCHOs advocate for **seamless, integrated and multidisciplinary care** through holistic internal programs and services and engagement with partner organisations.

The *Regional ACCHOs* case management approach ensures that clients move seamlessly between providers. This is particularly important when clients are dealing with numerous, and often quite complex, health and social problems that require contact with and help from more than one service provider. Case managers work closely with external providers to ensure clients are supported to access services. They are often the bridge between clients and mainstream services. This approach helps to reduce the burden on clients having to re-tell their story to different clinicians and providers.

Image 5 (over page) descibes ACCHO principles and approaches to tackling the social determinants of health.

Image 5: ACCHO Approaches to the Social Determinants of Health Model




## Model description

The ACCHO Approaches to the Social Determinants of Health Model highlights respect for client self-determination as a key principle. ACCHO staff work with clients to identify their needs before doing 'whatever is necessary' to support them to address the social determinants of health. The model demonstrates how ACCHOs act as a one-stop-shop for community through internal holistic services and programs and through partnerships with external service providers. ACCHOs create a positive experience for clients who walk through their doors through a range of services such as cultural activities, clinic services, employment and housing programs. The one-stop-shop model increases client confidence and engagement when managing complex circumstance by providing support to navigate numerous systems and services.

This model was developed through the CREATE project based on case studies with the ACCHO sector and consultations with the CREATE Leadership Group.

## ACCHO practises to address the Social Determinants of Health

The holistic view of health adopted by ACCHOs ensures that clients are supported to address their social and cultural needs as well as their physical and emotional health needs. ACCHOs provide multidisciplinary coordinated care within teams and across sectors and act as a gateway to a range of external social services. ACCHOs also commonly address the social determinants of health at a structural level to impact their clients' place in society as well as features of the society itself.

### 1. Our life experiences (*intermediary* determinants)

ACCHOs understand the impact of historical trauma on their communities and work tirelessly to support clients with their social, emotional and cultural wellbeing, and to improve their life circumstances. ACCHOs do this to enable clients to make positive lifestyle choices relating to diet, exercise, and risk behaviours (e.g. smoking, alcohol). Initiatives include healthy lifestyle programs, assisting with access to housing, food and transport, tackling social issues such as social isolation, and ensuring equitable health care services for all community members.

#### Material circumstances

At *Regional ACCHO*, staff advocate for clients at risk of losing their housing. Clients who are homeless or at risk of becoming homeless are supported to gain access to secure and affordable housing. At times staff also help older members of the community who cannot carry out maintenance on their homes.

Food security is promoted at the service through a positive food program run in conjunction with local schools where kids cook a healthy meal and share it with their parents. The service also has a community garden to encourage clients to reconnect with nature while also providing a source of fresh vegetables.

#### Behaviours and biological factors

The *Regional ACCHO* programs promote healthy lifestyle choices including a program to promote physical activity and tackle obesity. The service has an onsite gym and a dietician to provide tailored information about good eating habits. The Mothers and Babies Team focus on healthy lifestyles for children and organise community events to promote healthy choices. A range of drug and alcohol services and programs are available to promote healthy choices around substance use.

#### Psychosocial circumstances

The *Regional ACCHO* supports clients and community with their psychosocial wellbeing in several ways, led by their strong Social and Emotional Wellbeing Team comprising of case workers and a hospital liaison worker. The primary role of this team is case management and advocating with external agencies to ensure client needs are met. Flexible approaches are used with clients and their families over the long term. The team also provides a Pre-release Prison Advocacy Program to identify and support the social needs of prisoners prior to their release into the community.

The *Metro ACCCHO* has a Strong in Country program to enable community to spend time in Country practicing culture. It also has an extensive social and wellbeing program that connects members of the Aboriginal community through arts activities such as visual arts, music, dance and theatre workshops. The team has strong community connections that enable them to engage those members of the community who do not access services. The team engages the community to co-design program activities based on community-determined priorities. Services are flexible and holistic and include extensive advocacy and relationship building to enable community to access the services they need (e.g. health, legal, education, children's services, drug and alcohol services).

The *Regional ACCHO* has a Grief and Loss Support Group which aims to support community members on their healing journey and includes a monthly structured activity or guest speaker. There is also a Men's Shed program to provide a space for men of all ages to come together and for Elders to discuss and deal with community issues.

#### Health system

The *Regional ACCHO* provide an accessible and quality service tailored to community needs. The service provides transport to

support clients to attend appointments at the ACCHO and in partner organisations, and to attend community events. They also work tirelessly to ensure partner organisations are aware of and able to provide culturally safe services to meet the needs of Aboriginal and Torres Strait Islander peoples. In this way the ACCHO acts as an important bridge between Aboriginal and Torres Strait Islander peoples and mainstream services.

### Social Cohesion and Social Capital

As a community hub, ACCHOs provide a welcoming and culturally safe space where people can come together and create cooperative and mutually beneficial connections. ACCHOs focus on social inclusion and cultural programs through their comprehensive health model.

The *Metro ACCHO* has a Family Support Program that aims to keep families safely together at home. Their Family Support Workers provide intensive wrap around support for families, have established strong working relationships with government departments and other ACCHO programs (e.g. social and emotional wellbeing team, clinic, childcare service), advocate on behalf of clients, and assist children and families to access the services they need. Both the *Metro ACCHOs* Social and Emotional Wellbeing Team and Strong in Country program teams provide numerous opportunities for community to come together to connect and practise culture.

## 2. Our place in society (*structural* determinants)

ACCHOs support clients to improve their socioeconomic position through education, training and employment opportunities. ACCHOs also work at multiple levels to promote reconciliation and address racism.

### Income, education and employment

The *Regional ACCHO* creates partnerships with external agencies and seeks opportunities for clients to gain access to education and employment. Examples include linking with the local TAFE to create traineeship opportunities for clients. They employ local Aboriginal and Torres Strait Islander peoples within their workforce and invest in capacity development through supporting staff to undertake certificate training towards nationally recognised professional qualifications. In some instances, this can include supporting staff to take study leave, supporting the costs of the training, or supporting transport costs.

Much of the work of the *Regional ACCHO* to address income challenges includes advocating for clients to access Centrelink payments and assisting clients with household budgeting. Some ACCHOs also create social marketing campaigns around making good financial choices (e.g. anti-gambling campaigns).

### Racism

The *Regional ACCHO* works on several levels to strengthen cultural pride and combat racism within the community. They provide cultural awareness training to all staff including visiting specialists and partner organisations, host NAIDOC events and participate in Reconciliation Week events.

## 3. Features of society (*structural* determinants)

ACCHO leaders undertake extensive advocacy to promote the development of equitable policies and programs for their local communities.

The *Regional ACCHO* advocates in an ongoing way with local, state/territory and federal governments and a range of peak bodies for public health and social policies that consider the needs of Aboriginal and Torres Strait Islander peoples. This advocacy work also aims to strengthen positive societal views related to Aboriginal and Torres Strait Islander communities.

Table 4 presents a summary of programs and practices that ACCHOs undertake to address the social determinants of health. ACCHOs provide some or all of these depending on local context, size and community need.

Table 4: Summary of ACCHO activities to address the Social Determinants of Health

## ACCHO ACTIVITIES TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

### Features of society

*Structural Determinants*

**Social, public and economic policies**

- ACCHOs write letters and contribute to submissions to lobby and provide recommendations to government.
- Advocating for Aboriginal and Torres Strait Islander health as a priority area across sectors.

**Culture and societal values**

- ACCHO peak bodies advocate at a national level to promote positive societal values relating to Aboriginal and Torres Strait Islander rights and cultural respect.
- ACCHO leaders represent strong Aboriginal and Torres Strait Islander role models contributing to positive societal views.

**Governance**

- ACCHOs link with their state/territory and national peak bodies which advocate for Aboriginal and Torres Strait Islander sovereignty in governance.

### Our place in society

*Structural Determinants*

**Education and employment**

- ACCHOs are the largest employer of Aboriginal and Torres Strait Islander peoples.
- Support for capacity development including formal qualifications and other upskilling opportunities.
- Traineeships leading to formal employment.
- Work for the Dole programs.

**Income**

- Assistance and advocacy with Centrelink to promote financial security.
- Funeral funds.
- Emergency assistance.
- Financial budgeting.
- Social marketing campaigns to promote good financial choices (e.g. anti-gambling messages).

**Ethnicity and racism**

- Cultural awareness training and cultural mentorship to increase culturally safe spaces and services.
- Representation on local committees.
- Positive interactions between Aboriginal and non-Indigenous peoples to promote reconciliation through celebrations that showcase local Aboriginal and Torres Strait Islander dancers, artists, singers, caterers.

### Our life experiences

*Intermediary Determinants*

**Material Circumstances**

- Housing security: assisting clients to access secure and affordable housing.
- Transport and bus tickets.
- Assisting Elders with home maintenance.

**Behaviours and biological factors**

- Health promotion related to behavioural factors (physical activity, diet, smoking).
- Food security: programs that strengthen skills to grow and cook healthy and affordable food (e.g. community gardens, cooking programs).

**Psychosocial circumstances**

- Intersectoral case management through the Social and Emotional Wellbeing Team.
- Support to navigate the justice system: links with Police, supporting clients to attend court, pre-release Prison Advocacy Program.
- Linking and supporting Aboriginal and Torres Strait Islander communities to strengthen cultural and social action.
- Grief and Loss counselling.
- Men's Shed, Women's programs.
- Connecting with Country programs.

**Health system**

- ACCHOs provide accessible and culturally respectful primary health care, and support clients to gain access to services (e.g. dental) and navigate hospitals and specialist health services.
- ACCHOs form partnerships with external providers to link clients to other services.
- ACCHOs link with hospitals to promote effective discharge planning.

### Social Cohesion and Social Capital

- As a community hub, ACCHOs provide a welcoming and culturally safe space where people can come together and create cooperative and mutually beneficial connections.
- ACCHOs focus on social inclusion and cultural programs through their comprehensive primary health care model.

## Outcomes of the ACCHO Social Determinants of Health approach

### The One Stop Shop model

By doing whatever is necessary to support clients, ACCHOs become a one-stop-shop increasing access to both health and social services. ACCHOs create a positive experience for clients who walk through their doors through a range of services including cultural activities, clinic services, employment and housing programs. The one-stop-shop model increases client confidence and engagement when managing complex circumstance by providing support to navigate numerous systems and services.

### Positive client outcomes regarding health behaviours and housing security

ACCHO staff report positive client outcomes such as improved access to safe housing, increased access to health and social services, and a reduction in drug and alcohol use.

### Educational and employment outcomes for clients and staff

ACCHOs report a range of positive educational and employment outcomes for their clients and staff such as participation in training programs, gaining qualifications, new work opportunities, and even setting up small businesses.

## Enablers of the ACCHO Social Determinants of Health approach

### Community consultation and engagement

ACCHOs recognise that initiatives to address the social determinants of health are driven by consultation, engagement and input from their communities

### Highly skilled staff

The ACCHO social determinants of health approach is enabled by a dedicated ACCHO workforce who do not limit themselves to the responsibilities outlined by their role. They go over and above in their day to day work and are skilled in navigating complex systems and sectors. The ACCHO workforce understand the inequalities experienced by their local Aboriginal and Torres Strait Islander communities and are committed to creating positive outcomes. The ACCHO workforce also maintains partnerships with numerous external service providers to promote culturally responsive services for their clients.

### Respectful and collaborative relationships and partnerships

The ACCHO social determinants of health approach is enabled through multidisciplinary and coordinated service provision that links clients across teams within the ACCHO. It is also enabled through collaborations and partnerships across sectors. ACCHOs invest in close working relationships with a broad range of external organisations to ensure their clients can access all necessary supports across the social services system.

## Challenges to the ACCHO Social Determinants of Health approach

Challenges for ACCHOs include insufficient resources, challenges with staff wellbeing, recruitment and retention, inadequate staff salaries, managing relationships with numerous external partners, and administering multiple funding streams.

### Insufficient funding

Lack of funding is a key challenge of providing such a diverse range of services. Some ACCHO initiatives are implemented with little or no external funding. Reductions or a withdrawal of funding can also force ACCHOs to abandon successful initiatives that could have made a real difference. Unfunded activities undertaken by ACCHOs that address the social determinants of health can include: advocacy, supporting clients to navigate complex systems, transport, clinic appointments that extend past the MBS rebate time of 45 minutes, funeral funds, tenders and funding submissions, cultural awareness training and cultural mentoring, and program evaluation.

### Challenges with staff recruitment and retention

ACCHOs often face difficulties with recruiting and retaining staff which impacts their ability to address the social determinants of health. At times services can find it difficult to replace staff which means initiatives are suspended until appropriately skilled workers are recruited.

### Non-competitive adequate staff salaries

In order to provide comprehensive services to community, ACCHOs often accept inadequate funding from governments which threatens their financial viability and can result in non-competitive staff salaries. Service delivery is the focus for ACCHOs, which can mean that staff salaries are sacrificed.

### Staff wellbeing is threatened

Aboriginal and Torres Strait Islander staff feel responsible for the communities they serve, and work can be 24/7 when community members seek assistance after hours. In their unwavering commitment to community, ACCHO staff often take on roles and responsibilities beyond their scope of practice which can negatively impact on wellbeing.

### Maintaining relationships with numerous external partners and keeping services accountable

ACCHOs invest in relationships with an extensive number of partner organisations and funders. There are challenges in maintaining these relationships, particularly when organisations are bureaucratic and difficult to work with. ACCHOs also have a role in keeping government funders accountable for the consequences of policy decisions and priority setting. Delays in service provision from external providers can be problematic, and at times ACCHOs need to fill the gap when clients are on the waiting list of other organisations.

### Administering multiple funding streams

In providing comprehensive primary health care, ACCHOs often administer funds from multiple government departments and organisations. To be successful in this funding model, ACCHOs must build and sustain relationships with multiple government departments and other funders, must prepare tender applications and funding submissions in a timely way, must achieve accreditation across multiple standards, and must navigate complex financial administration and reporting requirements.

## Recommendations

### Recommendations for ACCHOs

- Hold partner organisations and governments accountable to their responsibilities to local Aboriginal and Torres Strait Islander communities.
- Maintain and strengthen engagement with partner organisations through mutual attendance at team meetings and case management meetings.
- Provide compulsory cultural awareness training for all ACCHO staff and visiting personnel. Recommend all workforce in partner organisations receive cultural awareness training.
- Develop a formal Memorandum of Understanding with partner organisations to recognise the cultural mentoring that ACCHOs provide. Consider fee for services. Note that Memorandum of Understandings are not legally binding documents, and may not always be adhered to by all parties.
- Advocate for clear pathways between the ACCHO and partner services to assist clients to navigate external services.
- Strengthen initiatives aimed at addressing the structural determinants of health that include a focus on culture, education and employment.
- Expand efforts to integrate local language within programs to enhance the provision of culturally-centred care.
- Promote the health and sustainability of Aboriginal and Torres Strait Islander staff through wellbeing initiatives, succession planning and capacity building.
- Seek training for strengthened negotiation skills when advocating for adequate administration and program funding. Programs need to be funded at the actual cost of service delivery so that staff can be remunerated appropriately.

### Recommendations for Policy Makers

- Commonwealth, state and territory governments formally acknowledge the extensive amount of work ACCHOs do in addressing the social determinants of health.
- Commonwealth, state and territory governments provide ongoing and specific funding streams to enable ACCHOs to continue to develop and implement strategies, programs and initiatives that directly address the social determinants of health. This funding should appropriately remunerate ACCHO staff, support integrated family-centred care coordination and adequately resource travel costs, administration expenses and program evaluation.
- Commonwealth, state and territory governments acknowledge and support ACCHOs as the preferred providers for health, mental health, alcohol and other drugs, aged care, disability and child protection services to build on their experience, knowledge and existing relationships with Aboriginal and Torres Strait Islander communities.
- Commonwealth, state and territory governments acknowledge the need for greater investment in an environmental health workforce and environmental health program agenda so that ACCHOs can support clients in gaining safe and secure living environments.

## Discussion

ACCHOs were established to provide comprehensive primary health care to Aboriginal and Torres Strait Islander communities who encountered racism and other barriers to access in the mainstream health system. They have long adopted a holistic definition of health that includes social, emotional and cultural wellbeing in addition to physical wellbeing. As defined in the Constitution of the National Aboriginal Community Controlled Health Organisation (NACCHO):

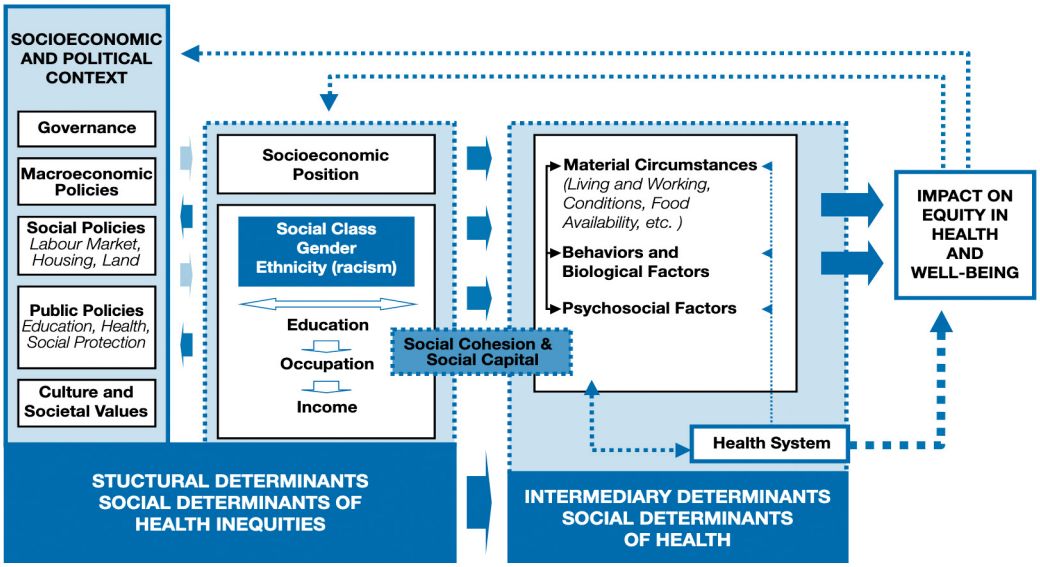
> *"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life* (NACCHO, 2018).

ACCHOs undertake extensive efforts to address the social determinants of health impacting their clients. A close connection to local Aboriginal and Torres Strait Islander communities enables the ACCHO workforce to support clients with their social and cultural needs. ACCHOs are a community hub that provide a culturally safe and welcoming space for local Aboriginal and Torres Strait Islander peoples. Through supporting clients to navigate multiple services, ACCHOs act as the unseen glue between systems. If ACCHOs didn't exist, local communities would lose this safe space where they come together to connect and would lose the support they need to navigate complex systems. ACCHOs must be adequately resourced for their work to address the social determinants of health so that they can provide an expanded scope of services to support clients to address the challenges they face such as related to housing and food security, employment security and social connection.

### The Conceptual Framework for Action on the Social Determinants of Health

The World Health Organisation's 'Conceptual Framework for Action on the Social Determinants of Health' (Solar and Irwin, 2010) outlines the multiple levels of health determinants and is depicted in Figure 1. On the left and centre of the image are the structural determinants which create social inequalities that cause some members of society to have more advantages than others. Structural Determinants include the overarching 'socioeconomic and political context' such as governance, policies, culture and societal values (i.e. features of society) in addition to socioeconomic position, social class, gender, ethnicity, income, education and occupation that determine our place in society. The Intermediary Determinants result from these social inequalities and include material circumstances, psychosocial circumstances, behaviours and biological factors and features of the health system itself (i.e. our life experiences). Social cohesion and social capital are positioned in the Conceptual Framework as bridging the intermediary and structural determinants. These include our connection to others and ability to share and exchange resources within our networks.

**Figure 1: The World Health Organisation's Conceptual Framework for Action on the Social Determinants of Health[3]**




[3]Reproduced with permission from World Health Organisation Press. Source: Solar O, Irwin A. (2010). *A conceptual framework for action on the social determinants of health*. World Health Organisation's Social Determinants of Health Discussion Paper 2 (Policy and Practice), 6.

## How do the social determinants of health impact Aboriginal and Torres Strait Islander peoples?

Australia was colonised without acknowledgement or regard for Aboriginal and Torres Strait Islander peoples (Sherwood, 2013) and included dispossession and marginalisation practices (Castle and Hagan, 1987) as well as discriminatory government policies that resulted in systemic racism, forcible removal of children, and limited opportunity for employment and education (Dudgeon et al, 2010). The Australian Constitution was developed without recognition of Aboriginal and Torres Strait Islander peoples and the right to vote was granted as late as 1967. This history continues to impact contemporary Aboriginal and Torres Strait Islander peoples and communities manifesting through the social determinants of health including the experience of racism and inequitable income, education, housing, psychosocial distress and access to health care.

In the 2016 Census, Aboriginal and Torres Strait Islander peoples were half as likely as non-Indigenous people (20% compared with 41%) to report an equivalised weekly household income of $1,000 or more, and more than twice as likely to live in a household with more than one family (5.1% versus 1.8%). Only 47% of Aboriginal and Torres Strait Islander peoples aged 20 to 24 years reported completing Year 12 (or equivalent) compared with 79% of non-Indigenous Australians (ABS, 2017).

Aboriginal and Torres Islander peoples in Sydney report a range of housing challenges (e.g. access, poor conditions, overcrowding) and link these to both poor physical health and social and emotional wellbeing (Andersen et al, 2016). For Aboriginal and Torres Strait Islander children, housing problems are associated with recurrent gastrointestinal infections (Andersen et al, 2018). Analyses of population health data from Victoria demonstrate that compared with non-Indigenous Australians, Aboriginal and Torres Strait Islander peoples experience lower socioeconomic status (unemployment and low income), lower social capital (e.g. inability to get help from family), and a higher prevalence of psychosocial risk factors (e.g. psychological distress, food insecurity, financial stress) risk behaviours (e.g. smoking, obesity, inadequate fruit and vegetable intake) and poor health (i.e. self-rated poor health, cancer, asthma, anxiety and depression) (Markwick et al, 2014).

In Aboriginal and Torres Strait Islander communities across the Northern Territory, Queensland and Western Australia, chronic kidney disease is associated with low socioeconomic status, unemployment, lack of home ownership and welfare (Ritte et al, 2017).

Racism is common for Aboriginal and Torres Strait Islander peoples and has dramatic health consequences. Compared with non-Indigenous adults, Aboriginal and Torres Strait Islander adults in Victoria are four times more likely to have experienced racism in the past year (Markwick et al, 2019). Experiences of racism lead to emotional, physiological and behavioural responses that include harmful health-related behaviours such as smoking and drinking (Ziersch et al, 2011). In Aboriginal and Torres Strait Islander youth, self-reported racism is associated with anxiety, depression, suicide risk and poor overall mental health (Priest et al, 2011). Systematic review evidence from international studies confirm the association between racism and poor general health, physical health and mental health (such as depression, anxiety, psychological stress) (Paradies et al, 2015). There is also evidence that racism negatively impacts social capital, since it creates psychological distress which limits the creation of social capital within peers and interracial networks (Brondolo et al, 2012). For urban-dwelling Aboriginal and Torres Strait Islander peoples in South Australia, racism and unequal access to wealth create barriers to bridging social capital (i.e. connections between Aboriginal and Torres Strait Islander groups) and linking social capital (i.e. connections between Aboriginal and non-Indigenous or mainstream groups). The health benefits of bonding social capital (i.e. connections within Aboriginal networks) are limited by stressful cultural demands and expectations (Browne-Yung et al, 2013). Considered together, these data demonstrate the great need for strengthened cultural awareness and competency across the Australian population to address the harmful effects of racism impacting Aboriginal and Torres Strait Islander peoples.

For Indigenous peoples internationally, social determinants of health features, including unemployment and low levels of education, negatively impact access to the health system (Davy et al, 2016). Practical barriers to access also exist for Aboriginal and Torres Strait Islander communities. In South Australia and New South Wales, driver's licenses are reported by only 51-77% of people and are associated with full time employment and educational attainment (Ivers et al, 2016).

### The Cultural Determinants of Health

It is evident throughout this chapter that culture is at the heart of ACCHO practice and is present throughout all activities to address the social determinants of health. ACCHOs provide opportunities for Aboriginal and Torres Strait Islander peoples to connect with the Aboriginal community through shared values, beliefs, world views and lived experiences, to heal, strengthen cultural identity and pride, and practice culture. There is widespread agreement that for Aboriginal and Torres Strait Islander peoples, health outcomes are greatly influenced by the 'enabling, protecting and healing aspects' (pg. 33) of culture that are critical in fostering resilience and contributing to Indigenous identity (Department of Health, 2015). The cultural determinants of health are promoted through 'traditional cultural practice, kinship, connection to land and Country, art, song and ceremony, dance, healing, spirituality, empowerment, ancestry, belonging and self-determination' (Department of Health 2017, p.7). Culture has been found to be the most prominent characteristic of Indigenous primary health care in a recent systematic review (Harfield et al, 2018). Community consultations on the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* also found that culture was the leading priority placed at the centre of change (Department of Health, 2017). A Roundtable on the cultural determinants of health, hosted by the Lowitja Institute, identified the need to 'advocate and lobby for the systems level changes that will strengthen culture and the cultural determinants of health' (Lowitja Institute 2014, p.6). It is evident in this chapter that the ACCHO sector is undertaking this advocacy work with state/territory and Commonwealth governments to highlight the importance of the cultural determinants of health. They are also working extensively to promote culturally safe environments, such as through cultural awareness training and cultural mentorship, to address the interpersonal and institutionalised racism experienced by their communities.

ACCHOs facilitate and strengthen the cultural determinants of health in multiple ways. The Tasmanian Aboriginal Corporation has a successful *rrala milaythina-ti* (meaning 'Strong In Country') program that began in 2017 and has enabled more than 200 community members to practice their culture in Country (Tasmanian Aboriginal Centre, 2018). The program provides opportunities to build strength and resilience through connecting with living culture, language and land. Activities include day trips through to extensive in Country camps and hikes over many days and provides community members with walking and camping equipment to address any barriers to access. *rrala milaythina-ti* is responsive to community identified priorities, is led by community, informed by community knowledge and represents shared power through participatory action research methods. The term 'in Country' was used in the project *'to show the complex interdependent relationship we have with our Country, and the way we draw strength from the Country and keep the country strong'* (Tasmanian Aboriginal Centre 2018, p.24). Participants of the program reported that *'the wellbeing of the whole community is strong when we are connected to our Country and to one another, and work together to achieve goals'* (Tasmanian Aboriginal Centre 2018, p.82).

### Addressing the social and cultural determinants of health

The importance of redressing health inequities by tackling the social and cultural determinants of health is well recognised at a national level. It is woven through key policy documents such as the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023* (Australian Government, 2015). The World Health Organisation's Conceptual Framework on the Social Determinants of Health highlights that real change can only be achieved by efforts that deliberately use intersectoral approaches to tackle the structural determinants of health (Solar and Irwin, 2010).

ACCHOs play a central role in combating the negative impacts of the social determinants of health. ACCHOs work closely with community to strengthen their social, economic and living circumstances by supporting access to social services such as Centrelink, housing, employment and training programs. The extensive efforts of ACCHOs to address the social determinants of health has been illustrated in a recent document review of ACCHO annual reports (Pearson et al, 2019). ACCHOs strive to provide transport, wherever possible, and minimise the out of pocket expenses of health care (Davy et al, 2016). ACCHO clients value the holistic and accessible nature of services, the welcoming and culturally safe spaces within ACCHOs, and the local Aboriginal and Torres Strait Islander staff (Gomersall et al, 2016).

The practical strategies outlined in this chapter demonstrate how ACCHOs act to tackle the structural determinants of health and the intermediary determinants of health. These efforts are often unfunded and well beyond the

expected scope of practice of a primary health care service. The key to achieving real change, however, are effective partnerships between Aboriginal and Torres Strait Islander organisations and advocates within governments and non-government organisations to collectively address the social determinants of health impacting Aboriginal and Torres Strait Islander peoples. This chapter highlights the need for greater resourcing of the ACCHO sector to support efforts to address both the social and cultural determinants of health impacting Aboriginal and Torres Strait Islander communities.

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# ACCHO Social Determinants of Health: Reflection Tool

The social determinants of health explain why there are health differences between people, communities and populations and include our life experiences, our place in society and features of the society itself. **Our life experiences** include our biology and behaviours, the environments we live and work in, who we connect and share resources with, and the health system we can access. These experiences are influenced by **our place in society** which includes our socioeconomic position, social class, gender, ethnicity, income, education and occupation. It is also influenced by **features of the society** we live in such as governance, policies (macroeconomic, social, public) and the values and culture of society.

ACCHOs work tireless to address the social determinants of health impacting their communities. They do **whatever is necessary** to support their clients by providing **seamless, integrated and multidisciplinary care** within their teams and by creating partnerships to assist clients to gain access to and navigate other services. ACCHOs ensure **culturally safe care** is provided and clients are supported to **make their own decisions** about the services they receive. This creates a one-stop-shop for community.

## ACCHO Approaches to the Social Determinants of Health Model

**Step 1. Consider the activities your ACCHO currently practises to address the social determinants of health.**

**Step 2. What other activities could your ACCHO consider in the future and what partnerships will be needed to achieve this?**

## Our life experiences: *intermediary determinants of health*

- ☐ We support clients and staff with their social, emotional and cultural wellbeing. We have a Social and Emotional Wellbeing Team that provides case management and supports clients to navigate other services.
- ☐ We promote healthy lifestyles relating to diet, exercise, smoking, alcohol and substance use.
- ☐ We promote food security and healthy eating behaviours.
- ☐ We support clients to improve their life circumstances through housing advocacy and home maintenance.
- ☐ We promote social wellbeing such as through a Men's Shed program, Women's programs and Elders group.
- ☐ We have a Grief and Loss Support Group to support clients on their healing journey.
- ☐ We are a welcoming community hub and provide social and cultural programs to unite communities.
- ☐ We promote access to health and social services through providing transport for clients.
- ☐ We form partnerships beyond the health sector and assist clients to navigate external health and social services.
- ☐ We advocate for culturally safe care in partner services to promote access for community. We have links to police and support clients to navigate child protection services and the justice system.

## Our place in society: *structural determinants of health inequity*

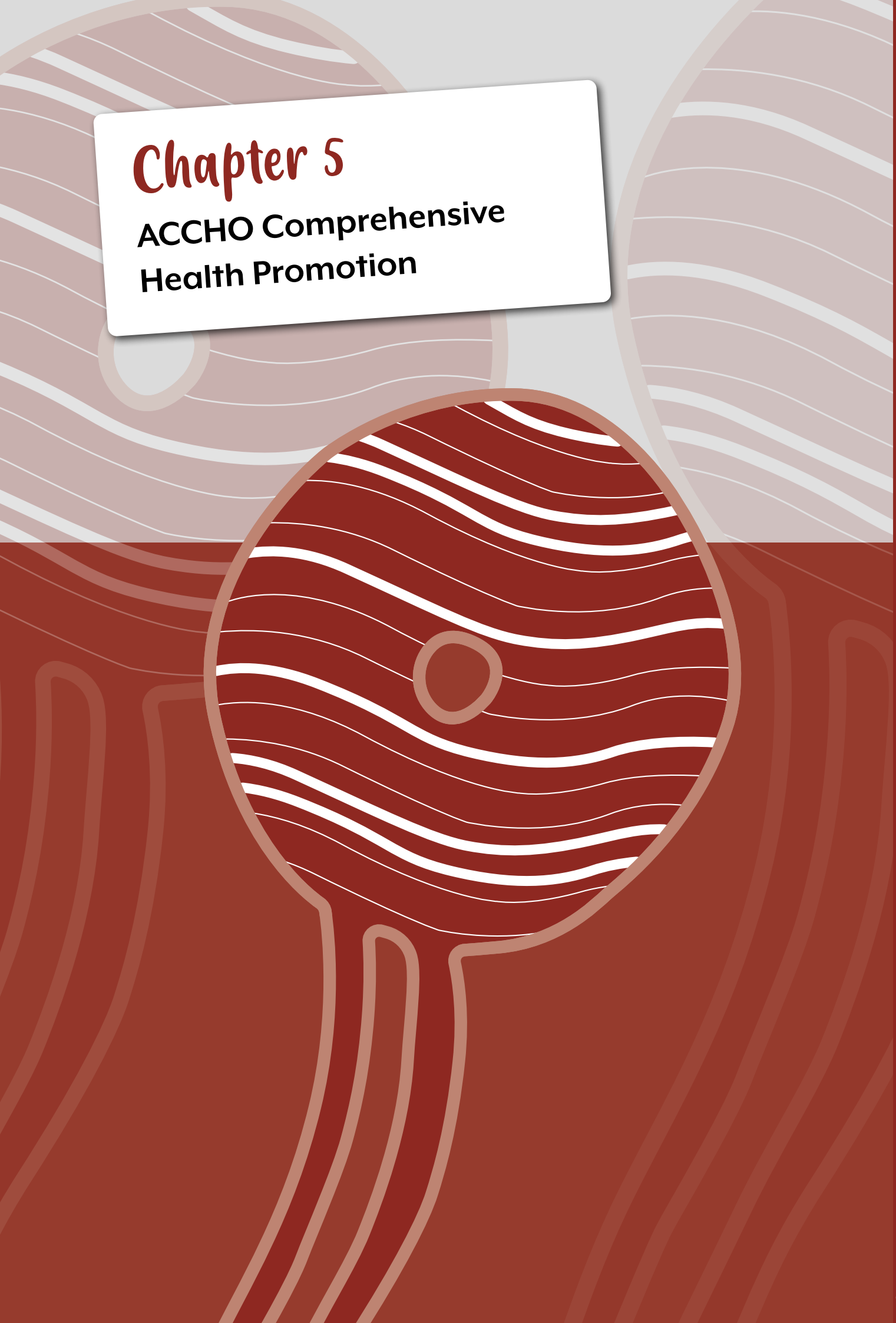
- ☐ We support clients to seek opportunities for education and employment including linking with the local TAFE to create traineeship opportunities for clients.
- ☐ We employ local Aboriginal and Torres Strait Islander peoples and provide opportunities for professional development.
- ☐ We support clients to access Centrelink payments and we have social marketing campaigns around good financial choices.
- ☐ We strengthen cultural pride and promote positive interactions between Aboriginal and Torres Strait Islander and non-Indigenous peoples through hosting celebrations that showcase local dancers, singers and artists (e.g. NAIDOC events).
- ☐ We combat racism by providing cultural safety training and cultural mentorship to visiting clinicians and to staff in partner services.
- ☐ We promote reconciliation through participating in Reconciliation Week events.

## Features of society: *structural determinants of health inequity*

- ☐ We advocate with local, state/territory and federal governments and peak bodies for public health and social policies that prioritise the needs of Aboriginal and Torres Strait Islander peoples.
- ☐ We write letters and contribute to submissions to lobby governments and provide recommendations to benefit our communities.
- ☐ Our leaders represent strong Aboriginal and Torres Strait Islander role models and contribute to positive societal views about our community.
- ☐ We link with our state/territory peak body to advocate for our sovereignty in governance.

# Chapter 5

## ACCHO Comprehensive Health Promotion



# ACCHO Comprehensive Health Promotion


## Summary

ACCHOs were established beginning in the 1970s to create primary health care services designed to meet the specific needs of Aboriginal and Torres Strait Islander peoples. In responding to community need, ACCHOs have been leaders in comprehensive health promotion practice over many decades. ACCHOs are culturally safe spaces where Aboriginal and Torres Strait Islander communities can access comprehensive primary health care. ACCHOs also promote cultural safety in mainstream services.

ACCHOs empower clients to manage their holistic health with self-determination. They strengthen and unite Aboriginal and Torres Strait Islander communities by providing a space where communities learn, grow, support, celebrate, heal and take action together. ACCHOs also take a lead role in advocating for public policies that achieve equity for Aboriginal and Torres Strait Islander peoples.


The content within this chapter was drawn from an in-depth case study with a Regional ACCHO that was reviewed and refined by the CREATE Leadership Group and strengthened with learnings and perspectives from the ACCHO sector nationwide.

### What we cover in this chapter:

## What is Health Promotion?

The Ottawa Charter for Health Promotion was developed by the World Health Organisation (WHO) in 1986 and describes health promotion as:

*'the process of enabling people to increase control over the determinants of health and thereby improve their health.'*[1]

Health promotion is not only focused on strengthening the skills and capabilities of individuals but is also directed at changing social, environmental and economic conditions that impact public and individual health.[2]

The Ottawa Charter provides a framework for implementing health promotion practice. It describes three key strategies (to advocate, mediate and enable) and outlines five health promotion action areas:

1. Reorienting Health Services
2. Creating Supportive Environments
3. Developing Personal Skills
4. Strengthening Community Actions
5. Building Healthy Public Policy

When all five action areas are addressed, this is described as comprehensive health promotion practice.

## Comprehensive Health Promotion in ACCHOs

While ACCHOs didn't always use the term 'health promotion,' they have been practicing comprehensive health promotion over many decades, and long before the five action areas of health promotion were described in the Ottawa Charter:

- ACCHOs are primary health care services designed (that is, oriented) to meet the specific needs of local Aboriginal and Torres Strait Islander peoples.
- ACCHOs are culturally safe spaces where Aboriginal and Torres Strait Islander peoples feel welcome and can access primary health care and other services addressing their holistic health needs. This care encompasses services to promote physical, social, emotional, cultural and spiritual wellbeing (that is, holistic health).
- ACCHOs don't tell people what to do, but rather empower clients through role modelling, mentoring and education to strengthen self-management skills, cultural pride and health knowledge and understanding.
- ACCHOs strengthen and unite Aboriginal and Torres Strait Islander communities by providing a space where communities learn, grow, support, celebrate, heal and take action together.
- ACCHOs take a lead role in advocating for and driving the development of public policies that can achieve equity for Aboriginal and Torres Strait Islander peoples.



[1]World Health Organisation. (1986). *Ottowa Charter for Health Promotion*. World Health Organisation, Geneva.
[2]World Health Organisation. (2016). *Health Promotion*. who.int/topics/health_promotion/en

Moving beyond the five action areas outlined in the Ottawa Charter, the five actions of comprehensive health promotion practice in ACCHOs are unique in that they are:

1. Focused on the needs of Aboriginal and Torres Strait Islander peoples.
2. Inherently grounded in Aboriginal and Torres Strait Islander ways of working.
3. Designed in response to the long history of systemic racism and exclusion experienced by Aboriginal and Torres Strait Islander peoples in mainstream health and social services.

Table 5 depicts the five action areas of comprehensive health promotion in ACCHOs matched against those outlined in the Ottawa Charter.

**Table 5: ACCHO Comprehensive Health Promotion action areas and the Ottowa Charter for Health Promotion action areas**

| ACCHO Comprehensive Health Promotion Action Areas | Description of the ACCHO Action Areas | Ottawa Charter for Health Promotion Action Areas |
|---|---|---|
| Primary health care designed by community for community | Orienting primary health care to meet community need: designed by community, for community. | Reorienting health services |
| Providing and promoting culturally safe spaces | Providing culturally safe spaces in the ACCHO and promoting cultural safe spaces in mainstream services. | Creating supportive environments |
| Strengthening cultural pride and personal skills | Strengthening cultural pride and personal skills through role modelling, mentoring and education. | Developing personal skills |
| Strengthening, empowering and uniting communities | Strengthening and uniting Aboriginal and Torres Strait Islander communities. | Strengthening community actions |
| Building equitable public policy | Advocating for and driving the development of public policies that achieve equity for Aboriginal and Torres Strait Islander peoples. | Building healthy public policy |

## Principles of comprehensive health promotion in ACCHOs

Threaded throughout the five action areas of ACCHO comprehensive health promotion are three guiding principles: a focus on strengthening self-determination, culture and holistic health. These principles are threaded through the five action areas of ACCHO comprehensive health promotion, as illustrated in Image 6 (over page).

### SELF-DETERMINATION

*ACCHOs value and enable self-determination by supporting clients to take control of their health and lives. ACCHO staff walk side by side with clients until they are ready to walk on their own.*

As Aboriginal community controlled organisations, ACCHO governance and service provision are driven by Aboriginal and Torres Strait Islander communities. ACCHOs do not tell clients what to do, blame clients for their health conditions, or pressure communities to reach standards of health primarily through disease treatment and management. They empower communities, place control in the hands of communities, and support communities to be self-determined in relation to their health and lives. This includes advocating for and mediating on behalf of clients with other services and service providers, and enabling clients to take control of their holistic health and wellbeing. In particular, ACCHOs play a crucial role in building the health knowledge and understanding of their local communities. Aboriginal and Torres Strait Islander staff are key translators in converting western medical concepts and terminology into language that can be easily understood by clients. In this way health knowledge and understanding enables heath equity, since it enables clients to confidently navigate mainstream health systems to address their health needs.



### CULTURE

*Promotion of culture is at the forefront of health promotion in ACCHOs. Cultural pride and identity are strengthened by ACCHOs to combat the negative impacts of colonisation and racism.*

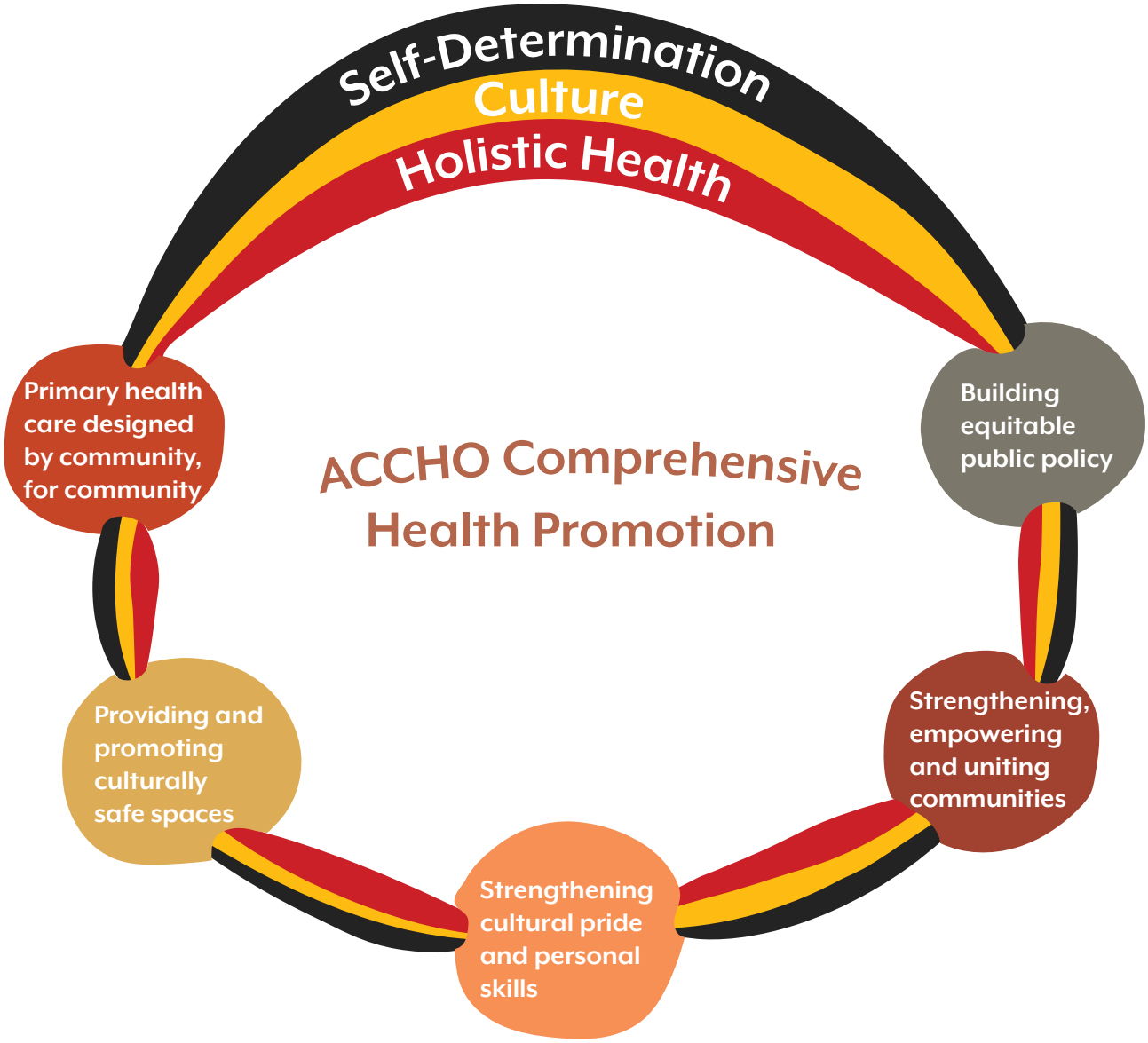
ACCHOs foster cultural pride and connection and create a welcoming space where community members can feel valued and safe. ACCHOs promote culture in everything they do and strengthen the cultural pride and identity of Aboriginal and Torres Strait Islander communities. They demonstrate valuing of cultural knowledge and cultural safety through employing Aboriginal and Torres Strait Islander staff who develop trusting relationships with community members. ACCHOs strengthen cultural knowledge through numerous cultural activities and cultural competency training. They support communities to manage the negative consequences of colonisation and marginalisation. They also promote healing through developing respectful relationships within the community and through providing positive interactions with Aboriginal and Torres Strait Islander peoples, breaking down racism, stereotypes and aiding reconciliation.

### HOLISTIC HEALTH

*ACCHOs focus on the promotion of holistic health, aligned with the Aboriginal definition of health.*

ACCHOs practise health promotion according to the holistic Aboriginal definition of health which includes cultural, physical, mental, spiritual, emotional and physical wellbeing. This holistic approach also considers the root causes of health inequities and risk behaviors, looking at factors that impact health such as income, housing, available resources, education, employment, living environments and health care access. In this way, ACCHOs undertake comprehensive health promotion that targets holistic wellbeing and the social determinants of health.

**Image 6: ACCHO Comprehensive Health Promotion Model**




**Model description**

The model depicts how comprehensive health promotion in ACCHOs is guided by the principles that include a focus on culture, holistic health and emowerment of community through self-determination. The five action areas include providing services that are designed by community, for community; providing and promoting culturally safe spaces; strengthening both cultural pride and personal skills; strengthening, empowering and uniting Aboriginal and Torres Strait Islander communities; and influencing the development of public policies that achieve equity for Aboriginal and Torres Strait peoples.

This model was developed through the CREATE project based on a case study with the ACCHO sector and consultations with the CREATE Leadership Group.

## ACCHO Action 1. Orienting primary health care to meet community need: designed by community, for community

**Primary health care designed by community, for community**

ACCHOs were established to provide targeted and tailored services to meet the needs of their local Aboriginal and Torres Strait Islander communities. Their unique and innovative primary health care model evolved from addressing service provision gaps in mainstream organisations. It was driven by an inherited responsibility to create better services and living conditions for local peoples, holding culture and community at the core. As an Aboriginal community controlled organisation, the strategic direction is led by a Board of Directors who represent and are elected by the local Aboriginal and Torres Strait Islander community. This model values a self-determination approach where the Aboriginal and Torres Strait Islander population lead decisions that affect their health. It also sees that culture is embedded throughout organisational operations and ensures a high level of community engagement in the design and delivery of culturally responsive services. Through a holistic health approach, ACCHOs act as a one-stop-shop and provide services directly through core service provision and indirectly through their investment in partnerships. They also advocate on behalf of their community for culturally safe services, workforce and environments within other health services and beyond (e.g. hospitals, specialist services, Centrelink) to adapt their models of care to better meet the needs of community members.

**The *Regional ACCHO* activities and approaches include:**

- Adopting a holistic Aboriginal definition of health.
- Addressing the cultural determinants of health.
- Multidisciplinary services to create a one-stop-shop for the community.
- Development of partnerships with other services that open channels beyond the health sector (e.g. housing, education, Centrelink, drug and alcohol, rehab facilities, local police).
- Employment of Aboriginal and Torres Strait Islanders staff increasing cultural safety of services.
- Provision of training and career development opportunities.
- Activities to enable the wellbeing and cultural safety of all staff.
- Advocating to other services, such as government departments, hospitals and specialist services, to adapt (that is, reorient) their models of care to better meet client needs.
- A focus on the promotion of health and prevention of illness rather than treatment of disease.

## ACCHO Action 2. Providing culturally safe spaces in the ACCHO and promoting cultural safe spaces in mainstream services

### Providing and promoting culturally safe spaces

Aboriginal and Torres Strait Islander peoples have long understood the connection between health, culture and land. ACCHOs create a supportive environment for Aboriginal and Torres Strait Islander peoples through the provision of a culturally safe place, located within the community, run by the community, and providing services for community. Culture is promoted to strengthen and build cultural pride. ACCHOs strive to provide a one-stop-shop where community can come to address all their holistic health needs. Aboriginal and Torres Strait Islander staff are also employed to ensure that community members are receiving culturally safe quality care. The creation of supportive environments also extends beyond the ACCHO through to partner organisations. ACCHOs advocate across sectors regarding cultural rights, values and expectations of their local Aboriginal and Torres Strait Islander communities increasing culturally safe spaces and workforce. Some ACCHOs provide extensive immersive cultural awareness training on Country for GP registrars, medical students and staff in mainstream health and other community organisations. ACCHOs also provide student placement opportunities such as for medical, nursing students and allied health professionals where students are mentored regarding cultural ways of working. In this way ACCHOs facilitate the development of culturally competent workforce and a culturally responsive health system.

**The *Regional ACCHO* activities and approaches include:**

- The service is a supportive community hub where culture is valued, promoted and respected.
- The service provides culturally safe services that aim to influence positive heath changes and empower community.
- ACCHO workforce includes Aboriginal and Torres Strait Islander staff and non-Indigenous staff who receive cultural safety training.
- Culture is celebrated through cultural days of significance where the strengths of local communities are showcased through hiring local professionals, businesses, celebrities, artists and dancers.
- Aboriginal and Torres Strait Islander languages are used to name the service, rooms and programs.
- Staff and leadership advocate for cultural safety across sectors to create culturally safe services and culturally competent workforce.
- Cultural competency training is provided for staff in other services to increase cultural competency and to create non-Indigenous champions to spread their gained cultural knowledge.

## ACCHO Action 3. Strengthening cultural pride and personal skills through role modelling, mentoring and education

### Strengthening cultural pride and personal skills

ACCHOs empower Aboriginal and Torres Strait Islander clients to better manage their holistic health and lives through strengthening life skills, health knowledge and understanding, cultural knowledge and pride. ACCHOs utilise several strategies to build the capacity of clients that go over and above building personal skills and include cultural activities and mentoring clients to better navigate complex mainstream systems and services. ACCHO staff use role modelling and mentoring to share their rich cultural knowledge and strengthen client self-management and life skills such as in relation to repayment of fines, budgeting skills, parenting skills, understanding legal documentation and responsibilities, employment and housing applications and training applications. When strengthening health knowledge, ACCHOs use methods that recognise oral and visual communication traditions and that accommodate diverse levels of understanding. ACCHOs also work with clients to strengthen knowledge of health and social service systems. Community engagement skills are developed through client participation in community consultations and tailoring of ACCHO programs, services and health promotion campaigns. Some ACCHOs facilitate day trips and camps on Country to support community members to practise culture and connect with other Aboriginal and Torres Strait Islander people. ACCHOs also develop the personal skills and cultural knowledge of their Aboriginal and Torres Strait Islander staff and non-Aboriginal staff through cultural activities and cultural awareness training.

**The *Regional ACCHO* activities and approaches include:**

- Clients are supported to develop health knowledge and management skills and empowered to make informed decisions about their holistic health.
- Services are tailored to community need and use cultural ways of working.
- Culture is practiced at community events to strengthen cultural participation and cultural pride.
- Clients are supported to confidently navigate mainstream systems and services through walking side by side, attending external appointments and/or advocating for clients with mainstream organisations.
- Programs are provided that aim to strengthen the life skills of clients (e.g. parenting, budgeting, management of fines, employment programs).
- Community are involved in designing and tailoring health promotion programs and events.
- Employment and training opportunities are provided to local community members.
- Staff and Board members act as role models and mentors.
- Clients are supported to improve health and wellbeing through specific lifestyle interventions such as smoking cessation and physical activity programs.
- Staff are supported to take control of their health through access to onsite services, leave policies and wellness programs.

## ACCHO Action 4. Strengthening, Empowering and Uniting Aboriginal and Torres Strait Islander communities

### Strengthening, empowering and uniting communities

ACCHOs bring their Aboriginal and Torres Strait Islander communities together to form a united voice. ACCHOs strengthen and unite communities by providing a space where communities learn, grow, support, celebrate, heal and take action together. ACCHOs strengthen communities by creating a place of belonging where the voice of local Aboriginal and Torres Strait Islander peoples strongly influences the design of holistic service delivery to meet local priorities and needs. Communities are involved in the design, development and implementation of strategies and programs. ACCHOs identify needs and priorities both through ongoing formal and informal feedback streams due to their strong links to communities. Community action is strengthened through activities that promote culture and holistic health. These approaches enable a sense of ownership and empower community members through actively taking part in the decisions and actions that affect their health.

**The *Regional ACCHO* activities and approaches include:**

- The service is a place of belonging where communities can feel safe and come together to take action.
- Community members are encouraged to become a member of the service and participate in AGMs, Board of Director elections and strategic planning.
- The service coordinates cultural groups (e.g. Men's Shed, Women's group, community lunches, youth camps, Elders group, Mums and Bubs groups).
- Celebration of days of cultural significance through community events, open days, health awareness days and family events (e.g. NAIDOC).
- Local people are employed and offered training opportunities.
- Community members are empowered through formal and informal engagement processes to provide feedback that tailors services to meet community needs.
- Community and staff are offered opportunities to participate in research.
- Local champions are utilised to promote their learnings and the programs available at the service.

## ACCHO Action 5. Advocating for and driving the development of public policies that achieve equity for Aboriginal and Torres Strait Islander peoples

### Building equitable public policy

ACCHOs influence the development of healthy public policy that is inclusive and addresses the priorities and needs of Aboriginal and Torres Strait Islander communities. ACCHOs undertake extensive advocacy work and intersectoral action at local, regional, state/territory and national levels. This drives the agenda of Aboriginal and Torres Strait Islander health and wellbeing across all sectors. In this way, ACCHOs hold other sectors accountable to their responsibilities to the Aboriginal and Torres Strait Islander population. Through their extensive engagement in research and evaluation activities, ACCHOs contribute to the generation of evidence to support the development of evidence-based policy.

**The *Regional ACCHO* activities and approaches include:**

- Staff and leadership advocate at the local, state/territory and national levels (e.g. PHNs, local councils, government departments) to influence the development of healthy public policy that aligns with the priorities of local communities.
- Collaborative relationships are built with other Aboriginal health services within the region and across the state/territory to enable coordinated care approaches for communities.
- Staff and leadership provide advice to partner organisations on cultural policies and strategies for Aboriginal and Torres Strait Islander peoples.
- Advice, support and direction is provided to partner organisations through staff participation on committees and working groups (e.g. local hospitals, PHN's, peak bodies and national bodies).
- The service participates in research that contributes to the development of evidence to promote policy change.

## Focus areas of ACCHOs Comprehensive Health Promotion

ACCHO health promotion activities focus on **communities, staff** and on building and maintaining **partnerships** with other services.

*The Regional ACCHO* focuses their comprehensive health promotion approach on the community, staff and partnerships as described below.

**Communities:** All health promotion efforts are designed to address local needs and priorities. The service empowers Aboriginal and Torres Strait Islander peoples to live strong healthy lives enriched through their connection to culture and land. Community members are involved in strategic planning and the development and evaluation of programs and services.

**Staff:** The service promotes healthy, culturally strong Aboriginal and Torres Strait Islander staff, and culturally aware non-Indigenous staff, who are accountable and are empowered to tailor services to meet local needs.

**Partnerships:** The development of accountable relationships with partner organisations enables the development of supportive environments beyond the ACCHO and increases access for clients to other health and social services. These partnerships also enable a more coordinated and collaborative local health and social services system.

## Outcomes of ACCHO Comprehensive Health Promotion

- Promotion of rich local Aboriginal and Torres Strait Islander culture.
- Strengthened cultural pride and cutural capacity of Aboriginal and Torres Strait Islander peoples.
- Promotion of healthy interactions between Aboriginal and Torres Strait Islander and non-Indigenous peoples and organisations (bringing two worlds together).
- Promotion of healthy inclusive communities.
- Promotion of holistic health including links to culture and land.
- Promotion of a healthy workplace and workforce.

## Enablers of the approach

- Strong ACCHO leadership and staff with local cultural knowledge and connections who are respected by their communities.
- Leadership and staff with extensive networks across sectors, and who undertake multi-level advocacy on behalf of communities.
- Difficult decisions are made in the best interests of the ACCHO (e.g. redistribution of funding, holding staff accountable, working only with partners that share a commitment to community).
- Multiskilled and qualified workforce who care about the Aboriginal and Torres Strait Islander communities and invest in developing respectful relationships with clients.
- United workforce ('like a family').
- Willingness and flexibility of clinical staff to operate under a holistic health approach.
- Effective relationships within and across teams and clear communication pathways enable staff to refer clients between clinic and community programs and share client responsibility across teams.
- Trust from communities enables an ongoing two-way process that ensure local priorities, culture and needs are being acknowledged, advocated for and addressed.
- ACCHOs drive, develop, maintain and hold partners accountable to addressing health inequities.

## Challenges to the approach

### Funding challenges

- Commonwealth funding mechanisms, reporting and KPI's don't support or reflect comprehensive health promotion practices.
- Funding for health promotion activities in ACCHOs is often short term, limited to the Tackling Indigenous Smoking program and other programs associated with risk behaviours, insufficient to employ qualified health promotion officers, and does not cover program evaluation.
- ACCHOs often have to compete for funding of health promotion initiatives with non-Indigenous organisations.

### Establishing partnerships and keeping partnerships accountable

- Establishing and maintaining partnerships takes significant time and investment and can be slow. At times ACCHO staff engage partner organisations in relation to client needs to hold partners accountable.

### Balancing self-determination and reliance

- Finding the balance between empowering clients to be self-reliant rather than relying on the service while maintaining community trust in the service.

### Community privacy and participation

- Participation by community is key to comprehensive health promotion activities. Community attendance is challenged at times due to life circumstances or competing demands, which can undermine engagement.
- Client privacy can be challenging when the ACCHO is a community hub. To ensure privacy of clients, ACCHOs consider more private access doors for clinics that are separate from the main entrance.

### Workforce Challenges

- ACCHO workforce challenges include staff turnover, challenges in achieving gender balance, and a lack of Aboriginal and Torres Strait Islander staff.

## Recommendations

### Recommendations for ACCHOs

- Undertake health promotion workshops for staff to understand how health promotion is embedded across ACCHO programs and services, and build the capacity of staff using health promotion terminology.
- Undertake succession planning to maintain staff capacity in comprehensive health promotion knowledge and activities.
- Provide training for staff regarding how best to evaluate health promotion activities (i.e. how to capture and utilise health promotion evaluation data).

### Recommendations for Peak Bodies

- That NACCHO develop a Framework for ACCHO Comprehensive Health Promotion to capture the outstanding contribution of and set future directions for Aboriginal community-controlled health organisations.

### Recommendations for Policy Makers

- Commonwealth and state/territory governments to allocate sufficient and flexible funding towards comprehensive health promotion activities in Aboriginal community controlled organisations that reflect the real time and personnel cost.
- Consult with Aboriginal and Torres Strait Islander peak bodies regarding comprehensive health promotion priorities.
- Acknowledge the comprehensive health promotion practice of ACCHOs embedded within their comprehensive primary health care service delivery model.
- Allocate funding to build a qualified Aboriginal and Torres Strait Islander workforce to undertake comprehensive health promotion in ACCHOs.
- Allocate specific and adequate funding and resources for appropriate evaluation of all comprehensive health promotion activities.

## Discussion

ACCHOs enact comprehensive health promotion as it was intended through enabling, mediating and advocating for community and by addressing five health promotion action areas targeted to the needs of their communities. This is in contrast with other health promotion programs which have been criticized for their focus on individuals and behaviours rather than on the creation of supportive environments and health services that enable individuals to take control of their health and lives (McPhail-Bell et al, 2015). The five action areas of comprehensive health promotion are embedded within and across ACCHO programs and services in such a way that ACCHO staff can find it difficult to identify and articulate their health promotion approach. Health promotion terminology often doesn't resonate with ACCHO staff, who see their enactment of the five health promotion actions as routine ACCHO service provision intended to support community to address their holistic health needs. In fact, ACCHO staff often describe their health promotion activities as limited to disease awareness days, cultural celebrations, social marketing methods, community groups and the Tackling Indigenous Smoking (TIS) program. Analysis of programs and services however clearly illustrates the many ways in which ACCHOs undertake comprehensive health promotion to enable clients to take greater control of their health, and the determinants of their health.

Key to implementing comprehensive health promotion in ACCHOs is an understanding of the social determinants of health. These include 'the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life' that include factors such as socioeconomic position, societal values, racism and social policies (WHO, 2018). Systems level factors are of significance in the context of colonized Australia where Aboriginal and Torres Strait Islander peoples have long experienced racism and marginalization and faced numerous barriers to accessing mainstream health and social services. Understanding this, ACCHOs invest in building strong relationships with partners to combat racism and reorient health and social services to better meet community needs. They also work closely with community to strengthen their social, economic and living circumstances by supporting access to social services such as Centrelink, housing, employment and training programs. The extensive efforts of ACCHOs to address the social determinants of health has been illustrated in a recent document review of ACCHO annual reports (Pearson et al, 2020).

The ACCHO comprehensive health promotion model outlined in this chapter is centered upon culture and the strengthening of cultural identity and pride. This is consistent with systematic review evidence which found that culture was at the center of all ACCHO primary health care service delivery (Harfield et al, 2018). It is similarly consistent with the findings of community consultations on the National Aboriginal and *Torres Strait Islander Health Plan 2013-2023* which yielded seven priority areas and placed culture at the center of change (Department of Health, 2017). Aboriginal and Torres Strait Islander peoples and communities have long known the importance of culture as a determinant of health and wellbeing. Government departments are increasingly recognising that the cultural determinants of health promote resilience, foster identity and support holistic wellbeing. The cultural determinants of health are promoted through 'traditional cultural practice, kinship, connection to land and Country, art, song and ceremony, dance, healing, spirituality, empowerment, ancestry, belonging and self-determination' (Department of Health 2017, p.7). As a cultural hub, ACCHOs positively impact the cultural determinants of health for both community and staff. In this way, services positively contribute to the promotion of the 'enabling, protecting and healing aspects' of culture that are critical in fostering resilience and contributing to Indigenous identity (Department of Health, 2015). The importance of traditional knowledge and caring for country as upwards factors enabling Aboriginal wellbeing and mitigating against racism, colonisation and the loss of traditional cultural knowledge is also highlighted in the *Exploratory Framework for Aboriginal Victorian peoples' wellbeing* (Kingsley et al, 2013).

ACCHO staff consistently speak about the importance of supporting community to make their own decisions and determine their own health and lifestyle priorities. McPhail-Bell et al (2015) describe how health promotion is oftentimes actioned in a top-down paternalistic manner of telling community what is good for them and what behaviours to avoid. Poor lifestyle choices undeniably impact health and can influence health issues such as diabetes, obesity, cardiovascular disease and cancer. However, McPhail-Bell and colleagues (2015) highlight that health promotion programs focused on individual

risk behaviours can have an undertone of telling people what to do without consideration of the cultural and social determinants of health and the underlying causes of risk behaviours. In contrast, ACCHOs practise health promotion consistent with the call to action for 'emancipatory health promotion practice' envisioned by McPhail and colleagues (2015). Emancipatory health promotion is 'capable of resisting entrenched individualism, which stigmatises those who 'fail' in their citizenry duty to 'be healthy'' (p. 198) and values the 'promotion of freedom and liberation, including from health promotion interventions that undermine individual and community control and agency' (p.198). With self-determination as a core principle underlying their approach, ACCHOs showcase how health promotion practice can be liberating and empowering rather than dictatorial.

ACCHOs invest strongly in the development of respectful relationships with partner organisations including with other health services (e.g. hospital, other ACCHOs) and a range of human and social services' (e.g. justice, housing). There are times when partner organisations lean too heavily on ACCHO staff to do their work rather than upholding their responsibility to support community with their social and human services' needs. At these times ACCHOs work with partners to keep them accountable. Challenges to the development of partnerships between Aboriginal community controlled and mainstream services have been described (Taylor et al, 2013). Successful partnerships between ACCHOs and mainstream health services are established and maintained by addressing tensions early, building trust and through leadership. The benefits of effective partnerships include broadening service capacity and improving the cultural security of healthcare (Taylor and Thompson, 2011).

In summary, ACCHOs practise comprehensive health promotion centered upon culture and holistic health and actioned through a self-determination model. The first ACCHO was established in Redfern in 1971, many years before the Ottawa Charter for Health Promotion was developed in 1986. As such, ACCHOs were orienting health services, creating culturally safe environments, uniting communities, empowering clients and advocating for more equitable public policy long before the five actions of health promotion were ever articulated. The ACCHO sector should be recognized for the extensive and comprehensive health promotion activities that many ACCHOs undertake to promote health and the determinants of health in Aboriginal and Torres Strait Islander communities across Australia.

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# ACCHO Comprehensive Health Promotion: Reflection Tool

Comprehensive health promotion in ACCHOs includes five actions guided by a focus on culture, holistic health, and empowerment of community through self-determination. ACCHOs are culturally safe spaces where Aboriginal and Torres Strait Islander communities can access comprehensive primary health care. ACCHOs also promote cultural safety in mainstream services and empower clients to manage their holistic health with self-determination. They strengthen and unite Aboriginal and Torres Strait Islander communities by providing a space where communities learn, grow, support, celebrate, heal and take action together. ACCHOs also take a lead role in advocating for and driving public policies that achieve equity for Aboriginal and Torres Strait Islander peoples.

**Step 1. Consider the activities your ACCHO currently practises under the five action areas.**

**Step 2. What other comprehensive health promotion activities could your ACCHO consider in the future and what partnerships will be needed to achieve this?**

## ACCHO Comprehensive Health Promotion Model

## Primary health care designed by community for community

- [ ] Our local communities are involved in identifying holistic health priorities and in tailoring our culturally responsive services including the design of health promotion programs and community events.
- [ ] We provide a holistic flexible service supportive of Aboriginal and Torres Strait Islander ways of working (e.g. transport, drop in appointments, home visits, longer appointment times).
- [ ] We offer multidisciplinary services to create a one-stop-shop for the community.
- [ ] We promote client self-determination, hold culture at the core, adopt an Aboriginal definition of health, and address the cultural determinants of health.
- [ ] We develop partnerships with other services to enable clients to access services beyond the health sector (e.g. housing, education).
- [ ] We advocate on behalf of our clients with other services such as hospitals and specialist services, to adapt (that is, reorient) their models of care to better meet client needs.

## Providing and promoting culturally safe spaces

- [ ] Our service is a supportive community hub where culture is valued, promoted and respected.
- [ ] We provide a culturally safe environment that influences positive heath changes and empowers community.
- [ ] We celebrate culture through Aboriginal days of significance and showcasing the strengths of the Aboriginal and Torres Strait Islander community through hiring of local professionals, businesses, celebrities, artist, dancers.
- [ ] We use Aboriginal or Torres Strait Islander languages to name the service, rooms and/or programs.
- [ ] We employ Aboriginal and Torres Strait Islander staff to provide culturally safe quality care.
- [ ] We provide cultural safety training for our staff and advocate for cultural safety across sectors.
- [ ] We provide cultural competency training for staff in other services to increase cultural competency across organisations.

## Strengthening cultural pride and personal skills

- [ ] We strengthen the health knowledge and management skills of our clients and empower them to make informed decisions about their holistic health.
- [ ] We practice culture at community events to strengthen cultural participation and cultural pride.
- [ ] We strengthen the capacity of our clients to confidently navigate mainstream systems and services through walking side by side, attending external appointments and advocating for clients with mainstream organisations.
- [ ] We provide education and services that strengthen the life skills of clients (e.g. parenting, budgeting, management of fines, employment programs).
- [ ] As a registered training organisation we offer accredited training programs to community members.
- [ ] We support clients to improve health and wellbeing through specific lifestyle interventions such as smoking cessation and physical activity programs.
- [ ] We support our staff to take control of their health through access to onsite services, leave policies and wellbeing programs.
- [ ] Our staff members and Board of Directors are role models and mentors for our communities.

## Strengthening, empowering and uniting communities

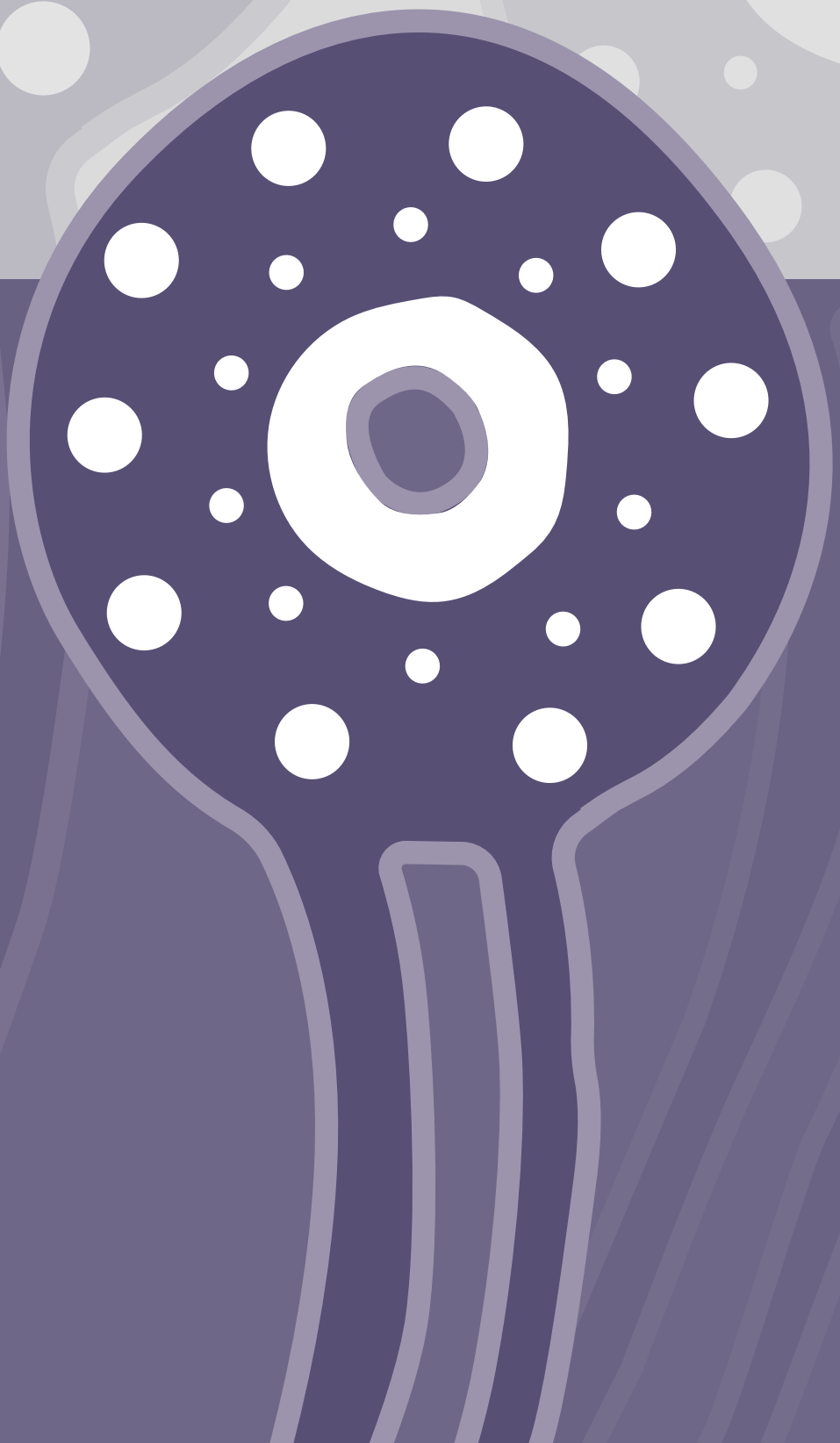
- [ ] We create a place of belonging where our communities feel safe and come together to take action.
- [ ] We are a member service where community members can be involved in Annual General Meetings, Board of Director elections and strategic planning.
- [ ] We strengthen community through the coordination of cultural groups (e.g. Men's Shed, Women's group, community lunches, youth camps, Elders group).
- [ ] We promote and celebrate days of cultural significance through community events, open days, health awareness days and family events (e.g. NAIDOC).
- [ ] We empower community members through formal and informal engagement processes to provide feedback that tailors our services to meet community needs.
- [ ] We empower local Aboriginal and Torres Strait Islander peoples through employment and training opportunities.
- [ ] We provide opportunities for community and staff to participate in research.
- [ ] We utilise local champions to promote their learnings and the programs available at our service.

## Building equitable public policy

- [ ] We advocate for our community at the local, state/territory and national levels (e.g. PHNs, local councils, government departments) to influence the development of healthy public policy that is inclusive, equitable and aligns with the priorities of our people.
- [ ] We build collaborative relationships with Aboriginal health services within the region and across the state/territory to enable coordinated care approaches for our communities.
- [ ] We provide advice to partner organisations on cultural policies and strategies for Aboriginal and Torres Strait Islander peoples.
- [ ] We participate in research projects and contribute to the development of evidence that can promote policy change.
- [ ] We provide advice, support and direction to partner organisations through staff participation on numerous committees and working groups (e.g. local hospitals, PHN's, peak bodies and national bodies).

# Chapter 6

## Caring for Elders in practice: Aged Care in ACCHOs



# Caring for Elders in practice: Aged Care in ACCHOs


## Summary

Aboriginal and Torres Strait Islander peoples are living longer and there are growing numbers of Elders requiring aged care services. Aboriginal community controlled services are best positioned to provide aged care services since they understand the unique needs of Elders, are connected to community and can provide culturally-centred care.

This chapter describes how ACCHOs can integrate aged care services within their comprehensive primary health care model. It details the steps ACCHOs can take to determine whether they can take on aged care service provision, and the process of integrating aged care with primary health care. It also provides information about the aged care funding currently available in Australia.


The content within this chapter was drawn from two in-depth case studies including with a metropolitan ACCHO and a metropolitan Aboriginal community controlled aged care service, and was refined by collective input from the CREATE Leadership Group to include perspectives from the ACCHO sector nationwide.

### What we cover in this chapter:

## Introduction to Aged Care

### Elders and Aged Care

Aboriginal and Torres Strait Islander peoples are living longer and there are a growing number of Elders[1]. Aboriginal and Torres Strait Islander Elders play an important role in the lives of local communities as knowledge holders, storytellers, family connectors and trail blazers who fought to bring about equity and social justice to enable better living conditions for generations to come. Elders can access aged care services through Aboriginal community controlled organisations, where available, and through mainstream aged care services.

### Aboriginal community controlled aged care service provision

In many jurisdictions around Australia there are ACCHOs who provide primary health care to Elders. ACCHOs understand the unique challenges their Elders face and strive to reduce barriers to access to ensure their Elders receive quality culturally safe care and can stay in their homes for as long as possible. Some ACCHOs have taken the steps to secure funding to become aged care service providers. ACCHOs are well positioned to provide aged care services as they are already connected to Elders through providing holistic primary health care. Around Australia there are also stand-alone Aboriginal community controlled aged care organisations that provide aged care services including residential care.

### Aged Care funding

Non-residential aged care in Australia is funded through several programs including the Commonwealth Home Support Program, Home Care Packages, and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These are outlined in the Appendix at the back of this Chapter.

## Principles of Aged Care Service Delivery

Aboriginal community controlled organisations provide aged care services in line with the following principles:

- **Connection with Elders and communities:** the aged care service actively builds and maintains relationships with Elders, their families and communities so they can understand the needs of Elders and support Elders to maintain connections with community.
- **Culturally safe care:** all service provision is respectful of traditional customs, values and beliefs and is guided by strong Aboriginal governance and enabled through cultural safety training for all staff.
- **Respect for self-determination:** clients are supported to make their own decisions.
- **A focus on holistic wellbeing:** supporting Elders with their physical, social, emotional cultural wellbeing needs.
- **Tailored services:** care is tailored to the holistic needs of Elders.
- **Credibility:** staff do what they say they are going to do and are clear about what they can't do.
- **Willingness to go the extra mile:** aged care staff have a fundamental compassion for Elders and a willingness to do whatever it takes to support Elders with their holistic needs.

[1]The term Elder (with a capital E) is used respectfully throughout this chapter and resource to refer to all older Aboriginal and Torres Strait Islander peoples aged 50 years and above, including but not limited to those who are recognised knowledge holders in their communities.

## ACCHO Aged Care service provision

Across Australia, ACCHOs have always supported Elders through culturally responsive holistic services such as health clinics, allied health services, community programs, Elders groups, assistance with transport and support to attend community events. Within their capacity, ACCHOs have also supported Elders to navigate external services and sectors to meet their needs including through providing outreach services to Elders living in residential aged care services.

There are several ACCHOs that have integrated aged care service provision within their comprehensive primary health care model based on community need and enabled through funding opportunities.

The *Metro ACCHO* decided to seek aged care funding and integrate aged care services into their comprehensive primary health care model. Prior to taking on aged care funding, the ACCHO provided primary health care through the health clinic and provided transport, allied health services, an Elders group and support for their Elders in mainstream residential aged care. After integrating aged care, the Metro ACCHO was able to offer two additional services to Elders including home care services and day respite care.

### Referral to the Aged Care Team

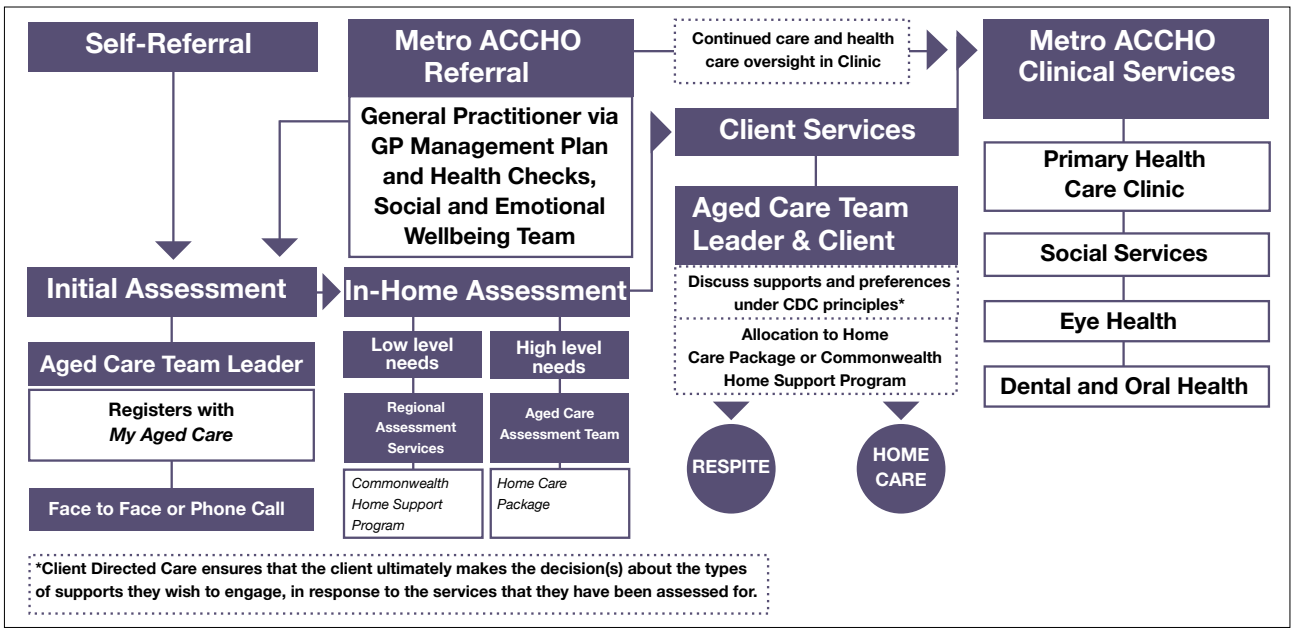
ACCHOs establish referral pathways to their Aged Care Team from their health clinics and community programs (e.g. the Social and Emotional Wellbeing Team). Elders can also self-refer directly to the Aged Care Team. The Aged Care Team reduces the complexities for Elders as they provide support with navigating the aged care system. An example of an ACCHO aged care referral flow chart is presented in Image 7.

### Registration via the My Aged Care portal

The ACCHO Aged Care Team can support Elders to register for aged care services through the *My Aged Care* portal. *My Aged Care* is an external online and phone-based aged care information portal used to register Elders for aged care and manage assessments and referrals (myagedcare.gov.au). All eligible Elders need to be registered with *My Aged Care* to receive services through the *Commonwealth Home Support Program* and *Home Care Packages*.

At the *Metro ACCHO*, the GP's, Aged Care Team Leader, Regional Assessment Team and Registered Nurse all have access to the *My Aged Care* portal to support the referral and assessment processes for Elders.

**Image 7: The Aged Care Referral Flow Chart**



### In-home Assessments

The Aged Care Team can support Elders to seek assessments through the Regional Assessment Service and Aged Care Assessment Team. The Regional Assessment Service undertakes in-home assessments to determine eligibility for the *Commonwealth Home Support Program* (note: this is low level need). This process assesses Elders' abilities in relation to mobility, transport, medical needs, supports, fragility and social networks. If the Elder has high level needs, the Aged Care Team will make a referral through the *My Aged Care* portal for an assessment through the Aged Care Assessment Team to determine eligibility for a *Home Care Package*.

### Aged Care Plans and Services

Aged Care Team Leaders can yarn with Elders to create an Aged Care Plan based on their needs and preferences. This plan can include a range of home care services and day respite services, depending on the needs of the Elder.

#### Home Care Service

Services provided to Elders in the home can include low-level care funded through the *Commonwealth Home Support Program* and high-level care funded through *Home Care Packages*. Services can include personal care, clinical care, domestic assistance, home maintenance, social support and transport. Elders also recieve advocacy and support to assist them in navigating the aged care system. The level of care provided is determined through the criteria of the aged care funding programs the Elder is eligible to receive. Elders approved for a *Home Care Package* are placed on a national queue until a package becomes available. Examples of home care services are included in Table 6.

**Table 6: Examples of Home Care Services**

| Clinical Care | House Hold Duties |
|---|---|
| • Nursing and allied health services | • Cleaning<br>• Lawn mowing<br>• Home modifications |
| **Personal Care** | **Transport** |
| • Showering<br>• Dressing<br>• Mobility support | • Transport to appointments, events and to attend the Day Respite centre |

#### Day Respite

Day Respite services provide a space for Elders to connect with other community members and provide a break for the carers of Elders. Day respite can include an extensive program of services, as described in Table 7.

The *Metro ACCHO*, Elders are provided with transport to and from the centre in addition to morning tea and lunch. A monthly program of respite activities is made available to all Elders, carers and families. The *Metro ACCHO* found verbal promotion as the most effective promotion approach for their Day Respite program.

**Table 7: Examples of Day Respite Services**

| Respite Service availability |
|---|
| • Monday-Friday respite<br>• Saturday respite (monthly basis)<br>• Overnight Trips<br>• Annual 4 -day holiday |
| **Activities** |
| • Theme Days<br>• Guest Speakers<br>• Outings<br>• Entertainment<br>• BBQs<br>• Painting and Weaving<br>• Bingo, Cards and Board Games<br>• Indoor Bowls<br>• Shopping Trips<br>• Computer lessons |
| **Clinical Care and Guest Speakers** |
| • Diversional Therapist Activities<br>• General Practitioner (fortnightly basis)<br>• Podiatrist (every 6 weeks)<br>• Physiotherapist, Dietitian, Occupational Therapist, Nutritionist (as needed)<br>• Continence Assessment and Hearing Tests<br>• Aged and Disability Advocacy<br>• Vision Australia, Alzheimer's Australia |

### Community Visitor Schemes

Aged Care Teams seek to connect with Elders across the community including those who live in mainstream residential facilities or who live at home. They can establish community visitor schemes including recruiting volunteers who connect with Elders.

### Residential aged care

Some services can provide 24-hour residential aged care services to Elders and support for their families. Residential aged care facilities can provide extensive services such as personal care, nursing, physiotherapy, podiatry, pet therapy, emotional and social wellbeing programs, palliative care, respite care, traditional medicine, advocacy and support. The service ensures there are clear internal and external referral pathways and support for when their Elders needs to access mainstream services.

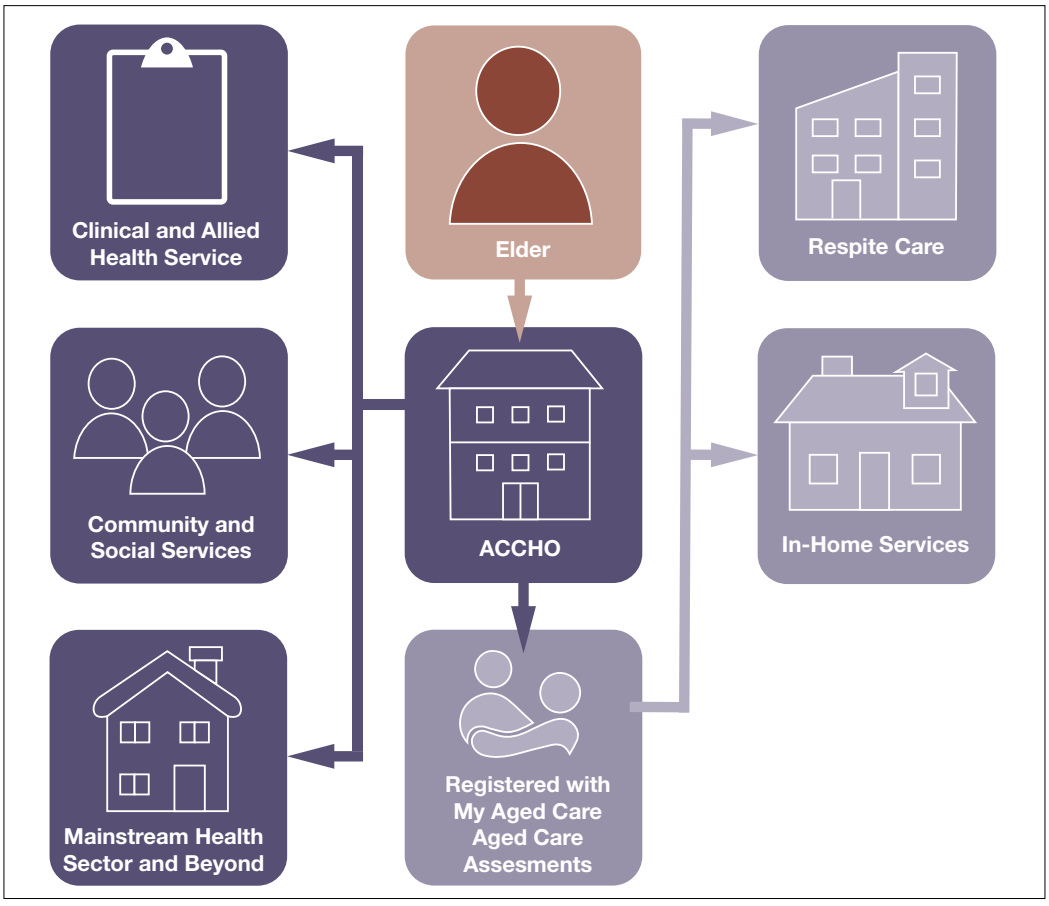
## Coordinating care between the ACCHO Clinic and Aged Care Teams

Integration of aged care enables Elders to access both holistic primary health and aged care services through the ACCHO as a one-stop-shop, as depicted in Image 8. This results in a continuous and coordinated care model which provides seamless pathways for Elders to access services across their holistic health and aged care needs. Care coordination is provided to Elders through the work of the Clinic and Aged Care Team and managed through informal yarns and formal case conferences. These meeting are attended by key personnel providing services to the Elders such as Aged Care workers, GPs, Aboriginal Health workers and Allied Health workers. Elders attend case conferences to be actively involved in decision making.

## Maximising services to Elders through funding coordination

ACCHOs supports Elders to direct their own care and get the most out of the funding available to them. This is achieved through maximising both MBS funding opportunities (e.g. allied health visits through their GP Management Plan) and funding available through their aged care package. This ensures Elders receive ongoing services (e.g. allied health, transport) without having to navigate the complexities associated with managing multiple sources of funding.

**Image 8: ACCHO integrated holistic health and aged care services**



## Aged Care Planning in ACCHOs

ACCHOs can undertake several external and internal mapping exercises to determine their readiness to integrate aged care services.

### External Mapping exercises

ACCHOs can undertake external mapping exercises to identify community need, to determine aged care service gaps within the local region, to identify the current and potential aged care workforce, and to envision what Aboriginal community controlled aged care service provision could look like in practice.

#### Consultations with Elders

ACCHOs can consult with Elders about their experiences accessing aged care services including the factors that support and challenge access. They can ask Elders about their knowledge of aged care services and the extent of services currently received. They can undertake broad consultations including with Elders accessing the health clinic, Elders currently receiving aged care and Elders within local residential aged care facilities.

#### Mapping Existing Aged Care Services

ACCHOs can collate information on aged care service providers in the region including where they are located and the number of Elders currently receiving services.

#### Mapping Aged Care Workforce

ACCHOs can examine the number of qualified aged care workers in the region and consider the number of community members currently providing unpaid aged care services as family members and carers.

#### Visiting an ACCHO already providing aged care services

ACCHOs can benefit from visiting other services already providing aged care, including interstate services.

### Internal Mapping Exercises

#### Desktop Audit

ACCHOs can undertake a desktop audit to identify Elders already receiving services within their organisation and those who are potentially eligible to receive aged care services. The patient management system can be used to collate data on the numbers of Elders, their locations and the services they access.

#### Aged Care Scoping Review

To determine their readiness to provide aged care, ACCHOs can undertake an aged care scoping review that explores domains such as quality, accreditation, funding, data and reporting systems, as described in detail in Table 8.

#### Financial modelling

ACCHOs can use financial models to help decide whether to take on aged care service provision. Support for this financial modelling can be requested from state and territory peak bodies. To build a financial model, ACCHOs can look at demographic data from their patient management system and other sources including the number and anticipated care needs of Elders in the region. Second, they can estimate the potential income that could be sought for these Elders through available aged care funding programs (i.e. *Commonwealth Home Support Program*, *Home Care Packages*, and *National Aboriginal and Torres Strait Islander Flexible Aged Care Program*). Next, the anticipated expenditure associated with providing aged care services can be estimated. Finally, a financial model can be built that compares the potential income with anticipated expenditure related to aged care service delivery. This model can assist services to determind whether it would be financially viable to take on aged care.

**Table 8: Aged Care Scoping Review**

| | |
|---|---|
| **Quality Care** | • What does our organisation already know about providing quality care to Elders and what continuous quality improvement processes are required to ensure an ethical process in caring and servicing Elders? |
| **Accreditation** | • What state and national accreditation Standards are required to provide aged care? |
| **Applying for Aged Care funding** | • What finance staff will be needed to support the additional finance management burden, including applying for and managing funding associated with aged care service provision? |
| **Recording and Reporting systems** | • What computer programs/software will be required to support the recording and reporting of aged care services?<br>• Will our current clinical/client database system be able to communicate with the aged care software?<br>• Who will need to be trained in utilising the new system? |
| **Clinic readiness** | • Is the clinic well-established and in a position to grow?<br>• Is the service currently drawing sufficient MBS income?<br>• Is the clinic in a position to provide additional services and accommodate potential growth due to aged care service demands?<br>• What will our organisation need to do to prepare, inform and provide support to clinic staff throughout the integration of aged care services?<br>• What will our referral pathway for aged care look like and how will aged care be linked into our clinic services? |
| **Aged Care policies and procedures** | • What aged care policies and procedures will our organisation require that support the provision of aged care services? |

The *Metro ACCHO* undertook external and internal mapping exercises and decided there was a need to improve aged care for Elders in their region and that they were in a strong position to do so.

The external mapping exercises identified a high number of Elders living within their region (and a projected growth in the coming decade), that Elders weren't receiving culturally responsive aged care services, and that there were many barriers and challenges for Elders in accessing services. The external mapping exercise also identified the regions in greatest need. The visit to an interstate ACCHO that offered aged care services provided valuable insight related to processes, learnings and documentation to support aged care.

The internal mapping exercise confirmed that many Elders were already connected to the *Metro ACCHO* clinic. It also identified that the service was functioning well and could manage the additional complexities of aged care relating to tendering processes, accreditation and compliance requirements, workforce capacity building, software systems, and financial management and reporting.

## Aged Care Implementation in ACCHOs

For ACCHOs who decide they are in a position to integrate Aged Care into their existing primary health care model, there are several integration actions that can be undertaken. These may be sequential or concurrent depending on local context.

The integration of aged care into the ACCHO primary health care model is enabled by the recruitment of key personnel with experience and sound knowledge of the aged care system including how aged care funding works, how outputs are measured, and the terminology used. These key personnel can drive internal and external mapping exercises and the integration process including developing an Aged Care Master Plan. The recruitment of experienced personnel brings knowledge of software and systems to support aged care service provision. The ability of the ACCHO to manage multiple and complex funding streams is another enabler of the integration process.

### Action 1: Inform the Commonwealth Government of an intention to take on aged care

### Action 2: Employ an Aged Care Project Officer to develop an Aged Care Master Plan

An Aged Care Master Plan can capture the ACCHOs vision for the delivery of aged care services and can drive the integration process.

The *Metro ACCHOs'* Aged Care Master Plan outlined the service's vision for the delivery of aged care across the region over a five-year period. It also outlined opportunities to achieve broader social and economic outcomes through the development of a sustainable and capable local workforce including increased workforce participation. It also recognised that aged care services operate as part of a broader health and social services system, and the need for a seamless interface between primary health care, disability services, aged care and other community support services.

### Action 3: Establish Aged Care Management structures

An aged care management structure can ensure effective management and care coordination across systems and services. Management structures that ACCHOs can establish are outlined in Table 9.

### Action 4: Apply to become an aged care provider

ACCHOs must successfully apply to become an aged care provider for *Home Care Packages* and the *Commonwealth Home Support Program*. As an approved provider ACCHOs can seek individual home care packages for Elders through the *My Aged Care* portal. ACCHOs can also apply through an open tender process to receive block funding under the *Commonwealth Home Support Program*. To become an aged care provider, ACCHOs must demonstrate they meet the Aged Care Quality Standards which consider a range of factors such as experience in providing aged care or other relevant forms of care, understanding responsibilities of aged care providers, aged care systems and financial matters. The new Aged Care Quality Standards that were introduced on July 1st 2019[2].

**Table 9: Aged Care Management Structures**

| | |
|---|---|
| **Aged Care Consortium** | An Aged Care Consortium can build a network across aged care and health services that creates a coordinated approach to the delivery of aged care services. |
| **Aged Care Integration Project Group** | An Aged Care Integration Project Group can include an Aged Care Manager and other senior executive including the CEO. Monthly meetings can be held to monitor how aged care services are integrated within day to day activities including in-services for clinic staff, care planning and care coordination (including case conferences and review of software to support efficient exchange of clinical information). |
| **Joint Management Committee** | A Joint Management Committee can consider how aged care services and clinical services inter-relate, and to look for efficiencies and economies of scale. IT specialists can help to ensure efficient communication between aged care software and the ACCHOs patient management system. |

[2]Aged Care Quality Standards website agedcarequality.gov.au/providers/standards/transitioning-new-standards

### Action 5: Develop partnerships to support the provision of aged care

ACCHOs invest in extensive relationship building and develop partnerships with numerous external organisations to support their aged care service delivery, as listed in Table 10. They also invest in the development of an effective working relationship with their funders.

### Action 6: Develop an Aged Care workforce strategy

To deliver quality culturally safe aged care services, ACCHOs can develop an Aged Care Workforce Strategy that outlines how they will recruit and train their workforce.

The *Metro ACCHO* identified a shortage in Aboriginal and Torres Strait Islander Aged Care Workers. They also identified that many Elders were being cared for by friends or family members. To address this gap and build the capacity of local community members, the *Metro ACCHO* developed an Aged Care Workforce Strategy to grow a local culturally competent aged care workforce. They contacted a local aged care training provider who supported the *Metro ACCHO* to remodel and conceptualise the Cert III Aged Care Training for the ACCHO Sector to ensure it was culturally appropriate. The *Metro ACCHO* then employed and trained their own educators to deliver the Cert III training through a partnering Registered Training Organisation. The *Metro ACCHO* sought funding from the Department of Education which enabled the training of several cohorts of aged care workers. The strategy resulted in sixty local Aboriginal and Torres Strait Islander peoples becoming qualified Aged Care workers. Today the *Metro ACCHOs* aged care workforce consists of 90 skilled and qualified workers providing services to Elders within their communities. Aged Care positions include Aged Care Team Leader, Home Care Nurse, Community Support Worker, Assessment Coordinator, Service Development Officer, Senior Quality Coordinator, Respite Workers, Social Support Workers, Respite Team Leader, Kitchen Hand and Respite Support Officer.

### Action 7: Purchase and embed Aged Care management software and systems

ACCHOs need the systems and software to support aged care service delivery, such as iCare. All staff providing aged care services require training to effectively use aged care management software. This software should be compatible with the ACCHOs patient management system. The compatibility of the two data management systems enables ACCHOs to have comprehensive oversight of the needs of Elders (e.g. outlined in the Health Check, GP Management Plan, Aged Care Plan), the number of services Elders have received, and the related expenditure of their primary health care and aged care funding (e.g. through eligible MBS items and *Home Care Packages*). The integration of data management systems can be continuously reviewed and improved through continuous quality improvement processes.

### Action 8: Embed staff credentials and compliance requirements into the Human Resource Management System

ACCHOs can manage their aged care workforce credentials and compliance requirements by adapting their current Human Resource Management system to capture necessary data and support reporting requirements.

### Action 9: Develop service delivery models

Develop service delivery models for both home care and respite services that outline ways of working such as principles and values, types of services provided, staffing, referral pathways, reporting, case management and transport.

**Table 10: Partnerships to support aged care service delivery**

| | |
|---|---|
| **Residential Aged Care services** | ACCHOs can develop close working relationships with residential aged care and respite providers to promote culturally safe quality care for their Elders. |
| **Hospital** | ACCHOs can work closely with local hospitals to ensure continuity of care through effective discharge planning to assist Elders to transition back to home and community. |
| **Regional Assessment Service** | ACCHOs can invest in a good working relationship with the local Regional Assessment Service that determines the eligibility of Aboriginal and Torres Strait Islander community members for the Commonwealth Home Support Program. |
| **Aged Care Assessment Team** | ACCHOs can establish a partnership with the local Aged Care Assessment Team to strengthen communication regarding Elder assessments for Home Care Packages. |
| **Meals on Wheels** | ACCHOs can work closely with Meals on Wheels who deliver food for their Elders. |
| **Home Assist Secure program** | ACCHOs can utilise a local service to provide home modifications for Elders such as rails and ramps. |
| **Mainstream specialist service** | ACCHOs can develop partnerships with mainstream specialist services to ensure effective care coordination for Elders across primary health, aged care and specialist services. |

## Outcomes and benefits of integrating aged care in ACCHOs

Aged care services that are Aboriginal community controlled organisations have inherent benefits, including that their connection to Elders and community means they can better tailor services to client needs and promote Aboriginal identity and cultural connections. This leads to better support for Elders' social, emotional and cultural wellbeing and improvements in physical health outcomes.

- ACCHOs can create aged care services tailored to the needs of their Elders and provided by local Aboriginal and Torres Strait Islander workforce with cultural knowledge and understanding.
- Elders can access their local ACCHO to receive both aged care services and holistic primary health care services reducing the complexities associated with navigating multiple services.
- ACCHOs can increase the number of Aboriginal and Torres Strait Islander Elders receiving aged care.
- Workforce strategies can lead to increased numbers of qualified local aged care workers with the capacity to provide culturally safe aged care services.
- Integration of aged care and primary health care can create economies of scale that enable and support unfunded activities such as transport services for Elders.
- An integrated aged care model enables optimal discharge planning following hospitalisations, efficient referrals between the clinic and aged care teams, and seamless integration of services.
- Effective aged care service provision through ACCHOs can reduce the pressures and responsibilities on family carers.

## Enablers of effective aged care service provision

- **Strong governance** including guidance and advice from the Board of Directors who are members of the local Aboriginal and Torres Strait Islander community and can inform the development of programs targeted to the needs of Elders.
- **Effective organisational structures and operating systems** including client management systems.
- **A local, caring, qualified and culturally safe aged care workforce.**
- **Effective workforce recruitment and training processes** to build a skilled caring and culturally safe workforce that can provide quality culturally safe care.
- **Effective communication between all staff and across teams.**
- **Clear referral pathways** across health and aged care teams.
- **Development of a model of aged care centred upon meeting Elders' needs** as identified through a thorough consultation process.
- **Effective relationships with external organisations** to enable effective advocacy and to ensure the holistic needs of clients are met.
- **Continuous quality improvement processes** to ensure that services are safe and are tailored to Elders' needs.
- **Effective back of house financial management systems** (e.g. to manage multiple income streams for aged care including the Commonwealth Home Support Program and Home Care Packages).

## Challenges of aged care service provision and integration of aged care

- **Funding challenges:**
  - ACCHOs meet with a great deal of complexity in coordinating multiple sources of funding in providing services for their Elders (e.g. MBS, Home Care Packages).
  - ACCHOs often go in to deficit during the process of integrating aged care services, and hence require a robust primary health care model drawing consistent MBS funding to be able to take on this financial risk.
  - To reduce barriers to access for Elders, ACCHOs often strive to provide aged care services at no cost to their clients, however this is not always possible
  - ACCHOs provide a range of unfunded services such as advocacy and support, coordination and community events.
- **ACCHOs must manage a change process** including communicating with clinic staff and establishing referral pathways from existing ACCHO clinics and program teams.
- **ACCHOs must rapidly develop their knowledge of the aged care system** processes, funding, terminology, applications and accreditation requirements and develop effective financial management systems to manage the increased complexity.
- **Workforce challenges including a lack of qualified culturally safe aged care workers.**
- **Elders can receive multilayered, unclear letters from *My Aged Care* and Centrelink** which they find difficult to navigate and that put them at risk of having packages ceased. ACCHO aged care staff invest considerable time supporting Elders to interpret and navigate the *My Aged Care* and Centrelink correspondence and systems.
- **The aged care system eligibility requirements** creates a challenge for couples that include Aboriginal and Torres Strait Islander Elders (who are eligible at 50 years) and non-Indigenous spouses (who are eligible at 65 years). ACCHOs invest considerable time in educating Elders to understand how the aged care system works, including in relation to eligibility.

## Recommendations

### Recommendations for ACCHOs

- A well-functioning primary health care model must be established before integrating aged care. Therefore, before considering aged care service provision, ensure the clinic is maximising MBS rebates.
- ACCHOs should undertake a range of mapping exercises to determine their readiness and the financial viability of aged care service provision.
- Employ a project officer to undertake necessary mapping exercises and ensure a smooth aged care integration process.
- Contribute to building aged care workforce capacity through advocating for or developing and delivering culturally appropriate aged care training.
- Create a regional network for ACCHOs, Regional Assessment Service assessors and Aged Care Assessment Teams to establish better reporting and culturally responsive care coordination.
- Strengthen partnerships with mainstream aged care service providers to advocate for quality culturally safe care for Elders.
- Seek support from peak bodies in relation to navigating the Aged Care space (e.g. becoming a provider, financial guidance, accreditation).
- Clients benefit from family-centred approaches where the needs of Aboriginal and Torres Strait Islander Elders and their non-Indigenous spouses are assessed together. Invest time in supporting Elders to understand how the aged care system works, including in relation to differing eligibility requirements.

### Recommendations for Policy Makers

- Commonwealth, state and territory governments resource initiatives to strengthen (i.e. attract, recruit and develop) an Aboriginal and Torres Strait Islander Aged Care workforce.
- The Aboriginal and Torres Strait Islander Aged Care Workforce to be considered within the implementation of the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023*[3].
- Commonwealth, state and territory governments acknowledge the well-established connection between ACCHOs and Aboriginal and Torres Strait Islander Elders and recognise ACCHOs as the preferred provider of aged care services.
- Mainstream aged care services who have received Aboriginal-specific aged care packages and are not engaged with Aboriginal and Torres Strait Islander communities to establish formal partnerships with and/or broker the funding allocation to their local ACCHO or recruit and support Aboriginal and Torres Strait Islander staff.
- All Aged Care workforce, and particularly those in the Regional Assessment Service and Aged Care Assessment Teams, to receive ongoing and mandatory cultural safety training to provide Elders with culturally safe assessments and care.
- Data captured through the *My Aged Care* portal needs to better identify Aboriginal and Torres Strait Islander older peoples to enable reviews of package allocation (i.e. to assess who is receiving services and from which service providers).
- *My Aged Care* and Centrelink evaluate and revise their communication strategies to ensure that Elders consistently receive accurate and non-threatening correspondence to enable them to access services they are entitled to.

[3]Department of Health. (2017). *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023.* Accessed on January 17, 2020 at: health.gov.au/internet/main/publishing.nsf/Content/work-pubs-natsihwsf

## Discussion

### The important role of Elders in community

Aboriginal and Torres Strait Islander Elders play an important role in the lives of their local communities and are well known and respected as knowledge keepers, story tellers and connectors. They are the older Aboriginal and Torres Strait Islander peoples who fought to bring about equity and social justice that will enable better living conditions for generations to come.

### Increasing numbers of Elders

The life expectancy of Aboriginal and Torres Strait Islander peoples is improving (AIHW, 2015), and consequently the number of older Aboriginal and Torres Strait Islander peoples is growing. While the total Indigenous population is projected to grow by 59% between 2011 and 2031, the older Aboriginal and Torres Strait Islander population aged 65 and over is projected to grow by 200% (Biddle, 2013). For Aboriginal and Torres Strait Islander peoples aged 55 years, numbers are projected to more than double from 59,400 in 2011 to up to 130,800 in 2026 (ABS, 2014). In mid-2018 it was estimated that there was already more than 123,000 Aboriginal and Torres Strait Islander peoples aged 50 years or over (AIHW, 2018).

### Barriers to accessing services

Disability rates are higher within older Indigenous peoples compared with non-Indigenous Australians. In the 2016 census, 27% of Aboriginal and Torres Strait Islander peoples reported a need for assistance with core activities (self-care, mobility or communication tasks), compared with 19% of non-Indigenous people aged 65 and over (ABS, 2017). At the same time, Aboriginal and Torres Strait Islander peoples encounter challenges in accessing health and welfare services. In 2014-15, 24% of Aboriginal and Torres Strait Islander peoples reported challenges with accessing service providers. In remote or very remote areas this was a greater problem, reported by 1 in 3 (33%) of Aboriginal and Torres Strait Islander peoples (ABS, 2016).

### Why ACCHOs are best placed to provide home care services to Elders

The Aboriginal community controlled sector, which provides culturally responsive, holistic and accessible services to Aboriginal and Torres Strait Islander Australians is ideally positioned to provide aged care services. ACCHOs support clients to tackle social factors such as racism, housing, income and employment and 'function as community spaces through which Indigenous people attempt to deal with their immediate health needs and the underlying structural causes that produce very poor health outcomes' (Khoury 2015, p.472). Aboriginal clients report that the accessible, culturally safe, holistic and diverse health care provided by ACCHOs brings value (Gomersall et al, 2017). Culturally respectful care is attributed to employment of Aboriginal staff, welcoming spaces, the integration of cultural protocols, a social view of health, and strategies to promote access (Freeman et al, 2014) and has been found to be at the centre of all ACCHO primary health care service delivery (Harfield et al, 2018).

An international review of how primary health and aged care services can support the wellbeing of older Indigenous peoples found there were three high level findings, including delivering culturally safe care, maintaining Indigenous identity and promoting independence (Davy et al, 2016). ACCHOs are in an ideal position to provide aged care services since they already address these three guiding principles. First, as an Aboriginal community controlled service - led by and for community under Aboriginal governance - they are connected to their Elders and they provide culturally safe client-centred care. This culturally safe care is enabled by understandings of the Elders' cultural needs, and through their culturally competent Aboriginal and Torres Strait Islander workforce. Second, ACCHOs support Elders to maintain their Aboriginal and Torre Strait Islander identity through community connection and through celebrating and promoting culture and cultural practices (e.g. story-telling, art, dance, basket weaving). Third, the founding ACCHO principle of self-determination aligns with the principle of 'promoting independence' and is demonstrated by supporting Elders to make informed decisions about the care they receive, and to stay in their homes for as long as they can.

Across Australia, ACCHOs have always acknowledged and paid respects to Aboriginal and Torres Strait Islander Elders through a Welcome to Country and Acknowledgement of Country at the beginning of meetings and events. Providing quality aged care services to Elders is a way that ACCHOs demonstrate this respect in practice.

## The added benefits that ACCHOS bring for Elders

### Safeguarding Elder wellbeing

A commissioned study on the wellbeing of older Aboriginal peoples in South Australia found that connectedness was a key element of wellbeing and included connection to community, connection to family, connection to other Aboriginal peoples and connection across generations (Davy et al, 2018). Holding on to culture was considered essential for wellbeing as was a focus on staying strong. The consultations led to the development of a Keeping You Strong Framework that promoted strengthening cultural identities, validating cultural traditions, maintaining cultural practices and upholding cultural connections (Davy et al, 2018). The added benefit that ACCHOs bring to Elders as an aged care provider is their ability to protect and promote the wellbeing of Elders through promotion of culture and knowledge of family and community. Compared with mainstream providers, ACCHOs are often intimately aware of any challenges the family and community are facing that impact the wellbeing of their Elders, and they can take the necessary steps to safeguard Elder safety. A commissioned report on preventing Elder abuse identified the following key recommendations for approaches to promote the safety of older Aboriginal peoples: raise awareness and provide useful and effective information, enable and support older Aboriginal peoples to connect with and to continue their culture, uphold the safety of older Aboriginal peoples, and enable community co-design (Dowling et al, 2019).

### Coordinating the health and aged care needs of Elders with complex needs

Long-term health conditions affect 88% Aboriginal or Torres Strait Islander peoples over the age of 55 years, with higher risks of chronic conditions such as diabetes, cardiovascular disease and respiratory disease (AIHW, 2018). In fact, many Elders have complex health conditions that include multiple chronic disease (AIHW, 2010). ACCHOs who provide holistic primary health care in addition to aged care services are in a strong position to manage these complex conditions for Elders. In providing services in the homes of Elders, the aged care team can identify when the needs of Elders change (e.g. increasing frailty, worsening chronic conditions). Through observation, their aged care workforce are the eyes and ears of the ACCHO. They can report back to the clinic team regarding the changing needs of Elders so that both the aged care needs and holistic health care needs of Elders are monitored and addressed in an ongoing way.

## Conclusion

The number of Aboriginal and Torres Strait Islander Elders is growing. It is important to develop aged care services for Aboriginal and Torres Strait Islander Elders that are culturally responsive, accessible and that support their unique needs. The ACCHO sector is ideally positioned to meet the needs of an increasing number of older Aboriginal and Torres Strait Islander Australians. The learnings outlined in this chapter may be useful for ACCHOs considering integrating aged care. Points of difference will depend on the ACCHOs size, context, workforce capacity, and the needs of the Elders they serve. The case studies informing this chapter were undertaken with metropolitan based services. There are likely to be unique challenges facing ACCHOs in regional and remote settings in relation to taking on aged care service provision and building a culturally safe aged care workforce.

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## Appendix: Aged care funding for home care and day respite services

The following Aged Care funding is available for Home Care Services and Day Respite Services in Australia. This information is accurate at the time of printing (February 2020).

### 1. Commonwealth Home Support Program

*Commonwealth Home Support Program* (CHSP) funding provides entry-level support for eligible Aboriginal and Torres Strait Islander Elders aged 50 years and over with less complex needs. The Program aims to provide assistance to enable Elders to continue to live in their homes and community. Eligibility is assessed through the Regional Assessment Service. CHSP funding is block funded and is structured to include four distinct sub-programmes: Community and Home Support, Care Relationships and Carer Support, Assistance with Care and Housing, and Service System Development[4].

#### How to become a CHSP provider

To become an eligible CHSP provider, an organisation must apply through an advertised selection process. These opportunities are advertised in the media and on the Australian Government's 'GrantConnect' website (grants.gov.au). Further information on becoming a CHSP provider can be obtained from the CHSP guidelines[1].

#### Regional Assessment Service

The Regional Assessment Service (an external agency) contacts the Elders to undertake an in-home assessment. The assessment is registered with the client's details via the *My Aged Care* portal[5].

### 2. Home Care Package

*Home Care Package* (HCP) funding is for Elders with more complex needs. HCPs are coordinated packages of care individually tailored for Elders to enable them to live independently in their homes. They are also provided to younger persons with a disability, dementia or other special care needs that are not met through other specialist services. HCP clients are not limited to a basic list of services. Clients can use their HCP funds to purchase a wide range of services (e.g. in-house cleaning, modifications, personal care, allied health services). There are four levels of packages available under the HCP funding including Basic care (Level 1), Low level care (Level 2), Intermediate Care (Level 3) and High level Care (Level 4)[6].

#### How to become an HCP provider

To gain approval as an aged care provider under the Aged Care Act (1997), applicants must undertake an application to the Department of Health to demonstrate they are able to provide aged care. Application forms are available on the Department of Health's Ageing and Aged Care website[7].

#### Aged Care Assessment Team[8]

The Aged Care Assessment Team contacts the Elders to undertake an in-home assessment. The Assessment is registered with the client's details via the *My Aged Care* portal.

### 3. National Aboriginal and Torres Strait Islander Flexible Aged Care Program: rural and remote regions

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program is targeted to the rural and remote context. It funds 'flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and/or community'. It encompasses a mix of residential and home care service provision in accordance with the needs of the community which are located mainly in rural and remote areas. More information regarding the National Aboriginal and Torres Strait Islanders Flexible Aged Care Program is available on their webpage[9].

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[4]Commonwealth Home Support Program guidelines: health.gov.au/resources/publications/commonwealth-home-support-programme-guidelines
[5]My Aged Care Portal: myagedcare.gov.au
[6]Home Care Package Program: agedcare.health.gov.au/programs/home-care/about-the-home-care-packages-program
[7]Department of Health's Ageing and Aged Care website: agedcare.health.gov.au/funding/becoming-an-approved-provider
[8]Aged Care Assessment Team: health.gov.au/sites/default/files/documents/2020/01/my-aged-care-assessment-manual.pdf
[9]National Aboriginal and Torres Strait Islander Flexible Aged Care Program Website: agedcare.health.gov.au/programs-services/flexible-care/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program

# Aged Care in ACCHOs: Reflection Tool

ACCHOs are closely connected to their Elders and are well positioned to provide quality culturally centred aged care services. This Reflection Tool has been designed for ACCHOs who may be considering taking on aged care. It outlines aged care planning processes, aged care implementation actions, and the principles and values supporting aged care.

## Aged Care Planning

ACCHOs can undertake several mapping exercises to determine their readiness to take on aged care services. These exercises can paint a picture of the needs of Elders, the aged care service gaps within the region, the available aged care workforce, the systems in place to support aged care service provision, and the financial viability of delivering aged care services.

**External mapping:**

- ☐ **Consultation with Elders:** Yarn with Elders about their aged care needs and their experiences of accessing aged care services including any barriers to access. Consult with Elders who are accessing your clinic or ACCHO programs including those who are currently receiving aged care and those that are not, and also consult with Elders in residential aged care. Yarning can be informal during Elders lunches, community events or you can host a yarning circle and invite Elders to attend.
- ☐ **Mapping existing aged care services:** Collate information on the aged care service providers in the region including where they are located and the number of Elders currently receiving services.
- ☐ **Mapping the aged care workforce to identify capacity or gaps:** Look at the number of Aboriginal and Torres Strait Islander aged care workers or culturally competent non-Indigenous aged care workers in the region. You might also assess the number of community members currently providing unpaid aged care services as family members and carers. Consider what registered training organisations are in the area that could provide training to develop a culturally-competent local aged care workforce.
- ☐ **Learning from other ACCHOs:** Visit another ACCHO who is well established as an aged care provider to observe how they operate including processes, systems and documentation that support service delivery.

**Internal mapping:**

- ☐ **Desktop audit:** An audit of the patient management system can identify the number and locations of Elders connected to your service, the number of Elders who are currently receiving aged care services through other providers, and those who are potentially eligible to receive services.
- ☐ **Aged Care Scoping Review:** An aged care scoping review can be used to map out the resources and systems needed to: apply for aged care funding and become accredited as an aged care provider, develop and manage policies and procedures that support quality care and continuous quality improvement, manage aged care client information and service scheduling, manage the additional finance management and reporting responsibilities and establish the referral pathways and case management processes across the clinic and aged care teams.
- ☐ **Financial modelling:** Build a financial model that compares the potential income from aged care funding with anticipated operating costs of aged care service provision to determine whether it would be financially viable to take on aged care. Data from the patient management system regarding numbers of Elders and their anticipated aged care needs can be used to estimate potential income that could be sought through the Commonwealth Home Support Program, Home Care Packages and National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Contrast this against an estimate of the costs of providing aged care such as staffing, consumables, transport and software. Expect that there will be a financial deficit while the aged care team is recruited, and services are established, so check that the clinic is drawing sufficient MBS income to cover it.

## Aged Care Implementation: actions to integrate aged care

Integrating aged care services within the ACCHO enables Elders to access both primary health care and aged care services as a one-stop-shop. The actions to consider when integrating aged care services within the ACCHO include:

- ☐ **Action 1:** Inform the Commonwealth Government.of your intention to take on Aged Care
- ☐ **Action 2:** Employ a Project Officer to develop an Aged Care Master Plan and drive the integration process.
- ☐ **Action 3:** Establish Aged Care Management structures.
- ☐ **Action 4:** Apply to become an aged care provider through the Commonwealth Home Support Program and/or Home Care Packages. Explore eligibility for National Aboriginal and Torres Strait Islander Flexible Aged Care Program funding (for regional and remote services).
- ☐ **Action 5:** Develop partnerships to support the provision of aged care such as with local hospitals, the Regional Assessment Service, the Aged Care Assessment Team, My Aged Care, Meals on Wheels, home modifications services, and mainstream specialist services. Develop a relationship with the Department of Health and the Aged Care Quality and Safety Commission to work through aged care funding, reporting and accreditation against the Aged Care Quality Standards.
- ☐ **Action 6:** Develop an Aged Care Workforce Strategy and build an aged care workforce including targeting training opportunities to community members currently providing unpaid aged care. Ensure that Certificate III Aged Care training is supportive of culturally safe client-centred approaches through developing a partnership with local registered training organisations where necessary. Identify funding opportunities to support the delivery of aged care training.
- ☐ **Action 7:** Purchase and embed aged care management software including training staff.
- ☐ **Action 8:** Embed staff credentials and compliance requirements into the Human Resource Management System.
- ☐ **Action 9:** Develop service delivery models for both home care and respite services that outline ways of working such as principles and values, types of services provided, staffing, referral pathways, reporting, case management and transport.

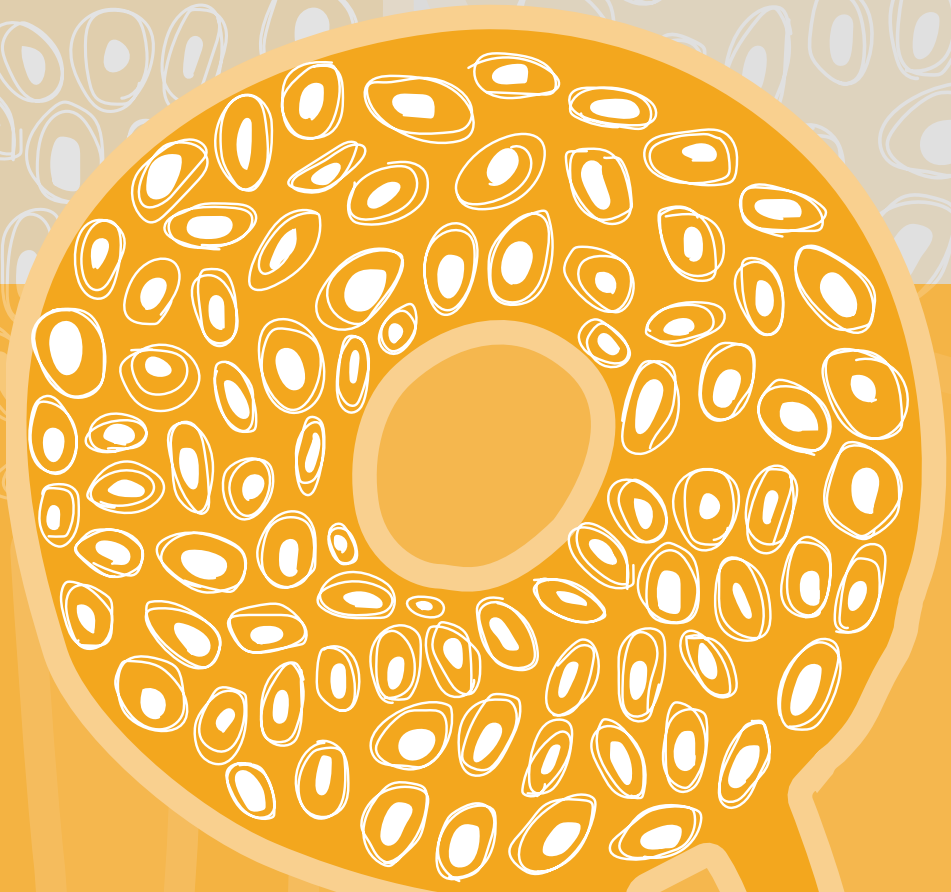
## Principles and values of Aged Care Service Delivery

**The principles and values of aged care service delivery to reflect upon:**

- ☐ **Connection with Elders and communities:** we actively build and maintain relationships with Elders, their families and communities so we can understand the needs of Elders and can support Elders to maintain connections with community.
- ☐ **Respect for self-determination:** we empower and support Elders to make their own decisions.
- ☐ **Culturally safe care:** our services are respectful of traditional Aboriginal and Torres Strait Islander customs, values and beliefs, are guided by strong cultural governance, and are enabled through cultural safety training for our staff.
- ☐ **A focus on holistic wellbeing:** we support Elders with their physical, social, emotional and cultural wellbeing needs.
- ☐ **Tailored services:** we tailor care to the holistic needs of Elders.
- ☐ **Credibility:** we do what we say we're going to do and we are clear about what we can't do.
- ☐ **Willingness to go the extra mile:** our aged care staff have a fundamental compassion for Elders and a willingness to do whatever it takes to support Elders with their holistic needs.

# Chapter 7

## Approaches to funding in newly established ACCHOs



# Approaches to Funding in newly established ACCHOs


## Summary

ACCHOs are small to large sized businesses which provide a complex array of programs to their local Aboriginal and Torres Strait Islander communities. ACCHOs strive to provide holistic, comprehensive, and culturally responsive health care to promote health and address the social and cultural determinants of health. This chapter explores how a newly established ACCHO created a sustainable approach to funding. To secure the financial position of the organisation into the future, the newly established ACCHO developed financial management strategies to maximise income and ensure operational expenditure is smart and strategic. Practical cost saving strategies included sharing IT expenses with other services and sub-leasing office spaces.

Funding constraints can limit the ability to address the social determinants of health through transport and home visits. The success of the approach is enabled by the strength and unity of the organisation, clear and transparent communication, staff capacity and passion, relationships with funders, monthly monitoring of income and expenditure, having a local community that supports the service, and positioning the service in a central and accessible location. The multi-level funding challenges faced by ACCHOs can include the time investment and resources needed to build relationships with funders and prepare submissions, the complexity of managing numerous income streams, and the inability to meet community priorities due to financial constraints.


The content within this chapter was drawn from an in-depth case study with a regional newly established ACCHO that was reviewed and refined by the CREATE Leadership Group and strengthened with learnings and perspectives from the ACCHO sector nationwide.

## What we cover in this chapter:

## Introduction to funding of ACCHOs

A broad array of programs and services provided by ACCHOs to Aboriginal and Torres Strait Islander communities are resourced via a range of funding streams such as state, territory and Commonwealth governments, primary health networks and the Medicare Benefits Schedule. This funding includes core funding through the *Indigenous Australians Health Program* in addition to program and grant funding such as through tender-based submissions. These multiple income streams and tender processes have different application and reporting requirements which create considerable administrative complexity and reporting burden for ACCHO workforce, leadership and Board of Directors. The available funding streams can vary greatly across the states and territories of Australia, and from one year to the next. In this sense, ACCHOs must be proactive in identifying available funding and responsive in preparing timely competitive funding submissions. The financial viability of ACCHOs is dependent on the income they can generate through the Medicare Benefits Schedule which is impacted by client numbers and the availability of general practitioners. Attracting and retaining general practitioners can be a challenge, especially for regional and remote services.

## Context for this chapter

The content in this chapter was based on an in-depth case study with a small and newly established ACCHO. In this sense it may not be representative of ACCHOs across Australia who have a longer history, larger client base and greater number of funding sources.

The content provides an example of how newly established ACCHOs can be proactive in financial management to promote financial security and sustainability. There are, however, limitations to service delivery and staff capacity development as a result, both of which are at odds with the principles of the ACCHO sector which aim to promote accessibility of services and development of the Aboriginal and Torres Strait Islander workforce.

## Values and principles guiding the funding approaches of newly established ACCHOs

### Quality Culturally Safe Care

The ACCHO mission to provide quality culturally safe community-centred care guides all decision making in relation to funding. A passion for providing quality culturally safe care drives staff to go above and beyond in their roles and drives services to provide programs even without allocated funding.

### Aboriginal community control: The Board and CEO make strategic decisions based on community priorities

ACCHO community-elected Board of Directors (the Board) work with the CEO to determine the strategic direction for the service. Decisions consider the funding opportunities available and the priorities of the community. Decisions are informed by financial projections developed by the accountant or finance team.

### Balancing Holistic Care with Long Term Financial Affordability

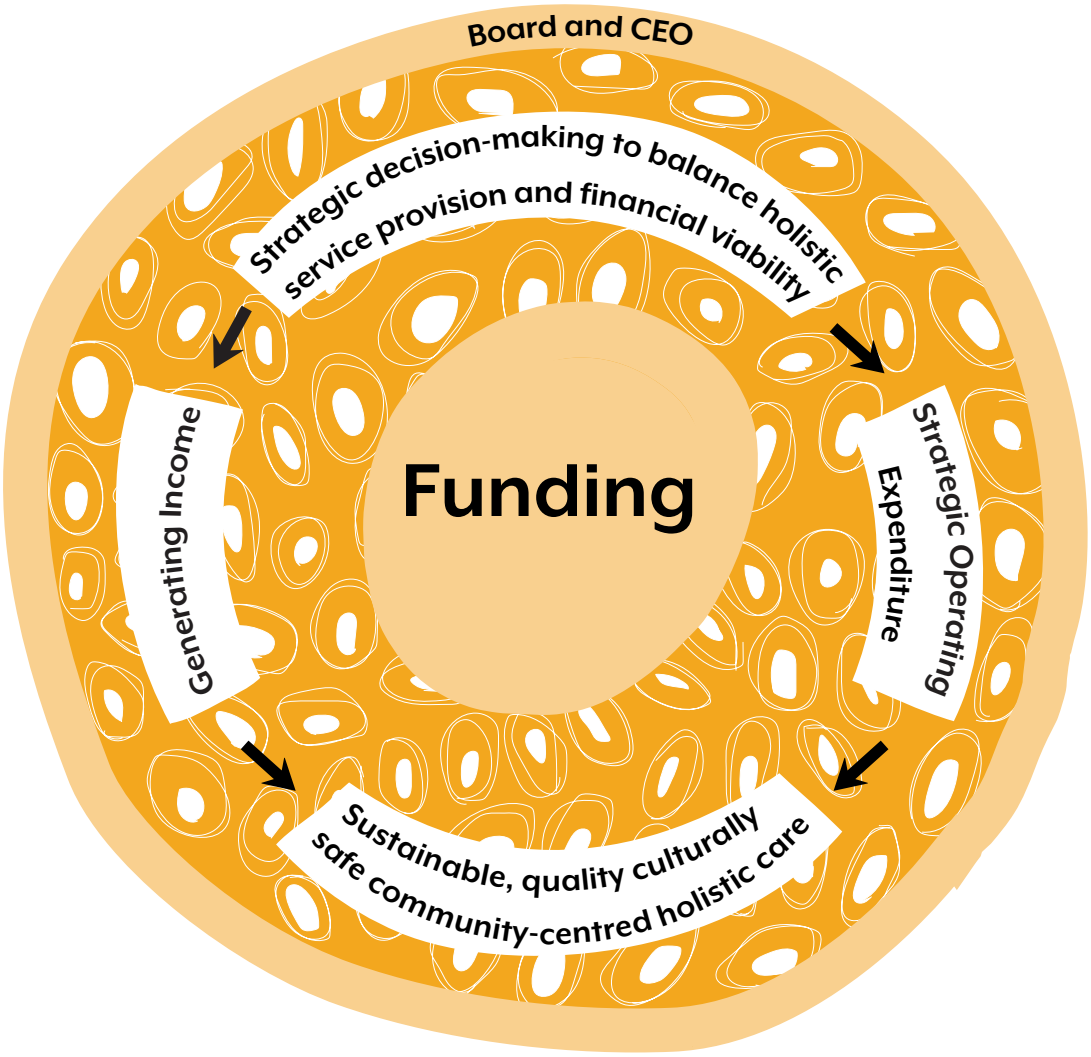
The CEOs and Boards of ACCHOs carefully consider how they can meet community needs whilst maintaining the sustainability and financial security of the ACCHO. The extent of programs and services provided by ACCHOs are determined by their core funding, their MBS income, successful grants and tenders, and targeted program funding for special initiatives. In this way, service delivery is targeted and selective. This means that for newly emerging ACCHOs, tough decisions need to be made in relation to providing unfunded services such as transport and home visits. Services are often forced to make strategic decisions to maximise income and minimise operating costs, balancing holistic service provision for community with the financial security of the organisation.

## Elements of funding approaches in newly established ACCHOs

Newly established ACCHOs work hard to develop funding approaches that are sustainable in the long term. They carefully consider how to maximise income generation and ensure operational expenditure is strategic so that they can provide quality culturally-centred care based on community priorities.

Newly established ACCHOs face two key funding constraints including the inability to fund capacity development opportunities for staff and services that promote accessibility (i.e. transport and home visits). These limitations are at odds with the principles of the ACCHO sector which aim to promote the accessibility of services and the development of the Aboriginal and Torres Strait Islander workforce. In this sense, the funding constraints impacting newly established services do not support the ways of working the ACCHO sector is known for, and that address the social determinants of health.

**Image 9: Approaches to funding in newly established ACCHOs**




### Image description

The image depicts how the Board of Directors and CEO undertake strategic decision-making that balances holistic service provision for community with the long-term financial viability of those services. The ACCHO leadership strive to generate income through multiple sources while ensuring that all operating expenditure is smart and strategic. The ultimate aim of the ACCHO approach to funding is to provide sustainable, quality, culturally-safe, community-centred holistic care to local Aboriginal and Torres Strait Islander peoples.

This image was developed through the CREATE project based on a case study with a newly established ACCHO and consultations with the CREATE Leadership Group.

## Generating Income

Newly established ACCHOs provide services to community based on what they believe they can offer over the long term, which is dependent upon their ability to identify and secure funding. The ACCHO receives core funding from the government and generates income through the Medicare Benefits Schedule and Practice Incentive Program. Additional revenue may be sought through the local PHN, GP training organisations, sub-leasing office space, and tender opportunities through special initiatives. The service carefully considers whether a source of funding is beneficial to the organisation, given the reporting and time commitments and burdens associated with taking on the funding.

### Commonwealth Funding

ACCHOs receive core government funding through the *Indigenous Australian's Health Program*[1] (both recurrent and one-off funding opportunities) and *New Directions Mothers and Babies Services* funding to provide primary health care services to Aboriginal and Torres Strait Islander communities.

### Medicare Benefits Schedule

ACCHOs generate income through the Medicare Benefits Schedule (MBS) for episodes of care provided by their General Practitioners, Registered Nurses, Registered Midwives and Aboriginal Health Workers. Income is generated through Aboriginal And Torres Strait Islander Peoples Health Assessments (also known as 'Health Checks' or '715s'), GP Management Plans, Team Care Arrangements, Brokerage, and Enhanced Primary Care items (for allied health services). There are claimable MBS items for reviews of GP Management Plans and Team Care Arrangements and also for Case Conferences.

The clinic staff work closely with the medical reception staff to ensure MBS billing is complete. To ensure income is maximised against investment of staff time, ACCHO staff are trained in MBS claiming and may check client eligibility for MBS items prior to service provision. Clients are eligible for only one health check per year.

At *Regional ACCHO*, the clinic reception staff call Medicare to determine whether clients are eligible for a health check, and to make sure they haven't already had a health check at another service.

Newly established ACCHOs provide patients with SMS clinic reminders to guard against avoidable missed appointments and undertake retrospective audits of MBS billing to ensure income is generated for each service provided. Incentives may be offered to clients to promote engagement with the service such as providing t-shirts on completion of health checks and hosting community lunches during health promotion events.

One of the ways ACCHO peak bodies may support member services is through developing funding flowcharts which outline how to navigate available MBS items in providing comprehensive client-centred primary health care. There are also a range of fact sheets and funding flowcharts available through the Commonwealth Department of Health and state and territory PHNs (e.g. the Department of Health's Chronic Disease Management – Provider Information Fact Sheet[2] and the Queensland Primary Health Network's Chronic Disease Management Flowchart[3]).

The clinic staff and leadership of *Regional ACCHO* attend forums provided by their peak body regarding the funding model of the *Indigenous Australian's Health Program* and how to navigate the MBS. They also use the MBS funding flowcharts developed by their peak body to ensure they are effectively claiming MBS items that ensure their clients are accessing a full range of eligible services.

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[1]Department of Health. (2018). *The Indigenous Australians' Health Programme*. Accessed on January 17, 2020 at: health.gov.au/internet/main/publishing.nsf/Content/indigenous-programme-lp

[2]Australian Government Department of Health. (2016). *Chronic Disease Management – Provider Information Fact Sheet*. Accessed on January 17, 2020 at: www1.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-factsheet-chronicdisease.htm

[3]Queensland Primary Health Network. (2016). *Chronic Disease Management Flowchart v5*. Accessed on January 17, 2020 at: primaryhealth.com.au/wp-content/uploads/2016/12/001.-Chronic-Disease-Management-Flowchart-v5.pdf

### Practice Incentive Program

ACCHOs eligible for *Practice Incentive Program* funding can receive income under the Close the Gap scheme for chronic care payments and scripts, for Diabetic and Asthma cycles of care, for Cervical Screening incentives and Medical Students.

### Primary Health Networks

ACCHOs often access funding through their local Primary Health Network (PHN) which at times can require a tender process.

The *Regional ACCHO* accesses funding for their Integrated Team Care program, Mental Health, and Drug and Alcohol funding through their local PHN.

### Rural Doctor's Network

The Rural Doctor's Network can contribute income to regional ACCHOs such as through room rental income, through funding Registered Nurse and Aboriginal Health Workers' services, and by providing client linkage to specialist services.

### GP Registrar Training

ACCHOs that train GP Registrars can be reimbursed for this service through their local GP training organisation. The training must be provided by a GP who is a Fellow of the Royal Australian College of General Practitioners.

### Sub-leasing office space

Some ACCHOs also generate income through renting or sub-leasing office space.

The *Regional ACCHO* receives rental income from the Rural Doctors Network and the local National Disability Insurance Scheme provider who rent office space.

## Strategic operating expenditure

Newly established ACCHOs have limited core funding through the I*ndigenous Australian's Health Program* and therefore need to minimise their operating costs to be sustainable. ACCHOs can register as a charity to save on Council rates and seek out business loans to purchase property to reduce rent expenditure. ACCHOs can also seek out opportunities to share costs with other organisations, such as sharing IT expenses or sub-leasing office space. To secure the financial position of the organisation, newly established ACCHOs may be forced to make tough decisions to limit services that are unfunded (such as transport and home visits) or that are not financial viable (e.g. dental services, aged care, disability services). They also carefully and strategically manage their expenditure on professional development, looking for subsidised training where possible.

### Registering as a charity to save on Council rates

ACCHOs who register with the Australian Charities and Not-for-profits Commission can request a waiver from the local Council for their annual council rates. This charity status also enables staff to be eligible for salary sacrifice opportunities. Salary sacrifice provides benefits to both organisations and employees, including associated tax benefits. Salary sacrificing reduces employees' gross taxable income which reduces the income tax they are required to pay.

### Seeking a business loan to purchase property and reduce rental costs

ACCHOs can be burdened by high rental costs. Some ACCHOs seek out business loans through Indigenous Business Australia to purchase their property. This process can take a long time but can result in reduced operating expenses since loan repayments can amount to less than the expense of renting premises. This is a long term strategy to ensure funds can be redirected to the provision of services for community.

The *Regional ACCHO* sought a loan to buy their property which resulted in an overall decrease in their operating expenses (since their mortgage repayments are less than their rental expenses). Moving forward, the service has positioned itself with a solid financial standing to continue growing the services provided to the local community and as a key employer of Aboriginal peoples.

### Sharing operating costs with other services

ACCHOs understand that the money they receive is to service the community, so they carefully manage their operating budget to ensure their funding is invested in programs and services. This includes looking for opportunities to share expenses such as IT with other services or by sub-leasing their office space.

The *Regional ACCHO* is strategic in their expenditure. They carefully consider how to minimise costs such as through sharing IT expenses with other services and replacing uniforms and equipment only when necessary.

### Seeking subsidised Professional Development for staff

Small or newly established ACCHOs may be limited in their ability to fund professional development opportunities for their staff and therefore encourage staff to seek out subsidised professional development opportunities wherever possible.

The *Regional ACCHO* has a limited budget for capacity building and hence looks for subsidised opportunities for training and professional development for their staff. The leadership ensures that any training undertaken will directly benefit the community.

## Enablers of financial security in newly established ACCHOs

The financial security of newly established ACCHOs can be enabled by the strength and unity of the organisation, clear and transparent communication, staff capacity and passion, building relationships with funders, effective financial managment strategies, and having an engaged community that supports the service.

### A strong and united organisation

Financial security is enabled by Boards, leadership and staff having a united approach to funding and service provision. It also helps when services have a clear short, medium and long-term strategy towards financial management and growth.

The *Regional ACCHO* has an organisational culture that all staff understand and are committed to. Staff are aware of the organisation's short, medium and long-term plan and understand why there are current limitations to their service delivery model.

### Clear and transparent communication

ACCHOs benefit from effective communication across the organisation including within the governance structure, between staff, with community and with funders. Effective communication provides all staff with a baseline understanding of the service's income and expenditure, which contributes to staff being 'on the same page'. Relevant staff have a more in-depth understanding of the financial strategies in line with their role.

### Building relationships with funders

ACCHO staff develop good working relationships with their funders, including Medicare. They communicate directly with a Medicare Officer to ensure they are correctly billing all items they are eligible for.

### Staff Capacity and Passion

The capacity of ACCHO staff is a key enabler of the financial success of the organisation. When CEOs and leadership have experience in Medicare and can write tenders this attracts income to the organisation.

At *Regional ACCHO*, all staff (nursing, Aboriginal Health Workers, managers and administration staff) know how to book appointments and claim items for the MBS. This ensures that MBS billing is up to date even when administration staff are away. The service provides training to clinical staff across all levels to ensure they can manage Medicare billing and the complexities of multiple funding streams.

### Effective financial management strategies

ACCHO CEOs and executive teams carefully monitor income and expenditure on a monthly basis and report this to the Board. This enables leadership to monitor finances in an ongoing way and enables the Board to make informed strategic decisions. ACCHOs strive to meet community need through quality service provision while generating sufficient income for the service. They use SMS and telephone reminders to minimise missed appointments, undertake 6-monthly retrospective audits to identify unclaimed MBS items, seek extra funding opportunities through submitting tenders, and check patient eligibility with Medicare prior to undertaking health checks.

### An engaged community

The sustainable funding of ACCHOs is dependent on MBS income, which is dependent on engagement from communities. Engagement by community is enabled when ACCHOs are situated in a high visibility location that is central and accessible for community.

The *Regional ACCHO* is on a bus route half way between the medical precinct and many other service providers such as pathology and x-rays. It is in a high visibility and central location which increases accessibility for clients.

## Challenges related to funding in newly established ACCHOs

The funding challenges facing newly established ACCHOs are wide ranging and multi-level such as high rent expenses, inadequate funding to address the social determinants of health, the time investment and resources needed to build relationships with funders and prepare submissions, the complexity of managing numerous income streams, and the inability to meet community priorities due to financial constraints.

### High rental expenses

ACCHOs are challenged by high rental expenses and staff salaries.

The newly established *Regional ACCHO* had high operating costs including particularly high rents. For this reason, the service went to great lengths to minimise expenditure over a two-year period so that they could purchase their site and reduce operating expenses over the longer term.

### Transport is not funded

Transport is not funded under the *Indigenous Australian's Health Program* and ACCHOs must fund their transport services using income generated through the MBS, or via alternate funding sources (e.g. aged care funding). Newly emerging ACCHOs often have minimal funds to purchase vehicles and employ a transport officer and therefore cannot routinely provide transport for clients to attend appointments. Exceptions are given to support clients in high need and in emergency situations where transport or taxi vouchers are provided. This is a challenge for ACCHOs because holistic culturally-centred care for community should include support to access services.

### Building staff capacity in relation to MBS billing

ACCHOs can find it challenging to meet the training and development needs of staff in relation to MBS billing. The ability of ACCHOs to build staff capacity is continually impacted by their limited funds. Some clinic staff can be hesitant to claim MBS items due to the complexity of the MBS system and the challenge of understanding client eligibility for MBS items.

### Unable to fund programs to meet all of community priorities

ACCHOs consult with community to identify their needs, but due to funding limitations cannot deliver all necessary services (e.g. dental services). Aboriginal and Torres Strait Islander people have an inequitable burden of oral and dental health challenges which can impact on health, social standing and employment opportunities.

The community of the *Regional ACCHO* identified dental health as a priority, yet the service could not offer dental services due to financial constraints. The service is also unable to routinely fund home visits and transport services out of its operating budget.

### MBS funding models may not always match Aboriginal ways of working

ACCHOs generate income through the MBS that provides only 20 minutes for a standard GP consultation, and 40 minutes for a long consultation. This is a challenge since Aboriginal and Torres Strait Islander patients often have needs which take much longer to address. The three-year freeze on MBS items was also a challenge for ACCHOs in addition to there being few items for Registered Nurse and Aboriginal Health Worker episodes of care.

### MBS income is reliant on GPs

The reliance of MBS income on GPs present a funding barrier for ACCHOs. To drive MBS income ACCHOs need GPs, and many ACCHOs experience challenges in attracting and retaining GPs including their need to subsidise GP contracts from core funding. For newly established ACCHOs and those with high GP turnover, it can take time for new GPs to earn the respect and trust of the local community which affects MBS income generation. This also impacts the ACCHOs ability to meet nKPI targets.

### Complexity of numerous income streams

ACCHOs need to manage numerous funding streams and the associated reporting burden. CEOs and leadership invest a great deal of time applying for tenders and managing various Memorandums of Understanding and financial reporting responsibilities.

### Wage increases are not matched by increases in Commonwealth funding

The core funding that ACCHOs receive from the Commonwealth is not currently indexed to inflation. The salaries that ACCHOs pay to staff are indexed to inflation, and therefore go up each financial year. This mismatch between Commonwealth funding and ACCHO salary costs leave ACCHOs with a deficit that they need to manage.

### Time and resources needed to build relationships and prepare funding submissions

There are different sources of funding available for ACCHOs in different states, which might include but not be limited to: mental health, Drug and Alcohol, Social and Emotional Wellbeing, Trauma informed care, National critical response, Tackling Indigenous Smoking, Closing the Gap, and a number of trials including health care homes, national suicide prevention, partners in recovery and family partnership. The challenge and burden for many ACCHOs is in having the human resources (both in terms of time and staff capacity) to work with funders to build strong relationships and determine the service's eligibility for different funding streams. Without time and resourcing to invest in staff training, ACCHOs face significant barriers to preparing tenders and funding applications.

### Competing and negotiating with PHNs and NGOs for Aboriginal health funding

ACCHOs must compete through tender processes with PHNs and NGOs for funding set aside for Aboriginal and Torres Strait Islander clients. PHNs are often allocated funding by the Commonwealth such as for Integrated Team Care, Mental Health and Drug and Alcohol which then requires a process of negotiation before it is re-allocated to ACCHOs. There are delays in funding allocation to ACCHOs because of inefficiencies during the co-design and negotiation process. This mechanism creates a system where PHNs represent another barrier for ACCHOs in accessing funding for Aboriginal and Torres Strait Islander peoples. In contrast, ACCHOs that have an embedded Integrated Team Care coordinator within their workforce model reduce duplication and increase continuity of care between the ACCHO and both secondary and tertiary services. Activities include care planning, care coordination, family conferences, client advocacy, transport, and coordination of equipment and medication. Clients benefit from a seamless, coordinated culturally safe service with workforce they know and trust, who advocate on their behalf to promote access to the equipment and services they need to manage chronic conditions.

### Staff turnover due to delays in funding announcements

When there are delays in funding announcements, staff who are on short-term contracts are faced with uncertainty around whether their contracts will be renewed. This leads to a high turnover of staff in the ACCHO and loss of corporate, program and cultural knowledge in addition to community engagement.

### Ongoing reform challenges

The ACCHO sector is frequently faced with reforms and changes to their funding model which brings uncertainty to organisations and drains on resources during change management processes.

## Recommendations

### Recommendations for ACCHOs

- Develop a strong relationship with Medicare so that you can build staff capacity in relation to MBS billing and ensure the service accesses all eligible MBS income.
- Seek support from your state/territory peak body in relation to maximising MBS income.
- There are potential savings in operational expenses by obtaining loans to purchase ACCHO sites. Some ACCHOs may be in a position to undertake a cost-benefit analysis to weigh up purchasing versus renting the premises.
- Look for opportunities to share expenses with other services, such as IT costs.
- Include rental costs in funding submissions so that the government is aware of the expense ACCHOs incur through renting premises.
- Carefully consider whether a source of funding is beneficial to your organisation, given that it will come with various reporting requirements. Some services only accept funding for over $100,000 to make it worthwhile.

### Recommendations for Peak Bodies

- Continue to support member ACCHOs with financial modelling to maximise all forms of income and through training in relation to preparing tenders and funding submissions.

### Recommendations for Policy Makers

- The salary costs of ACCHOs have increased over time and are not covered by increases in Commonwealth funding. ACCHOs would benefit from a fair investment of core funding from the Commonwealth and state health departments to adequately fund the services they provide.
- Consider a review of MBS items for ACCHOs to reflect the real time costs of providing holistic services to the Aboriginal and Torres Strait Islander community that supports Aboriginal ways of working.
- Fund ACCHOs to provide integrated family-centred care to their communities and provide transport and home visits to promote accessibility of services.
- Fund ACCHOs through an outcome focused model with priorities set by the ACCHO sector that includes resourcing activities that ACCHOs undertake to address the social and cultural determinants of health.
- Streamline the reporting requirements and processes related to ACCHO funding to reduce the administrative and reporting burden.
- Directly fund ACCHOs for Mental Health, Drug and Alcohol and Integrated Team Care rather than indirectly through PHNs to minimise delays in service provision to community.
- Ensure sufficient timelines are provided for funding submissions so that ACCHOs with limited staff capacity can participate and be competitive.
- Develop subsidised training and professional development opportunities for ACCHO staff as these are challenging for individual services to support under core funding.
- The ACCHO sector needs to be funded to directly provide dental services, where there is capacity, or facilitate access to dental health services through collaboration with jurisdictional government dental services and private dentists.

## Discussion

ACCHOs are small to large sized businesses which provide a complex array of programs to their local Aboriginal and Torres Strait Islander communities. ACCHOs are charged with the responsibility of providing 'holistic, comprehensive, and culturally appropriate health care to the community which controls it' which encompasses physical, social, emotional, cultural and spiritual dimensions of health (NACCHO, 2018a). ACCHOs have long been recognised for the holistic service provision they provide to community and are valued by community for their culturally safe and appropriate holistic care in addition to their accessibility and welcoming social spaces (Gomersall et al, 2017). ACCHOs provide a breadth of services that address the social determinants of health (e.g. racism, housing, income, employment, education) and cultural determinants of health, as illustrated in a recent document review of ACCHO annual reports (Pearson et al, 2019). This chapter, however, demonstrates that newly emerging or smaller ACCHOs with limited funding cannot promote accessibility through transport and home visits and are therefore limited in their ability to address the social determinants of health.

ACCHO programs and services are resourced via a range of funding streams which can include core government funding, funding through the Medical Benefits Schedule, program funding and tender-based or grant funding. ACCHOs are faced with multiple different funding streams and tender processes all of which have different reporting and application requirements. The reporting burden and complexity associated with administering income across multiple funding sources was highlighted by Dwyer and colleagues close to a decade ago (Dwyer et al, 2009). An in-depth case study with Rumbala Aboriginal Co-operative in Victoria clearly demonstrates the ongoing burden of reporting for ACCHOs and argues that this burden negatively impacts service delivery (Silburn et al, 2016). In the delivery of holistic services in the 2013-14 financial year, Rumbala Aboriginal Co-operative held 48 separate agreements with 12 funding agencies that included state and federal government departments, government-funded not-for-profit organisations and other agencies. They were required to provide 409 reports against 46 of these agreements, with reports at monthly, quarterly, half-yearly and annual intervals (Silburn et al, 2016).

The available funding streams can vary greatly across the states and territories of Australia, and from one year to the next. In this sense, ACCHOs must be proactive and responsive in identifying the funding available and preparing submissions. Competitive funding submissions take time, and therefore precious human resources. This is challenging for ACCHO leadership, who are often overwhelmed by multiple competing responsibilities (Hill et al, 2001) and the challenges of managing their organisations, supporting and growing their staff and providing services to community. This is particularly challenging for leadership in newly established ACCHOs who must invest significant time and resources towards navigating the transition to an incorporated Aboriginal community controlled service and in establishing the necessary organisational structures and processes in addition to governance mechanisms. The transition to Aboriginal community control is frequently challenged by inadequate resourcing with respect to time, money and capacity (Dwyer et al, 2015).

The ACCHO model of service provision requires a greater time and financial investment than mainstream primary health care services who generate sufficient income by servicing a volume of patients with shorter appointment times. In providing culturally safe care to Aboriginal and Torres Strait Islander clients with complex needs, ACCHO staff invest time in developing trusting relationships with clients. It is for this reason that ACCHO clients often require greater time with staff than the MBS reimburses through the schedule. This additional time, which needs to be funded out of the service's operating budget, is what ACCHO staff describe as 'doing it for love'. This is a challenge for newly emerging ACCHOs with limited core funding and demonstrates how MBS funding models do not align with ACCHO service provision.

ACCHOs need to constantly balance a fine line between meeting community expectations and ensuring the ongoing financial security of the service. If an ACCHO loses the trust and connection with community, the financial position of the organisation is threatened through fewer appointments and a loss of MBS income. On the other hand, if an ACCHO provides an extensive range of services to community to meet all expectations, it is likely to go into financial deficit. ACCHOs carefully select service provision that is achievable and can be provided over the long term. They communicate with community in a transparent way what their funding model can and cannot provide, maintaining community trust and connection through this approach. The limited core funding of newly established ACCHOs can

impede their ability to routinely provide much needed transport to their clients. More established ACCHOs often provide transport to and from appointments to increase primary health care access to Aboriginal and Torres Strait Islander clients impacted by the social determinants of health (Davy et al, 2016).

ACCHOs and other First Nations' primary health care services are characterised by a culturally appropriate and skilled workforce in addition to flexible approaches to care and other key elements (Harfield et al, 2018). In contrast to other primary health care services, ACCHOs often have to invest a significant amount of time and resources in training and developing Aboriginal and Torres Strait Islander staff which can affect their income generation. As the single largest employer of Aboriginal and Torres Strait Islander peoples across Australia (NACCHO, 2018b), ACCHOs would benefit from commensurate resourcing for the key role they play in building the capacity of local Aboriginal and Torres Strait Islander workforce. This could enable ACCHOs to fund tailored external professional development opportunities for their staff to further strengthen ACCHO workforce capacity.

ACCHO staff report a considerable time cost associated with preparing funding submissions and preparing reports for the various funding streams they access. This is a challenge for services and is consistent with the burdensome reporting load of ACCHOs described by others (Dwyer et al 2009). The need for ACCHOs to invest time and resources in tendering for Aboriginal and Torres Strait Islander health programs through their local PHNs demonstrates that governments do not recognise the ACCHO sector as the preferred provider for Aboriginal and Torres Strait Islander clients. The need for streamlining of reporting requirements and funding mechanisms for ACCHOs, or greater support for emerging ACCHOs in navigating these funding mechanisms, is evident. Given the burdensome nature of multiple funding streams and reporting requirements, ACCHOs must carefully weigh up the benefit of any additional funding stream against the time costs incurred in administering the funds.

To enable ACCHOs to provide quality culturally safe care to community, the Commonwealth could consider a review of MBS items to reflect the real time and resource costs associated with developing relationships and providing services to clients. A match in the core funding of ACCHOs in line with increases in salary expenses would support ACCHOs, in addition to directly funding ACCHOs for Aboriginal health programs rather than indirectly through PHNs. ACCHOs would also benefit from additional support and subsidised professional development opportunities for staff, in recognition of their key role in building capacity in Aboriginal and Torres Strait Islander workforce nationwide.

## Further considerations

This chapter focused on the funding approaches and challenges of a newly established ACCHO. In Table 11 on the following page, funding challenges broadly impacting the ACCHO sector are outlined. These challenges were drawn from a review of ACCHO case studies on the social determinants of health, health promotion, aged care, funding and workforce. Potential policy level responses to the identified funding challenges are also included for consideration.

**Table 11: ACCHO Funding challenges and policy implications**

| Domain | Challenge | Potential policy level response |
|---|---|---|
| **Funding agreements** | Funding that is insufficient, short term and/or insecure. | Funding agreements to provide long-term sustainable funding to adequately resource the ACCHO comprehensive primary health care model and program evaluations. |
| | Restrictive funding agreements including programs with predetermined priorities or that do not support a comprehensive social determinants of health approach.<br><br>ACCHOs consult with community to identify local needs, but due to funding limitations cannot deliver identified services. | Engage the sector to co-design relevant KPIs that reflect and capture the comprehensive primary health care model of ACCHOs.<br><br>Funding agreements to incorporate flexibility that enables ACCHOs to consult with their communities, identify local priorities and tailor services to local need. |
| | Complexity in coordinating multiple sources of funding including reporting burden. | The frequency and complexity of reporting to be streamlined to reduce the burden on the ACCHO sector. The sector requires additional resourcing for administration including IT, data and reporting and financial management. |
| **MBS** | MBS funding models may not always match Aboriginal ways of working (e.g. short consult times, few MBS items for Aboriginal Health Workers).<br><br>ACCHOs that meet with challenges in recruiting and retaining GPs are limited in their ability to generate MBS income.<br><br>ACCHOs can find it challenging to meet the training and development needs of staff in relation to MBS billing. | MBS to consult with the ACCHO sector regarding MBS items needed to support cultural ways of working.<br><br>ACCHOs benefit from support and training for workforce related to MBS billing. |
| **Submissions and tenders** | Considerable time and resources needed to build relationships with potential funders and prepare tenders and funding submissions. | Funding opportunities through tenders and funding submissions to have reasonable timeframes and be promoted to the ACCHO sector.<br><br>The ACCHO sector would benefit from capacity building in relation to preparing competitive submissions.<br><br>The ACCHO sector would benefit from support to develop financial models (that contrast potential income against anticipated expenditure) to inform decision making related to the financial viability of additional program delivery. |
| | Competing for Aboriginal health funding with non-Indigenous organisations. | ACCHOs to be recognised as experts in Aboriginal comprehensive primary health care and the preferred recipient of funding for Aboriginal and Torres Strait Islander initiatives. |

| Domain | Challenge | Potential policy level response |
|---|---|---|
| **The social determinants of health** | ACCHO funding does not adequately resource activities to address the social determinants of health. ACCHOs are not funded for their extensive advocacy activities or to provide transport (note: some ACCHOs use income generated through the MBS to fund these activities).<br><br>Aboriginal and Torres Strait Islander people have an inequitable burden of dental health challenges which impact social standing and employment opportunities. | Funding agreements to resource ACCHOs to address the social determinants of health through intergrated family-centred care coordination and including services to promote accessibility to holistic health care such as transport and home visits and for their extensive advocacy activities.<br><br>The ACCHO sector to be directly funded to provide dental services, where there is capacity, or funded to facilitate client access to dental health services through collaboration with jurisdictional government dental services and private dentists. |
| **Workforce recruitment and retention** | Funding that is insufficient, short term or insecure can lead to non-competitive staff salaries, job insecurity, staff turnover, lost corporate knowledge and community connections. Delays in funding announcements cause staff to leave ACCHOs. | Funding agreements to provide greater resourcing for ACCHO programs, indexed to inflation, so staff can be competitively remunerated in line with other sectors. Long-term and secure program funding is needed to promote job security and retain corporate knowledge. |
| **Workforce capacity building** | ACCHOs invest in strengthening the capacity of ACCHO staff including mentorship of non-Indigenous staff around cultural ways of working. | Funding agreements to recognise and resource ACCHOs for their key role in strengthening the capacity of Aboriginal and Torres Strait Islander workforce and non-Indigenous workforce. |
| **Funding reforms and sector reforms** | While desperately needed, funding reforms create uncertainty for the ACCHO sector. | NACCHO could be funded to develop and disseminate resources and training packages to support ACCHOs to navigate the funding reforms including beyond the 3-year grace period. |
| | ACCHO resources are drained when taking on new programs and navigating sector reforms (e.g. staff training, time invested in adopting new systems, processes and terminology). | When major initiatives and reforms are planned, policy makers to consider preparing an ACCHO Impact Assessment and an implementation guide for the ACCHO sector. |

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# Funding approaches in newly established ACCHOs: Reflection Tool

Newly established ACCHOs work hard to develop funding approaches that are sustainable in the long term. They carefully consider how to maximise income generation and ensure operational expenditure is strategic so that they can provide quality culturally-centred care based on community priorities. The Board of Directors and CEO undertake strategic decision-making that balances holistic service provision for community and the long-term financial viability of those services. The ultimate aim of the ACCHO approach to funding is to provide sustainable, quality, culturally-safe, community-centred holistic care to local Aboriginal and Torres Strait Islander peoples.

**Step 1. Consider the values and principles guiding funding approaches in newly established ACCHOs, and the strategies some services use to generate income and ensure operating expenditure is strategic.**

**Step 2. What strategies do you have in place and are there others that you could consider?**

## Approaches to funding in newly established ACCHOs

## Values and principles guiding the funding approaches of newly established ACCHOs

- ☐ Our mission to provide quality culturally safe community-centred care guides all decision making in relation to our funding and drives our staff to go above and beyond in their roles.
- ☐ Our Board of Directors and CEO make strategic decisions about service provision that consider the funding opportunities available and the priorities of the community. These decisions are informed by financial projections developed by our finance team.
- ☐ We balance holistic care with long term financial affordability: our CEO and Board carefully consider how we can meet community needs whilst maintaining the sustainability and financial security of our service. Our service delivery is targeted and selective and determined by core funding, MBS income, successful grants and tenders, and targeted program funding for special initiatives.

## Strategies to maximise income through the MBS

- ☐ We provide clients with SMS reminders to minimize missed appointments.
- ☐ We use funding flowcharts to ensure that clients are receiving all services they are eligible for.
- ☐ We check client eligibility with the MBS prior to undertaking health checks (to ensure community members have not completed a health check in the past year at another service).
- ☐ We provide incentives to community members to attend the service (e.g. all clients receive a t-shirt when completing their health checks).
- ☐ We undertake retrospective audits to ensure all MBS claims are complete.
- ☐ We provide training and support to all staff to ensure that MBS claiming processes are functioning well.

## Other income generation strategies

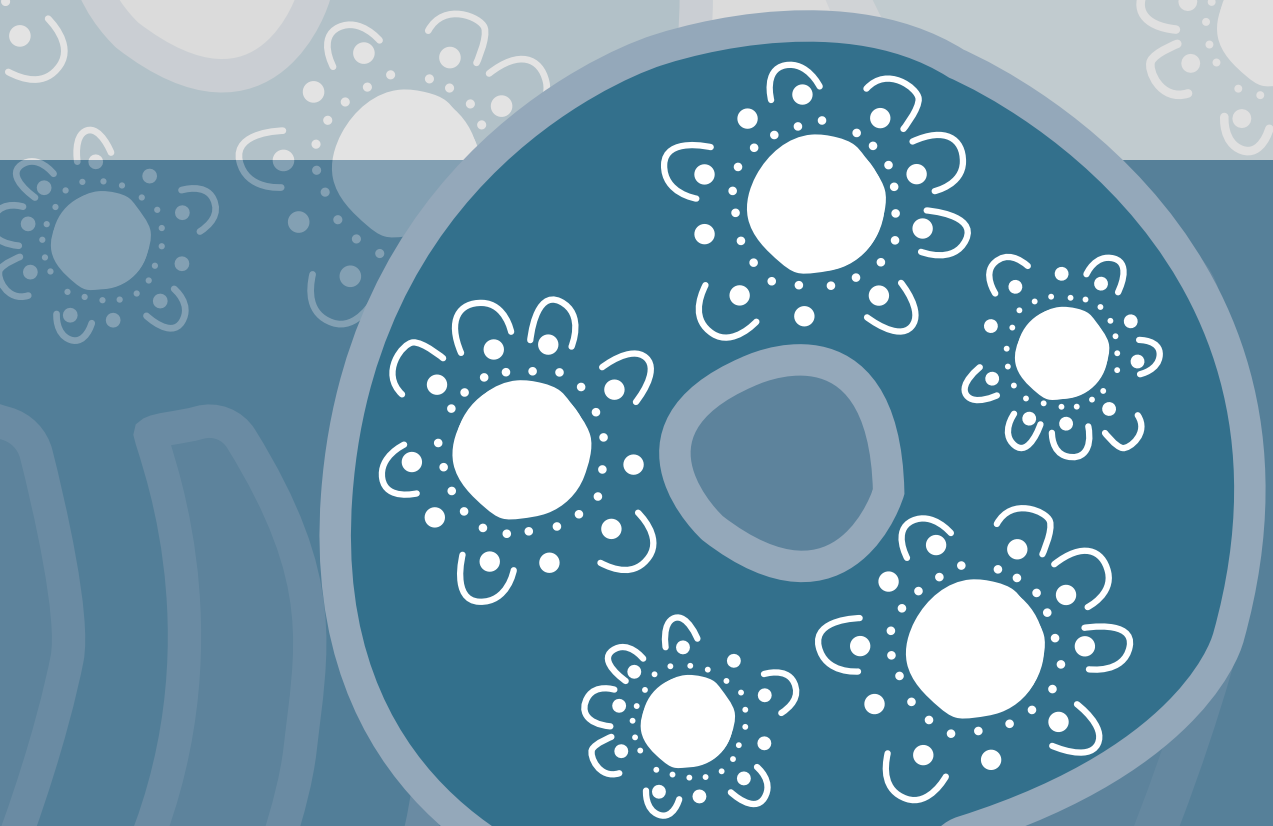
- ☐ We have registered for the Practice Incentive Program to receive income under Close the Gap for services we provide to community and for hosting medical students.
- ☐ We generate income through training GP Registrars in our clinic.
- ☐ We sub-lease our office space, where possible.
- ☐ We look for funding opportunities through government departments, PHNs and non-government organisations and prepare tenders and funding submissions for special initiatives.

## Strategies to ensure operating expenditure is strategic

- ☐ We have registered as a charity with the Australian Charities and Not-for-profits Commission and have a waiver from the local Council for annual council rates.
- ☐ We provide salary sacrificing to our staff to reduce their taxable income and their yearly tax bill.
- ☐ We have obtained a business loan through Indigenous Business Australia to purchase our property to reduce our operating expenditure (as our mortgage payments are less than rent expenses).
- ☐ We share operating costs with other services wherever possible, such as sharing IT expenses.
- ☐ We seek out subsidized professional development and training courses for our staff wherever possible to ensure that our staff receive the capacity building they deserve.

# Chapter 8

## A Health Check for the service: ACCHO approaches to accreditation



# A Health Check for the service: ACCHO approaches to accreditation


## Summary

Accreditation is the formal process that ACCHOs and other health organisations go through to demonstrate they meet national Standards of practice. Achievement of accreditation provides independent and external recognition that the ACCHO is a well-functioning and professional organisation. To conduct their day to day business as a health service, ACCHOs must have clinic accreditation. Those that offer extended services (e.g. aged care, disability services, mental health, dental, early childhood education) have additional accreditation requirements.

Accreditation can be managed by a small group or large team of ACCHO staff, depending on the size of the service, though all staff contribute to achieving accreditation. Representatives from external accrediting bodies visit the ACCHO to meet with staff and collect information. ACCHO staff provide Accreditors with documents (e.g. policies, procedures and reports) as evidence of the systems they have in place to fulfil the requirements of the Standards. Accreditation benefits the ACCHO since it provides community, funders and partner organisations with assurance that the ACCHO has systems in place to provide a quality and professional service.


The content within this chapter was based upon an in-depth case study with a metro ACCHO, further refined with input from the CREATE Leadership Group, and strengthened with additional learnings from other ACCHO case studies.

## What we cover in this chapter:

- What is accreditation?
- Why do ACCHOs need accreditation?
- Who coordinates the accreditation process?
- Accreditation Standards and how they apply to ACCHOs
- How often do Accreditors come?
- How do ACCHOs collect, store and prepare information to support accreditation?
- How is the information provided to the Accreditors?
- What resources do ACCHOs use?
- What happens when the Accreditors come to the service?
- Benefits and outcomes of accreditation
- Enablers of accreditation
- Challenges of accreditation
- Recommendations
- Discussion
- References
- Reflection Tool

## What is accreditation?

Accreditation is the formal process that ACCHOs and other health organisations go through to demonstrate that they meet all requirements of national Standards of practice (the 'Standards'). It can be seen as a 'health check for the organisation' and generally includes long cycles of assessment (e.g. every three years). Achievement of accreditation provides independent and external recognition from an authoritative accrediting body that the ACCHO meets national Standards.

## Why do ACCHOs need accreditation?

Clinical accreditation is a requirement of the Federal government's funding agreements for ACCHOs and is needed to apply for additional funding opportunities such as the Practice Incentives Program for general practices. Accreditation also gives assurance to clients, funders and partner organisations that the ACCHO has the systems in place to deliver quality health care.

## Who coordinates the accreditation process?

Depending on the size of the ACCHO, a small group or large team of people may coordinate the accreditation process and prepare the organisation for the visiting Accreditors. It is good to have a group of people managing the process rather than just one person, so that there is increased capacity within the organisation and so that it doesn't burden just one staff member. This team of people can help to drive accreditation and subsequent quality improvement activities and may notify ACCHO staff of the upcoming accreditation activities via email and during staff meetings. The following boxes provide examples of how different ACCHOs manage the accreditation process.

The *Metro ACCHO* has a team of three people within the 'Accreditation and Quality Unit' that coordinate most of the accreditation activities. The Unit's primary role is to support the organisation with coordination of quality improvements, planning and reporting processes and preparing documentation for the accreditation process. This includes uploading evidence to the online portal of the accrediting body prior to the Accreditor's site visit.

At a large *Regional ACCHO*, a 'CQI and Accreditation Officer' coordinates the organisation's continuous quality improvement and accreditation activities and supports staff across the organisation to contribute to both processes.

At a small *Regional ACCHO*, the executive assistant to the CEO coordinates the accreditation process for the ACCHO with support from a nurse in the clinic. This responsibility is in addition to the diverse tasks they do to support the CEO.

## Accreditation Standards and how they apply to ACCHOs

There are several Standards that ACCHOs can be accredited against, that cover the health clinic, whole organisation, or specific programs and services.

### Health clinic accreditation

ACCHOs require clinical accreditation under the *Royal Australian College of General Practitioners Standards.* Those that train general practice registrars require accreditation under the *Royal Australian College of General Practitioners Vocational Training Standards.*

### Organisational accreditation

There are multiple organisational accreditation Standards such as the *Quality Improvement Council Health and Community Services Standards,* the *International Organisation for Standardization (ISO) 9001 Quality Management System Standards* and the *Australian Service Excellence Standards (Version 5).* Organisational accreditation is not compulsory in all jurisdictions though is a condition of many funding agreements. It is for each ACCHO to decide whether to undertake organisational accreditation and to choose the accreditation Standard that best suits the service.

### Accreditation for specific programs and services

ACCHOs that have extended services have additional accreditation requirements, such as accreditation under the *Aged Care Quality Standards* for those that provide aged care, accreditation under the National Disability Insurance Scheme's (NDIS) *NDIS Practice Standards* for those that provide NDIS disability services, and accreditation under the Australian Children's Education and Care Quality Authority's *National Quality Standards* for those that provide early childhood education. There are some ACCHOs that have a functioning Registered Training Organisation that also require accreditation under the Australian Skills Quality Authority's *Standards for Registered Training Organisations*. There may be additional state or territory-based accreditation requirements that the ACCHO must also achieve.

Seven examples of accreditation Standards for the ACCHO sector are outlined in Table 12, with details of each accrediting body and what the accreditation demonstrates.

The *Metro ACCHO* is accredited under four separate accreditation frameworks. These provide accreditation for the whole organisation, accreditation for the general practice clinic, accreditation to provide training to GP Registrars, and accreditation to offer a range of nationally recognised training courses through their Registered Training Organisation. The Metro ACCHO elected to voluntarily obtain organisational accreditation to establish the ACCHO as a quality service.

**Table 12: Accreditation Standards relating to ACCHOs**

| Standard | Part of the ACCHO being accredited | Accrediting Body | What accreditation against these Standards demonstrates |
|---|---|---|---|
| **Essential Accreditation Requirements** | | | |
| Clinic accreditation: | | | |
| Royal Australian College of General Practitioners Standards (5th Edition) | General Practice Clinic | Australian General Practice Accreditation Ltd, Quality Practice Accreditation Pty Ltd, and other providers | The health clinic has systems in place to provide quality general practice care. |
| **Voluntary Accreditation** | | | |
| Organisational accreditation under one of the following: | | | |
| International Organisation for Standardization (ISO) 9001 Quality Management System Standards[1] | Whole of organisation related to the quality management system | International Organization for Standardization | That the ACCHO meets international organisational standards that specifies requirements for a quality management system. |
| Quality Improvement Council Health and Community Services Standards (7th edition) | Whole of organisation | Quality Improvement Council | Organisational systems are in place across multiple areas including governance, corporate systems, service delivery. |
| Australian Service Excellence Standards (Version 5) | Whole of organisation | Quality Innovation Performance Limited | Organisational systems are in place across management; people, partnerships and communication; and service provision.. |
| **Additional Accreditation Requirements for some ACCHOs** | | | |
| The Royal Australian College of General Practitioners Vocational Training Standards | General Practice Clinic | Australian General Practice Accreditation Limited | The ACCHO has systems in place to be an 'Indigenous Health Training Post' providing culturally appropriate training and supportive environments for GP Registrars*. |
| Australian Skills Quality Authority – Standards for Registered Training Organisations 2015 | Registered Training Organisation (RTO) | Australian Skills Quality Authority | The RTO provides courses that are nationally recognised and meet an established industry, enterprise, educational, legislative or community need[2]. |
| Aged Care Quality and Safety Commission's Aged Care Quality Standards** | Aged Care Service | Aged Care Quality and Safety Commission | The ACCHO has systems in place to provide quality aged care services. |

* GP Registrars are doctors who have finished medical school and who are in a formal training program to become General Practitioners (GPs).

** Note that the Aged Care Quality Standards were brought in July 2019 and replace the Commission's Accreditation Standards (for residential aged care) and Home Care Common Standards.

[1]American Society for Quality (ASQ). (no date). *What is ISO 9001:2015 – Quality management systems?* Accessed on January 17, 2020 at: asq.org/quality-resources/iso-9001

[2]Australian Skills Quality Authority. (2019). *Accreditation with ASQA*. Accessed on January 17, 2020 at: asqa.gov.au/course-accreditation/accreditation-asqa

## How often do Accreditors come?

Representatives from external accrediting bodies visit the ACCHO to look at whether the ACCHO meets the national Standards. The accreditation cycle is often every three years once an ACCHO has completed the initial application process and has been assessed by an external accrediting agency. For an ACCHO to maintain their accreditation they must successfully be re-assessed at each cycle of accreditation.

## How do ACCHOs collect, store and prepare information to support accreditation?

The ACCHO provides Accreditors with documents (e.g. reports, policies and staff and community feedback reports) as evidence of their systems and services. Depending on the size of the ACCHO, information may be stored in paper based or electronic files, or through quality management system software. Evidence is provided in the form of policies and procedures and other documents negotiated with the Accreditors. This evidence need not include any specially created documents but rather the day-to-day operational policies and procedures that the ACCHO uses. Clinical accreditation is outcome-focused and patient centred and includes outcome focused indicators. To prepare for Accreditation, staff ensure sound practices all year round such as keeping client records up to date and being familiar with policies and procedures.

At a *Regional ACCHO*, the size of the service allowed them to incorporate a quality management system to record and store all organisational documentation electronically. The only road-block for this approach is that it is a license-based software, and they only have enough funding to buy 30 licenses in a service that employs over 50 staff.

At a small *Regional ACCHO*, information is collected and collated by hand (either electronic or written) as the service is unable to fund quality management system software.

## How is the information provided to the Accreditors?

ACCHO staff upload documentation to the online portal of the accreditation body before the due date set by the Accreditors. The Accreditors assess the documents prior to the visit and then meet with staff onsite to discuss. Staff aim to establish and maintain strong working relationships with accrediting organisations and liaison officers. This connection bridges the gap in understanding of the pros and cons of accreditation.

## What resources do ACCHOs use?

To support their clinic accreditation process, ACCHOs can use the in-depth guide produced by the Royal Australian College of General Practitioners, the *Interpretive Guide to the RACGP Standards for general practices (4th Edition) for Aboriginal Community Controlled Health Services*[3]. Note that there has not been an interpretive guide developed that aligns with the latest (5th edition) of the *RACGP Standards for general practices*. The Quality Improvement Council has an online portal with guidance related to organisational accreditation.

At a *Regional ACCHO*, the accreditation team regularly uses the Quality Improvement Council's portal which provides the list of Standards and how information can be used across different areas. The portal also provides useful paper resources.

[3]Royal Australian College of General Practitioners. (2015). *Interpretive guide to the RACGP Standards for general practices.* Accessed on January 17, 2020 at: www.racgp.org.au/running-a-practice/practice-standards/standards-4th-edition/interpretive-guide

## What happens when the Accreditors come to the service?

The designated Accreditation Officer or team within the ACCHO hosts the Accreditors and discusses how the service is meeting each of the Standards. Other ACCHO staff are also interviewed by Accreditors such as the CEO, Board member, General Practioner, Aboriginal Health Worker, community member or client. Staff and stakeholder interviews take place to ensure systems are effectively implemented and communicated throughout the service. Depending on the accrediting body, the Accreditors may visit the service for a few hours or up to 3 days.

The *Metro ACCHO*, two Accreditors from Australian General Practice Accreditation Limited (AGPAL) came to the service for four hours, including one General Practitioner and one Registered Nurse. The Accreditors met with the team, went through the documents that were uploaded to the portal, and let the service know if anything was missing. The service found some additional evidence on the request of the Accreditors.

At a *Regional ACCHO*, three auditors from the Quality Improvement Council (QIC) came to the service for three days. Before the visit, QIC sent the service a Preparation Form outlining their site visit itinerary. During the visit, QIC auditors met with staff from across the organisation. After the site visit, QIC sent a report to the service outlining what Standards had been met, what Standards had not, and where additional evidence was required. The service had 3 months to provide additional evidence (known as 'a period of grace'). A Quality Improvement Plan was then developed which the service reported on after 18 months to demonstrate what they had implemented to meet all of the Standards. The service was given a contact person at QIC who they could communicate with in an ongoing way between the three yearly accreditation cycles.

## Benefits and outcomes of accreditation

Accreditation can be used as a value adding mechanism to ensure ongoing quality improvement processes are in place, and the service has clear policies and procedures to promote patient safety and quality care. A benefit of accreditation is the quality focus it brings to organisations. When ACCHOs involve all teams in the process through clear and transparent communication, staff can see how their individual activities play a key role in enabling the organisation to achieve accreditation and provide quality services to community. Accreditation can focus all staff on a common goal.

Accreditation ensures that systems are in place that promote client safety and identify and manage risks within the service. It also ensures a clear community feedback process is in place, increasing client engagement and participation, as well as an internal referral system to ensure continuity of client care across the service.

At the *Metro ACCHO*, accreditation has brought many benefits for ACCHO staff, the organisation and the community. Due to their close connection with clients and an inherited responsibility to provide quality care, staff are engaged in the quality improvement process. The service is a quality focused organisation with accreditation used as a value adding mechanism to identify quality improvement priorities and build a culture of continuous quality improvement at all levels. It has promoted consistent, quality services to the community by focusing on client and community needs. It also supported the delivery of cultural safety training to the workforce to enable the delivery of culturally safe care. Clients reported that the accreditation sticker gave them confidence - 'confidence that you guys know what you are doing'.

## Enablers of accreditation

- **The Board of Directors (hereafter, simply referred to as the Board), CEO and Senior Management Team champion the organisation in building a quality culture and promote staff investment.** Staff investment in accreditation is enabled by leadership promoting the value of accreditation to the organisation.
- **Achieving accreditation is everyone's business:** staff understand that accreditation ensures the ACCHO provides quality and client-centred care. All data and evidence for accreditation is recorded all the time, not just in preparation for the accreditation cycle. Staff have efficient and effective access to policies and procedures to support client services.
- **The Accreditation Coordinator/Team has a good understanding of the Standards:** this helps to streamline the process of gaining accreditation, minimise duplication across the Standards, and increase the efficiency of the accreditation process.
- **There are several people in the organisation who understand accreditation:** accreditation is undertaken by a team of people who manage the process. This also ensures there is succession planning in place and that knowledge of accreditation isn't lost when key people leave the organisation.
- **The ACCHO accreditation team has someone they can contact within the accrediting body:** a good relationship with the Accreditors helps to support the accreditation process because questions are answered in a timely way.
- **A quality management system is in place in larger organisations:** Some ACCHOs have quality management system (QMS) software which helps to store the information needed for accreditation. Smaller organisations often maintain a paper-based document management system.
- **Accreditation is ongoing:** There are 'quality items' on the agendas of monthly meetings to be discussed and documented. This helps to keep quality and readiness for accreditation on the agenda for all teams and staff.
- **ACCHOs celebrate the wins:** Organisations often celebrate achievement of accreditation with staff lunches and dinners.

## Challenges of accreditation

- **Accreditation terminology is unfamiliar and complex**

The first time an ACCHO undertakes accreditation, or the first time a staff member is involved in the accreditation process, it can be daunting and difficult. With increasing experience, the accreditation process becomes more streamlined and efficient.

A *Regional ACCHO* was able to overcome this challenge by making accreditation and continuous quality improvement everyone's business. Communication was a key factor (e.g. via emails, staff meetings and newsletters). The more information that was available for staff the more everyone felt encouraged to be a part of the process.

- **Accreditation is difficult when it is coordinated by just one person**

Accreditation is manageable when the responsibility is shared across the whole organisation. Having capacity and knowledge across multiple staff and roles helps to maintain corporate knowledge when there is turnover of staff. Larger organisations can benefit from having a team of people who support the accreditation and quality improvement process. The responsibility of accreditation should be acknowledged within the job descriptions of staff, so it is not just an added burden on top of other duties. Funding constraints play a vital role in determining how many staff members can be involved in managing accreditation.

The *Metro ACCHO* established an Accreditation and Quality Unit which is responsible for coordinating and communicating about the services' accreditation activities. This includes informing staff of accreditation visits and processes and reminding staff of policies and codes of conduct.

- **Increased workload for ACCHO staff**

Accreditation brings an increased workload for staff, who are often managing the activity along with other responsibilities in their role.

The *Metro ACCHO* established a team of employees to manage accreditation as the service had enough funding to do so and flagged it as an organisational priority.

A *Regional ACCHO* established a defined "Accreditation Officer" role within the service to support the everyday business of accreditation. This also decreased duplication of documentation and reports and helped prepare the organisation for accreditation as an ongoing activity, rather than just in the months prior to the Accreditors visit.

- **There are multiple accreditation frameworks that need to be met, some of which overlap**

Some ACCHOs require accreditation under multiple Standards for their health clinic, organisation and programs. For those with extended services (e.g. aged care, disability, early childhood, dental), there may be as many as eight or more Standards to achieve.

The *Metro ACCHO* increased efficiency when undertaking accreditation by identifying key documents that could satisfy the requirements of multiple Standards. This was enabled by their Accreditation and Quality Unit having a good understanding of all of the Standards.

- **Interpreting the Standards and identifying relevant and specific evidence**

Determining what evidence to provide auditors to demonstrate compliance against Standards can be a challenge. The Interpretive Guides (e.g. *Interpretive Guide to the RACGP Standards for general practices (4th Edition) for Aboriginal Community Controlled Health Services*) have been helpful, but not all Standards have guides for the ACCHO sector.

A *Metro ACCHO* overcomes this by discussing within their internal Accreditation Working Group what evidence can be used to show it meets the criterion. This requires a solid understand of the criterion and the underlying objectives.

- **Considerable financial resources are needed for undertaking accreditation against multiple Standards**

The process of accreditation is costly for ACCHOs who invest considerable staff resources over an extended period to prepare for, host and communicate with the accrediting bodies. There is considerable staffing pressures and financial burden for ACCHOs that need to achieve accreditation across multiple Standards.

A *Regional ACCHO* seeks support from their peak body to help them prepare for and achieve accreditation.

- **Delays in Accreditor site visits impacting on ACCHOs**

Regional and remote ACCHOs often experience delayed or rescheduled site visits due to a lack of Accreditor availability. This causes increased stress to staff and contributes to inefficiences within ACCHOs.

## Recommendations

### Recommendations for ACCHOs

- Develop and foster a quality culture where accreditation is everyone's business. Make accreditation work for the organisation.
- Invest resources (e.g. time, staff and money), to embed accreditation processes across the organisation and centralise the coordination of accreditation activities.
- Employ and establish a dedicated team who is responsible for the day-to-day management of accreditation and continuous quality improvement, supported by key positions such as the CEO, executive management and the Board.
- Invest in the professional development of staff and teams (e.g. Accreditation Officer/ Accreditation and Quality Unit) within the ACCHO that prepare and manage the accreditation process.

### Recommendations for Peak Bodies

- ACCHOs would benefit from additional support from peak organisations in relation to accreditation. This could relate to financial support, training and networking opportunities. (e.g. a yearly state-based networking meeting of ACCHO Accreditation Teams which could be discussed at the CEO forums).
- ACCHOs would benefit from a yearly national networking meeting of ACCHO Accreditation Teams (e.g. hosted by NACCHO).

### Recommendations for Policy Makers

- As providers of comprehensive primary health care and extended services ACCHOs must achieve accreditation across multiple Standards which creates considerable staffing pressures and financial burden. Commonwealth and state/territory governments could provide additional supports (e.g. training and capacity building activities) to build capacity in ACCHO staff to enable the achievement of accreditation across multiple frameworks.
- Commonwealth and state/territory governments could allocate adequate resources within core funding agreements towards accreditation activities in ACCHOs that reflect the real time and personnel costs (e.g. allocate additional funding for a designated role to manage accreditation processes).
- Commonwealth and state/territory governments could support the development and implementation of Interpretive Guidelines for all accreditation frameworks for the ACCHO sector.

### Recommendations for Accrediting Bodies

- Accreditation bodies to understand the unique characteristics of the ACCHO sector and provide dedicated training and support mechanisms for ACCHOs with fewer financial and human resources.
- ACCHOs would benefit from RACGP Standards that align with concepts of holistic health rather than those only aligned with a biomedical focus.
- ACCHOs would appreciate development of an updated interpretive guide to the RACGP Standards, (i.e. *Interpretive Guide to the RACGP Standards for general practices (5th Edition) for Aboriginal Community Controlled Health Services)*.

## Discussion

### Coordination of accreditation in Australia

Recognition of the value of accreditation to promote sustainable quality systems in health has been building at a global level since the early 2000s. It is valued as a move from 'institutional regulation to integrated health system development, that is from static control to dynamic improvement' (World Health Organisation 2003, p. 53). In Australia, accreditation is promoted by the Australian Commission on Safety and Quality in Healthcare (the 'Commission') as an effective mechanism for continuous improvement in health care safety and quality (Australian Commission on Safety and Quality in Healthcare, 2006). The Commission was established in 2006 (Australian Commission on Safety and Quality in Health Care, 2017) and continues to lead and coordinate improvements in safety and quality at the national level. Since 2010 its initial focus on the acute care sector has expanded to include primary health care (Australian Commission on Safety and Quality in Health Care, 2011).

### History of accreditation in ACCHOs

Accreditation was first introduced to the Aboriginal Community Controlled Health Organisation sector by the Australian Federal Government as part of the 2006-07 Budget measures. These measures included a strategy to further develop Indigenous-specific service delivery and sector capacity including continuous improvement processes and support for organisations and health management systems (Department of Health and Ageing, 2006). The aim was to encourage more Aboriginal and Torres Strait Islander health services to achieve accreditation through mainstream agencies and upgrade their health information management processes.

The 2007-08 Budget measure, *A Better Future for Indigenous Australians – Establishing Quality Health Standards*, provided funding until 2011 to assist eligible organisations funded by the then Department of Health and Ageing through the then Office for Aboriginal and Torres Strait Islander Health to become accredited against Australian health care standards. The initiative sought to achieve clinical accreditation against the Royal Australian College of General Practitioners (RACGP) framework and organisational accreditation. This focus on accreditation was met with overwhelming support within the sector as voluntary accreditation was already well underway. Some ACCHOs were already undertaking accreditation activities at this time and suggested that prioritising quality improvement through accreditation shifted the focus from 'undertaking the minimum required to achieve accreditation to implementing best practice standards for improved service delivery, evidenced in part through accreditation' (Winnunga Nimmityjah Aboriginal Health Service 2008, p. 46).

ACCHOs are now encouraged to both obtain and maintain clinical accreditation. An implication of the Australian Commonwealth Government's focus on ACCHOs is that all funding agreements with the Commonwealth Government now have a condition that services must maintain clinical accreditation. It is also essential to become eligible for other sources of funding (e.g. Practice Incentive Program funding). ACCHOs applying for initiative specific funding must acquire additional accreditation such as for mental health, dental, NDIS and aged care.

National accreditation bodies suggest that accreditation benefits organisations by providing independent recognition that an organisation is dedicated to safety and quality, supports a culture of quality, fosters quality and performance assurance within an organisation, increases the organisations capability and reduces risk (Quality Innovation Performance, 2017). The value of accreditation for the ACCHO sector is yet to be determined from the ACCHO perspective. Accreditation is a mainstream concept that supports ACCHOs in capturing evidence and increasing quality service provision, which can benefit both the ACCHO and the community.

What is yet to be questioned is the degree to which accreditation has added burden to ACCHOs in relation to time and resources required to undertake accreditation activities; and whether accreditation and CQI support culturally-centred flexible and responsive service provision.

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# The ACCHO approach to accreditation: Reflection Tool

This Reflection Tool is designed to assist ACCHOs to reflect on the activities and mechanisms in place to prepare for and undertake accreditation.

Accreditation is the formal process that ACCHOs and other health services undertake to demonstrate that they meet the requirements of national Standards of practice. It can be seen as a health check for the organisation and provides independent and external recognition that the ACCHO is a well-functioning and professional service. ACCHOs must have health clinic accreditation as a minimum and may have additional accreditation requirements for specific programs and services. Accreditation can be used as a value adding mechanism to ensure ongoing quality improvement processes are followed and the service has clear policies and procedures in place to promote patient safety and quality care.

**Step 1. Reflect on the accreditation requirements of your ACCHO and the systems you have in place to support the accreditation process.**

**Step 2. Are there additional approaches relevant to your scope of practice and context that your ACCHO could consider implementing in the future?**

## We are accredited under the following Standards:

**Health clinic accreditation:**

- ☐ Royal Australian College of General Practitioner's Standards for general practices (5th edition).

**Organisational accreditation:**

- ☐ Quality Improvement Council Health and Community Services Standards (QIC).
- ☐ International Organisation for Standardisation (ISO) 9001 Quality Management System Standard.
- ☐ Australian Service Excellence Standards (Version 5)

**Accreditation for specific programs or services:**

- ☐ _____
- ☐ _____
- ☐ _____

## Our organisational approach to accreditation:

- ☐ Our Board, CEO and executive champion a quality culture in the organisation and promote staff investment in the accreditation process.
- ☐ There are multiple people who understand accreditation processes and are responsible for the coordination of accreditation activities. We have succession planning mechanisms in place in our accreditation team to ensure that corporate knowledge about accreditation is retained in the service even when key staff leave.
- ☐ Our accreditation team have a good understanding of the Standards to streamline accreditation processes, minimise duplication and increase efficiency.
- ☐ Our accreditation team have built a good working relationship with the Accreditors which enables us to seek support during the accreditation process where necessary.
- ☐ Our accreditation team seeks support from our peak body to help us prepare for and achieve accreditation.
- ☐ We strive to make accreditation everyone's business. We provide information to our staff on accreditation processes and activities via emails, newsletters and staff meetings. This includes reminding staff of policies and codes of conduct and informing staff of accreditation requirements and Accreditor's visits.
- ☐ We view accreditation as an ongoing process and have systems in place to ensure all data and evidence is recorded in an ongoing way, not just in preparation for the accreditation cycle.
- ☐ When we achieve accreditation, we come together to celebrate.

## Coordination of accreditation:

Recognising that each ACCHO is unique in size, scope of practice and context, the accreditation team may look like one of the following:

- ☐ Our ACCHO incorporates the coordination of accreditation and continuous quality improvement into existing roles, such as the executive assistant to the CEO and the Clinic Nurse working together to undertake the accreditation process.
- ☐ Our ACCHO has a designated staff member whose role focuses on the coordination of accreditation and continuous quality improvement activities. This staff member works with staff across the organisation with the support of the executive.
- ☐ Our ACCHO has a team of staff members who coordinate accreditation activities and continuous quality improvement processes.
- ☐ Other: _____

_____

_____

_____

_____

## Undertaking accreditation: storing and preparing evidence and meeting with Accreditor's:

- ☐ We use a paper-based recording system to record and store information.

**OR**

- ☐ We have an electronic Quality Management System to store our policies and procedures and other data.

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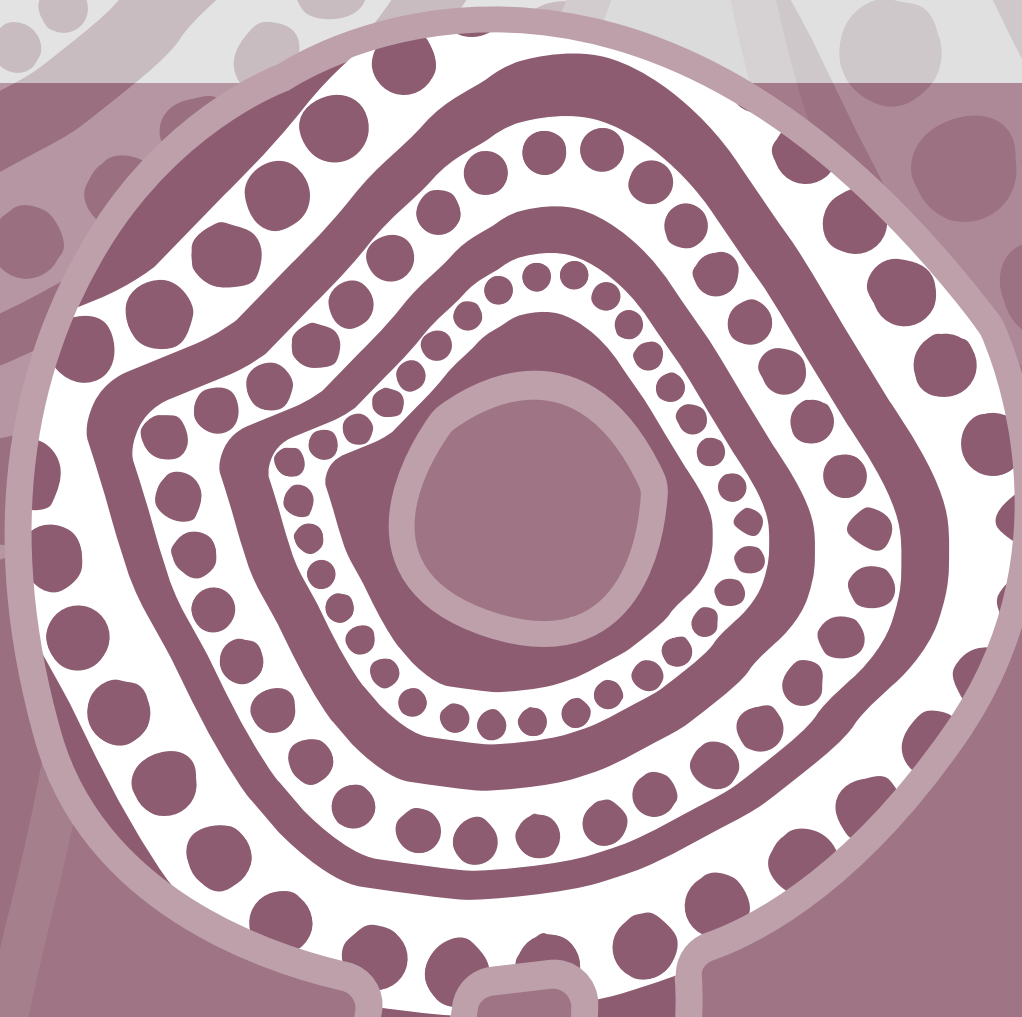
- ☐ We invest time in understanding and interpreting the Standards and reading through the online resources and interpretive guides provided by the accrediting body. We communicate with the liaison officer at the accrediting body to seek clarification where necessary.
- ☐ We have negotiated practical ways of providing evidence to demonstrate we are meeting the required Standards.
- ☐ We provide Accreditors with various documents (e.g. reports, policies, procedures and staff and community feedback reports) as evidence of our systems and services.
- ☐ We have identified key documents that can satisfy the requirements of multiple Standards. This helps increase efficiency when we need to achieve accreditation across multiple Standards.
- ☐ We upload documentation to the online portal of the accreditation body before the due date set by Accreditors.
- ☐ We meet with the Accreditors during their site visit to describe our policies, procedures and processes. We provide additional information upon request to ensure we achieve the Standards.
- ☐ Following the Accreditor's site visit, we review their report. If we haven't sufficiently met all the Standards, we prepare additional evidence and forward it to the accrediting body within the due date.

# Chapter 9

## It's everyone's business: Continuous Quality Improvement in ACCHOs



# It's everyone's business: Continuous Quality Improvement in ACCHOs


## Summary

ACCHOs strive to provide quality comprehensive primary health care to their Aboriginal and Torres Strait Islander communities and consistently review their programs and services to look for ways to improve. Consulting with local Aboriginal and Torres Strait Islander peoples is fundamental to the process which is known as continuous quality improvement (CQI). CQI processes differ across ACCHOs but consistently include collecting and analysing relevant data to identify what is and isn't working, designing and implementing improvements where necessary, and then monitoring and evaluating whether improved processes and outcomes are achieved over time. CQI is a whole-of-organisation approach with processes integrated within all teams and programs and embedded within the organisational culture of ACCHOs.

The drivers of CQI include the inherited responsibility of ACCHOs to tailor services to the needs of local communities and external drivers such as accreditation requirements, national key performance indicators and funding requirements. Common enablers of CQI include community connection and engagement, effective corporate systems, a corporate culture that promotes CQI as an everyday whole-of-organisation process, staff commitment and engagement in CQI, support from ACCHO state/territory affiliates, effective communication across the ACCHO and designated CQI Coordinators. In 2018 NACCHO launched the *National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023* that describes four key domains of CQI practice.


The content within this chapter was based upon an in-depth case study with a regional ACCHO, further refined with input from the CREATE Leadership Group, and strengthened with additional learnings from other ACCHO case studies.

## What we cover in this chapter:

- What is Continuous Quality Improvement?
- The National CQI Framework
- ACCHO approaches to CQI
- CQI processes within ACCHOs
- Benefits and outcomes of CQI
- Enablers of CQI
- Challenges of CQI
- Recommendations
- Discussion
- References
- Reflection Tool

## What is Continuous Quality Improvement?

Continuous Quality Improvement (CQI) is referred to as:

*'a simple, practical process of using information and analysis at the health service or practice level to understand the quality of care that clients are receiving, working to improve those elements that are not working as well as they might, and measuring change'(pg.2)*[1].

CQI consists of ongoing monitoring of quality of care and the way an organisation operates. CQI processes enable individuals, teams and organisations to review what is and isn't working, design and implement improvements where necessary, and monitor and evaluate whether improved processes and outcomes are achieved over time. In an ongoing way, ACCHOs reflect on community feedback and undertake CQI to tailor services to better meet the needs of community and staff and improve operational efficiency.

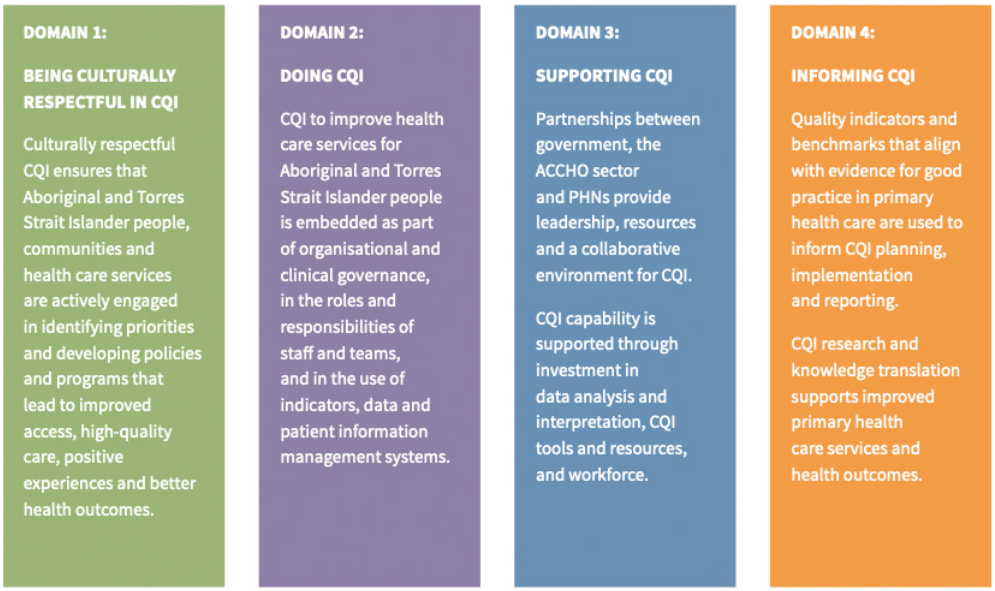
## The National CQI Framework

Following an extensive national consultation, in 2018 the National Aboriginal Community Controlled Health Organisation (NACCHO) released the *National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023*. The Framework describes CQI in the following way:

*CQI drives service improvements through continuous and repeated cycles of changes that are guided by teams, using data to identify areas for action, develop and test strategies, and implement service re-design. It works alongside accreditation, governance, monitoring and evaluation to improve health care and outcomes. CQI is most effective when it is embedded as part of the core business of providing health care*[2].

The Framework is relevant for all primary health care services for Aboriginal and Torres Strait Islander peoples, including ACCHOs, government-funded Aboriginal Medical Services and general practices. It outlines four key domains outlined in Figure 2.

**Figure 2: The National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023**[2]




[1]Lowitja Institute. (2014). *Final Report: Recommendations for a National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care*. Accessed on January 17, 2020 at: health.gov.au/internet/main/publishing.nsf/content/cqi-framework-atsih

[2]Reproduced with permission from National Aboriginal Community Controlled Health Organisation. Source: National Aboriginal Community Controlled Health Organisation. *National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023*. Accessed on January 17, 2020 at: naccho.org.au/wp-content/uploads/NACCHO-CQI-Framework-2019.pdf

## ACCHO approaches to CQI

The main driver of CQI in ACCHOs is the inherited responsibility of ACCHOs to deliver quality services to Aboriginal and Torres Strait Islander communities through tailoring services to local needs. External drivers include national accreditation Standards, national key performance indicators and funding requirements.

### Community consultation and participation is fundamental to ACCHO CQI

In an ongoing way, ACCHOs engage with and listen to local Aboriginal and Torres Strait Islander peoples so that they can tailor services to local needs. They consult with community to find out what services are working and whether there are unmet needs that need to be considered in service re-design. This can include seeking feedback through formal and informal ways such as through a client feedback box or yarns with clients. In addition to seeking feedback on existing programs and services, ACCHOs invite clients to participate in the design of community events and new programs. Where possible, ACCHOs seek feedback from community members who do not access their services as well as from their active clients.

At the *Regional ACCHO,* community members are invited to come in to the service to share their ideas and help design upcoming events (e.g. NAIDOC celebrations, community events). This can happen during community lunches (held on every second Friday) or scheduled meetings.

### A whole-of-organisation approach: *CQI is everyone's business*

ACCHOs enact CQI at all levels within the organisation. When CQI processes and mechanisms are embedded across the service, an organisational culture is created where staff practice CQI every day. Effective CQI is founded upon CQI structures and processes underpinned by the motivations, attitudes and approaches of staff who are deeply committed to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples. ACCHO staff bring to their roles a strong sense of accountability, passion and drive, and commitment to both quality care and safety and wellbeing. They connect with Aboriginal and Torres Strait Islander community members to understand what their needs are and try to meet their holistic health needs as best as possible.

At the *Regional ACCHO,* CQI is not just a tick a box activity, it is collective process of looking for ways to promote the health and wellbeing of clients and staff. Many staff including members of the Senior Management Team speak of their inherited responsibility towards closing the gap in health inequality. They draw on their own, their families and their communities' experiences and knowledge to identify problems and gaps in care and to develop workable strategies. Their insights are often incorporated into CQI planning, evaluation and reporting processes.

### CQI embedded within ACCHO governance and operational leadership

CQI is closely linked to ACCHO governance and operational leadership at multiple levels:

- **CQI and cultural governance**
  CQI is embedded within cultural governance processes. ACCHO staff consult with local Aboriginal and Torres Strait Islander peoples to understand their cultural needs, review their programs and services to determine whether they are following cultural protocols and providing culturally centred care, and then re-design service provision as necessary.

- **CQI and strategic governance**
  CQI is integrated within strategic governance processes whereby the ACCHO Board of Directors (the Board) reflect on what is and isn't working in governance before implementing and evaluating improvements in their own processes.

- **CQI and clinical governance**
  CQI is key to clinical governance processes where clinical teams reflect on their practices and client feedback to look for ways to improve the quality of care provided to promote holistic health.

- **CQI and operational leadership**
  CQI processes are embedded within operational leadership where the Senior Management Team continually look for ways to improve the ACCHOs corporate practices such as finance management and human resource management.

### Central CQI Coordination

ACCHOs benefit from centralised coordination of CQI activities by an individual or small team of people with the expertise, resources and time to maintain quality improvement records and systems for the organisation. A designated CQI Coordinator can ensure CQI is embedded across the organisation and can prepare documents and reports for accreditation. The CQI Coordinator may establish and monitor a quality management system that enables all documents and reports, incidents, risks, client feedback and Board directives to be stored in one location. Many ACCHOs cannot fund a designated CQI Coordinator position, and instead have CQI coordination responsibilities included within another role.

At the *Regional ACCHO,* the Board and Senior Management Team employed a part time CQI Coordinator who developed a pragmatic and strategic approach to incorporating CQI into everyday practice. They established clear policies and processes that ensured the smooth running of the health service, with increased responsiveness to funding requirements, clinical standards and local community needs. CQI activities were embedded at an individual, team and organisational level and were not the responsibility of the CQI Coordinator alone. Staff and managers from across the organisation had a personal and professional responsibility and commitment to quality improvement and to ensuring the organisation was safe and functioned well. They began to say 'CQI is everyone's business, it's in the veins now. It's just what we do'.

### Systems that support CQI: Patient Information Management Systems and Quality Management Systems

An effective patient information management system and quality management system (QMS) enables ACCHOs to efficiently review client data and manage CQI processes. Many ACCHOs use a patient information management system such as Communicare to enable accurate recording, monitoring and evaluation of client health and wellbeing records and medical information. Summaries can be extracted and reported to support Medicare claiming and income generation for the organisation.

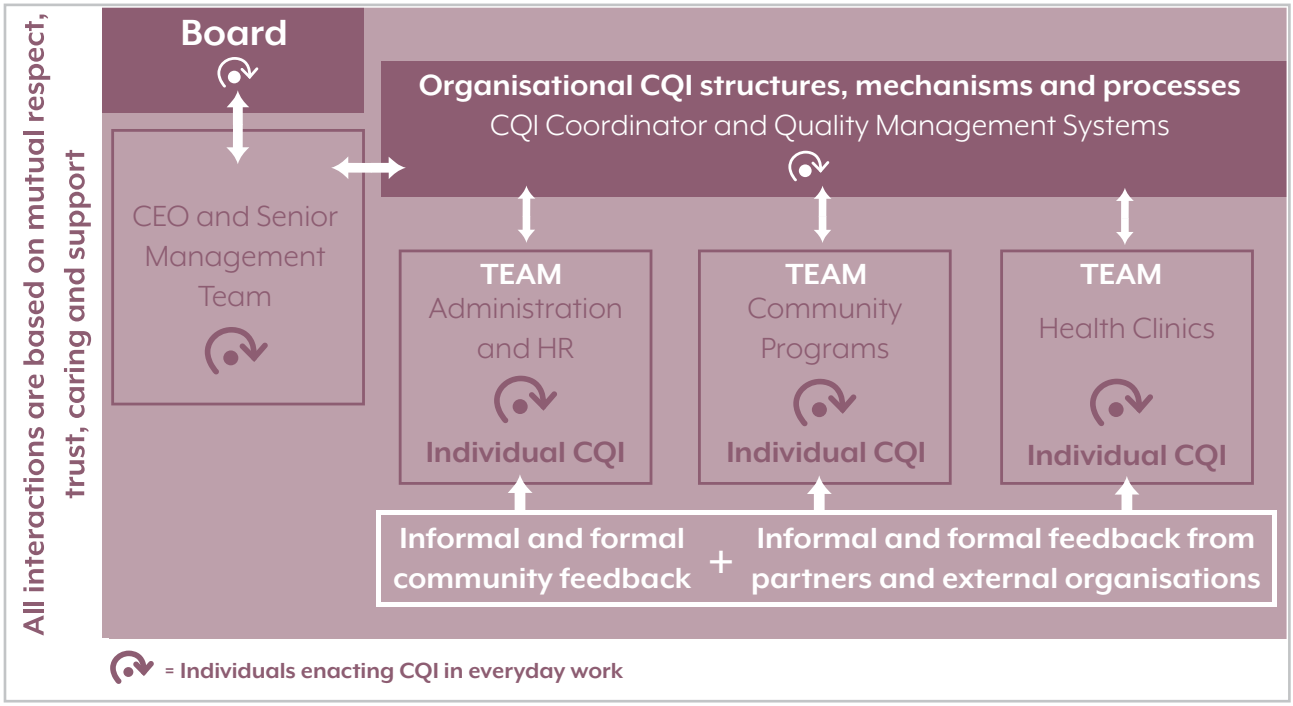
A QMS stores policies, procedures, staff documents, performance appraisals, leave requests, licences, registrations, professional development and accreditation requirements in one place so that they can be easily monitored and updated. ACCHOs may have a paper based or electronic QMS, depending on resources, funding and staff capacity. Some ACCHOs cannot afford an electronic QMS and others can only purchase a limited number of licenses resulting in some employees experiencing barriers to access. In these cases, part-time, casual and visiting staff need to access the QMS through other staff and managers.

The *Regional ACCHO* has an electronic QMS where all CQI documents including identified challenges, suggestions, requests and responses can be tracked within the system, rather than being scattered across emails, meeting minutes or personal communication. The CQI Coordinator maintains the QMS, archives the information, and uses the documents as evidence to prepare for accreditation.

## CQI processes within ACCHOs

CQI is enacted by individuals and teams who reflect on the feedback received from the local community and partner/external organisations and review their programs and services using internal data (e.g. incident reports, staff complaint reports, client data from the patient information management system). Feedback is entered into the Quality Management System and reports generated from this system by the CQI Coordinator are shared with the CEO, Senior Management Team and Board. The ACCHO teams reflect on internal data and feedback they receive and then redesign programs and services if necessary, trial and evaluate new processes, and incorporate new processes as standard practices when they are considered to be an improvement. The ACCHO Continuous Quality Improvement Model is depicted in Image 10.

**Image 10: The ACCHO Continuous Quality Improvement Model**




This model was developed through the CREATE project based on a case study with a regional ACCHO and consultations with the CREATE Leadership Group.

### Organisational CQI processes

The ACCHO Board and the Senior Management Team (also known as the Executive) are responsible for obtaining funding and ensuring safe and quality operations. The Board ensures that the organisation is undergoing planning and review processes, safety and risk management and is meeting accreditation standards. The Board and Senior Management Team also reflect on their own performance and look for ways to improve.

The ACCHO Chief Executive Officer (CEO) ensures that CQI processes are embedded within teams and that specific quality measures are being met. The CEO and the CQI Coordinator play key roles in embedding and monitoring CQI. Key CQI processes include developing and reviewing systems, processes and structures, making sure organisational priorities and goals meet community needs, and that improvements can be measured.

At the *Regional ACCHO,* the CEO and CQI Coordinator have a close working relationship which enables them to efficiently make decisions and act on issues that arise. The CQI Coordinator established effective CQI through the following structures, approaches and processes.

Structure

- Well-functioning quality management system.
- CQI Coordinator located near the CEO.
- Combination of quality and safety committee meetings.

Approach

- CQI is everyone's business.
- Prioritise SMART (Specific, Measurable, Achievable, Realistic, Timely) goals.
- Training as a priority.

Processes

- Check records, registrations, insurances and accreditation requirements are up to date.
- Review and streamline policies and procedures.
- Promote CQI and accreditation.
- Present suggestions and concerns to Senior Management and Board.
- Communicate effectively with the Board.

### Team CQI processes

Key CQI activities within teams include discussing what is and isn't working, looking for ways to improve, trialling solutions, and preparing reports for the Senior Management Team. Managers are responsible for reporting to the Senior Management Team and ensuring effective processes are being used (e.g. effective use of the patient information management system, maintenance of clinical equipment). Specific CQI activities occur within clinical areas in ACCHOs such as reviewing the patient management system to ensure data has been adequately captured, contrasting this data with KPIs and ensuring adequate follow up care has been provided to clients. Managers work with their team to ensure the organisation's vision, strategic plan and priorities are met in service provision. These activities are also informed by community feedback and the lived experiences of staff members which can lead to adapting national and state/territory programs to better suit local needs and preferences.

At the *Regional ACCHO*, there is a strong emphasis on opportunities and support for capacity building and shared governance within teams. Teams are encouraged to provide feedback and identify any gaps and needs through a monthly reporting template, and this is reviewed by managers with key concerns fed back up to the Senior Management Team and the Board. Staff are encouraged to increase their skills and learn about the less visible drivers of CQI (such as achieving KPIs set by funding bodies in order to secure ongoing funding, which in turn helps to better meet client needs).

CQI Coordinators often play a key role in team-based CQI activities within ACCHOs. In larger and more resourced ACCHOs, a CQI Coordinator may support six-monthly planning meetings and compile the monthly reports from teams and individual staff members. They may also ensure that managers respond to team concerns and take major issues to the CEO and Board for consideration and response. The CQI Coordinator may also ensure the ACCHO staff are well trained in relation to CQI processes and the QMS system. An 'open door policy' in relation to CQI coordination enables staff to clarify tasks and roles when unsure. This can prevent mistakes and inaction and ensure that any concerns are addressed in a timely manner.

### Individual CQI processes

Individual staff members are at the centre of effective CQI. Individual staff enact CQI in their daily work and bring a personal and professional commitment to CQI. This helps to create a culturally, clinically and personally safe and welcoming environment where individuals across the organisation strive to provide the best holistic care possible. Clinical staff may understand CQI as 'providing quality care' for individuals and their families and consider that they include CQI in every interaction with clients. Administration staff may understand CQI as ensuring the organisation is safe for everyone and functions well.

Some of the ways that the *Regional ACCHO* staff enact CQI include:

Structure

- Access to the quality management system.
- Training provided by the CQI Coordinator.
- Team meeting agendas have a quality item for discussion as standard.

Approach

- Individual accountability, passion and drive.
- Commitment to providing quality culturally centred care to local Aboriginal and Torres Strait Islander peoples.

Processes

- Consult with Aboriginal and Torres Strait Islander community members to understand their needs.
- Attend team meetings and share personal feedback as well as client feedback.
- Upload incident reports and professional registrations to the QMS.
- Prepare quality reports for the Senior Management Team.
- Keep up to date with clinical guidelines, policies and procedures.
- Undertake professional development to improve clinical skills.
- Seek support from the CQI Coordinator as required.
- Participate in CQI training including use of QMS.

## Benefits and outcomes of CQI

### ACCHO services are tailored to the needs of local Aboriginal and Torres Strait Islander peoples

Effective CQI ensures that ACCHOs respond to community feedback in an ongoing way and tailor services to the changing needs of local Aboriginal and Torres Strait Islander peoples. Once an effective process has been established, CQI becomes common practice and incorporated as part of the simplest of everyday tasks. Policy and procedure documents are collected and stored in a central location to minimise duplication and confusion, leading to more effective procedures and shared understanding across the organisation.

### ACCHOs provide quality culturally safe care

CQI processes enable potential or actual problems in patient care and equipment maintenance and use to be identified in a timely way, such as ensuring immunisation fridges are kept to safe temperatures. This ensures that safe, quality care standards are upheld.

### Eligibility for the Practice Incentives Program Quality Improvement Incentive

Effective CQI processes enable the ACCHO to gain funding through the Practice Incentives Program (PIP) Quality Improvement Incentive.

### Accreditation is gained

Evidence of effective CQI systems and processes is needed to gain both organisational accreditation and clinic accreditation. Accreditation is a process where external auditors determine whether a service meets agreed national Standards of quality care and safety. The results of accreditation can determine what funding the ACCHO can access and the programs the organisation is able to offer the local community.

Examples of ACCHO CQI practices and outcomes (described in greater detail over page) include:

- Creating a welcoming and culturally safe environment
- Personal safety
- Clinic appointments and transport
- Staff recruitment processes
- Funding submissions

- **Creating a welcoming and culturally safe environment**

Staff in the *Regional ACCHO* identified the service could do better to ensure all clients and visitors felt safe and welcomed, both culturally and personally. The service added local artwork and expanded the floor space in the reception area, placed interactive toys in the children's section, and added lockable safety doors so that community members could feel safe and protected when attending appointments. A small private seating area was created so families could sit outside in good weather and the service offered 'backdoors' for clients that have avoidance relationships. These measures helped to create a warm, welcoming and culturally respectful environment for clients and staff.

- **Personal safety**

At the *Regional ACCHO* there were several incidents where staff safety was threatened. The CQI process captured these incident reports and brought together teams to develop solutions. A range of policies and strategies were developed and implemented including client behaviour policies, changes to the physical environment (screens, videos, lockable doors, response alarms), executive action (e.g. clients being sent letters notifying them of restrictions in response to aggressive behaviour) and anti-bullying policies.

- **Clinic appointments and transport**

Clients of the *Regional ACCHO* provided feedback that transport was a barrier to attending clinic appointments, and clinic staff felt that standard appointment times were insufficient to support clients with their needs. Through the CQI process *Regional ACCHO* increased clinic appointments to 45 minutes and the Senior Management Team and Board allocated resources to establish a transport service. The Transport Workers have close links to clients and now play an important role in CQI by informally seeking client feedback.

- **Staff recruitment processes**

The *Regional ACCHO* leadership identified that some non-Indigenous staff didn't share the organisation's values around developing Aboriginal and Torres Strait Islander workforce. The Senior Management Team implemented a question within interview processes that asked applicants to discuss their commitment to strengthen the capacity of Aboriginal and Torres Strait Islander peoples within the organisation. This has ensured that all new employees share the organisation's values around capacity development.

- **Funding submissions**

At the *Regional ACCHO*, the Senior Management Team reviewed their funding submissions and identified that they did not adequately resource the travel costs for their remote outreach services. As part of their CQI process they created a template for future submissions that factored in the real costs of remote travel, including travel allowances for staff. This CQI process ensured that the service no longer went in to deficit when providing outreach services to remote communities.

## Enablers of CQI

- **Policies, procedures and standards are maintained, regularly reviewed and updated as necessary**
- **Use of an electronic quality management system** to store and update policies, procedures and other key documents including ACCHO staff professional registrations and certificates.
- **Effective use of patient information management systems** to enter and monitor client records, results, referrals and to follow up in a timely way.
- **Staff commitment, investment and active engagement in CQI processes**
- **Regular staff training in CQI systems** to equip staff with knowledge to fulfil their roles and to use CQI processes and systems correctly.
- **Effective communication within and across teams** to generate a shared understanding of the needs, goals and strategies of the organisation.
- **A strong corporate culture that promotes proactive CQI as an everyday whole-of-organisation practice** that is centred on tailoring services to community needs.
- **Strong community connection and engagement** ensures that the service understands community priorities and needs and can respond to these needs in a timely way.
- **Support for CQI and CQI training provided by ACCHO state/territory affiliates** Peak bodies support the CQI processes of member ACCHOs depending on the needs of and permissions from these member services. This support can range from providing CQI training and forums to on-the-ground assistance with CQI processes.
- **A designated CQI Coordinator role or team** to ensure that CQI systems and processes are maintained across the organisation.
- **Efficient CQI systems** When minor problems are addressed within a timely manner, staff become confident in the processes of CQI and feel encouraged to identify gaps or challenges and suggest new ways of working.

## Challenges of CQI

### New staff lack knowledge around CQI processes

There can be a lack of awareness and knowledge in new employees regarding the processes and benefits of CQI which can impact investment of staff. This can be overcome with training provided during staff induction procedures and supported with ongoing staff updates and training opportunities.

### Not everyone relates to CQI language and terminology

Some ACCHOs find that their staff don't connect with CQI terminology.

At a small *Regional ACCHO*, CQI is enacted in an informal way. They overcome barriers relating to CQI feeling daunting and confusing by simplifying the language and processes used. They brainstorm better ways of working by asking 'How can we improve?' and 'What feedback have we received from clients?' during team meetings. In this way, CQI is done informally as teams, managers and individuals reflect on what they are doing right, what needs to be improved, and how to improve it in practical everyday operations. They trial new ways of working and embed what works well.

### Access to an electronic Quality Management System

QMS software is expensive and is often costed under a licence per person arrangement. Often newly established or smaller services do not have the financial resources to purchase the software. Other ACCHOs can only afford to purchase a QMS with a restricted number of licences which can make it difficult for casual and part-time staff to access the system, often calling upon other employees to gain access which draws on the ACCHOs human resources and results in lost work time.

### Financial constraints limit the ACCHOs' ability to respond to unmet community need identified through CQI

Service improvements often have associated costs such as in relation to buying infrastructure and training staff which presents a challenge to ACCHOs with financial constraints. There are times when unmet needs and priorities identified by community through CQI processes cannot be provided by the ACCHO (e.g. dental services, aged care services).

### Funding and recruiting a CQI Coordinator

While ACCHOs benefit from a designated CQI Coordinator, many face challenges in funding the position, and in recruiting CQI Coordinators with experience in CQI processes and systems.

## Recommendations

### Recommendations for ACCHOs

- Position CQI as everyone's business, everyday – effective CQI needs a whole-of-organisation approach with all individuals and teams engaged.
- Combine quality and safety roles and meetings as the two are interconnected.
- Develop clear and efficient processes that enable staff to provide monthly reports that identify achievements as well as any issues or concerns. These are then addressed by managers and the CQI Coordinator as appropriate.
- Establish a QMS that enables staff to store documents and reporting required for accreditation. The QMS can be managed and updated by a CQI Coordinator.
- Ensure the CQI Coordinator has the skills and experience to fully utilise a QMS for accreditation preparation.
- Develop strategic plans that link quality and services that meet community needs.
- Ensure CQI focuses on interpersonal approaches and motivations as well as systems, structures and mechanisms.
- Experienced ACCHOs and CQI Coordinators to share learnings through mentoring less experienced or newly emerging ACCHOs and CQI Coordinators.
- Seek support from state/territory affiliates, as needed.
- Participate in regional CQI forums hosted by state/territory affiliates to showcase CQI activities, learn from other ACCHOs and participate in statewide quality improvement activities.

### Recommendations for Policy Makers

- Commonwealth Government to fund the implementation of the *National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023.*
- Commonwealth Governments to subsidise QMS' for ACCHOs to ensure that all services and staff have access to effective systems.
- Additional funding be provided to ACCHO state/territory affiliates to support CQI mechanisms, structures, training and activities.
- Specific funding, training and mentoring be provided to initiate and support CQI Coordinator positions in ACCHOs.

## Discussion

Consistent with the Aboriginal community controlled model of governance, ACCHOs have always consulted with community and reviewed their ways of working to tailor services to local priorities and needs. As described by NACCHO, the ACCHOs have been

*'innovators in locally driven primary health service delivery for nearly 40 years with an unceasing ambition to improve the quality of life, health and wellbeing for the individuals and the communities to whom they are directly accountable'* (NACCHO 2015, p.12).

CQI initiatives for the sector are seen to build upon this existing experience, knowledge and long-term commitment to improvement with an intent to guide future efforts through formalised processes that encourages change to achieve better outcomes (NACCHO, 2015).

The ACCHO sector has seen, been involved in, and impacted by numerous government CQI initiatives since 2002: the Continuous Improvement Projects, funded between 2002-2006 by the Australian Government Office of Aboriginal and Torres Strait Islander Health that included 13 ACCHOs; the National Primary Care Collaboratives funded by the Australian Government in 2003-2004; and the Healthy for Life program funded from 2005 by the Australian Government Department of Health and Ageing (Bailie et al, 2008). Measures to promote accreditation and CQI processes were formally introduced to the sector in the 2007–08 Federal Budget under Establishing Quality Health Standards in Indigenous Health Services (Department of Health, 2007). Reinvestment followed in the 2011-12 Federal Budget with the Establishing Quality Health Standards in Indigenous Health Services continuation (Commonwealth of Australia, 2011). Prior to these government measures, some ACCHOs were already undertaking voluntary accreditation and prioritising quality improvement, such as Winnunga Nimmityjah Aboriginal Health Service (Winnunga Nimmityjah Aboriginal Health Service, 2008).

In the research space, there has been extensive work undertaken in relation to CQI. The Audit and Best Practice for Chronic Disease (ABCD) Project beginning in 2002 was a CQI action research study that employed a systems approach to enhancing care delivered through Indigenous primary health care services across Australia. It brought together service providers, policy makers and researchers with the aim of strengthening and enhancing the effectiveness of CQI tools and processes (Bailie et al, 2008). A related non-profit entity, One21Seventy, was established in 2010 to provide primary health care services with practical tools, training and clinical audit support and a web-based reporting system to enable CQI including comparing performance with other similar primary health care services (Menzies School of Health Services Research, 2019). More than 270 Indigenous primary health care services utilised the standardised evidence-based clinical and systems assessment tools to assess and reflect on performance and health service delivery outcomes and improvements (Bailie, 2017). The Lowitja Institute has also supported a range of projects, knowledge translation activities and conferences focused on CQI in Aboriginal health care including a National Appraisal of Continuous Quality Improvement Initiatives in Aboriginal and Torres Strait Islander Primary Health Care (Wise et al, 2013). A Centre of Research Excellence in Integrated Quality Improvement (CRE-IQI)[3] was established in 2015 to support improved Aboriginal and Torres Strait Islander health outcomes by strengthening CQI efforts in primary health care (McCalman, 2018).

Implementation of regular and formalised CQI processes positively impacts clinical practice in ACCHOs (Hogg et al, 2017). A review of CQI activities in primary health care undertaken through the ABCD project identified that ongoing participation in annual CQI resulted in a range of service improvement for Aboriginal and Torres Strait Islander children (e.g. recalls, hearing assessments, skin checks, developmental milestone checks, and nutrition and oral health advice) (McAullay et al, 2018). A whole of organisation approach to CQI is thought to support best practice with CQI enacted and prioritised by each individual staff member, manager, executive and Board member to enable ACCHOs to provide high quality care while also meeting Aboriginal community members holistic health needs (Bailie, 2007). There are challenges in implementing CQI, however. Newham and colleagues (2016) conducted a qualitative study of CQI implementation in ACCHOs and state government services in South Australia and found implementation was

[3]University Centre for Rural Health. (no date). *Centre of Research Excellence in Integrated Quality Improvement*. Accessed on January 17, 2020 at: ucrh.edu.au/cre-iqi/

impacted by the external pressures of a changing health system, resourcing, access to a CQI coordinator, management and leadership for quality improvement, and organisational readiness. Resistance to change and lack of awareness of CQI in staff in addition to staff turnover were micro level barriers to implementation. The study highlights the importance of greater support for CQI, including regional level collaborations, efforts to increase organisational and clinic team CQI capacity, and dedicated funding at the national level (Newham et al 2016). A scoping review of the implementation of CQI in Aboriginal and Torres Strait Islander primary health care in Australia that included but was not limited to ACCHOs also identified barriers that related to both professional and organisational processes and that operate at the level of individuals, teams, service and also health system (Gardner et al, 2018).

The NACCHO *National Framework for Continuous Quality Improvement in Primary Health care for Aboriginal and Torres Strait Islander People 2018-2023* (NACCHO, 2018) is a sector-level response to strengthening CQI. It was developed following extensive effort and collaboration by the ACCHO sector, Aboriginal and Torres Strait Islander communities and governments. It 'recognises the importance of best practice in primary health care for Aboriginal and Torres Strait Islander peoples, provides a basis to plan and prioritise improvements in comprehensive care, and reflects the experience of the Aboriginal Community Controlled Health Organisations' (NACCHO 2018, p.2). The Framework provides a structure for embedding CQI into primary health care for Aboriginal and Torres Strait Islander peoples and outlines four domains for effective CQI including Being culturally respectful in CQI, Doing CQI, Supporting CQI and Informing CQI. Being culturally respectful in CQI ensures that Aboriginal and Torres Strait Islander peoples are actively engaged in the processes of CQI and assist with identifying priorities and developing programs and policies that lead to improved access to services, high-quality care and better health and wellbeing outcomes (NACCHO, 2018). The implementation of the National CQI Framework requires dedicated investment to enable services to effectively implement and embed CQI in everyday practice.

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# Continuous Quality Improvement in ACCHOs: Reflection Tool

Continuous quality improvement (CQI) consists of ongoing monitoring of quality of care and the way an organisation operates. In an ongoing way, ACCHOs collect and analyse relevant data through internal reviews and through engaging with their communities to look for ways to improve how services respond to changing local priorities and needs. CQI processes enable individual staff, teams and the ACCHO as a whole to review what is and isn't working, design and implement improvements where necessary, and monitor and evaluate whether improved processes and outcomes are achieved over time.

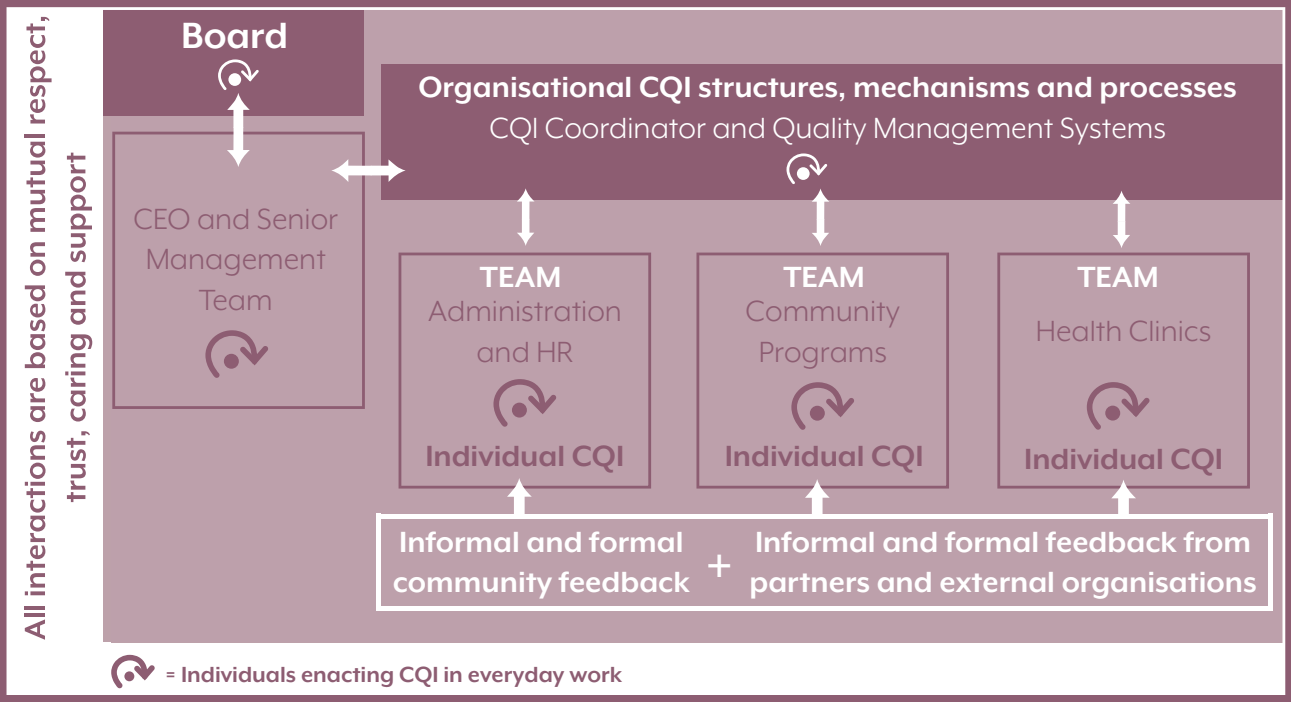
**Step 1. Consider the CQI approaches your ACCHO currently practises.**

**Step 2. What other CQI activities could your ACCHO consider in the future and what systems or resources will be needed to achieve this?**

### A whole-of-organisation approach: *CQI is everyone's business*

- ☐ We have an organisational culture where our staff practice CQI every day.
- ☐ Our staff are deeply committed to improving the health and wellbeing of our Aboriginal and Torres Strait Islander communities and this motivation (along with good systems and processes) drives effective CQI in our service.
- ☐ Our staff connect with our community members to understand what their needs are and try to meet their holistic health needs as best as possible.
- ☐ Our staff and Board of Directors draw on their own, their families and their communities' experiences and knowledge to identify problems and gaps in care to develop workable solutions.
- ☐ We have a standard quality item on meeting agendas and all teams prepare quality reports for the Senior Management Team.

### The ACCHO Continuous Quality Improvement Model



## Community consultation and participation

- ☐ We consult with community to find out what services are working and where there are unmet needs to be considered in service re-design.
- ☐ We seek formal and informal feedback from clients (e.g. client feedback box, informal feedback during client interactions).
- ☐ We invite clients to participate in the design of community events and new programs.
- ☐ We attempt to engage Aboriginal and Torres Strait Islander peoples who are not active clients of the service to learn about how we could meet their needs.

## CQI embedded within ACCHO governance and operational leadership

- ☐ Our CQI processes are closely linked to our cultural governance processes: our staff consult with community members to understand their cultural needs then review and redesign services to provide culturally-centred care that aligns with local cultural protocols.
- ☐ Our clinical teams undertake CQI in clinical governance where they reflect on their practices and client feedback to look for ways to improve the quality of care provided to our communities. They ensure data has been adequately captured, contrast this data with KPIs and ensure adequate follow up care is provided to clients.
- ☐ Our CQI is integrated within strategic governance processes whereby our Board of Directors reflect on what is and isn't working in their own processes before implementing and evaluating improvements.
- ☐ CQI processes are embedded within operational leadership where the Senior Management Team continually look for ways to improve the ACCHOs corporate practices such as finance management and human resource management.

## Central CQI Coordination

- ☐ While CQI is everyone's business, we have designated staff who coordinate CQI activities. They have the expertise, resources and time to maintain quality improvement records and systems for the organisation.
- ☐ We have a designated staff member (sometimes known as a CQI Coordinator) who ensures CQI is embedded across the organisation and ensures any concerns are addressed in a timely way.
- ☐ Our CQI Coordinator establishes and monitors a quality management system that stores all documents and reports, incidents, risks, client feedback and Board directives in one location.
- ☐ Our CQI Coordinator ensures our staff are well trained in relation to CQI processes and our quality management system.
- ☐ Our CQI Coordinator compiles monthly reports from teams and can support planning meetings. They also ensure managers respond to team concerns and take major issues to the CQI and Board for consideration.

## Systems that support CQI: Patient Information Management Systems and Quality Management Systems

- ☐ We have a patient information management system that enables us to accurately record, monitor and evaluate client health and wellbeing records and MBS claims.
- ☐ We have a quality management system that stores policies, procedures, staff documents, performance appraisals, incident reports, staff complaint reports, leave requests, licences, registrations, professional development and accreditation requirements so they can be easily monitored and updated.
- ☐ Our quality management system is maintained by our CQI Coordinator who stores and archives all documentation and prepares information to be used as evidence of our CQI processes during accreditation.

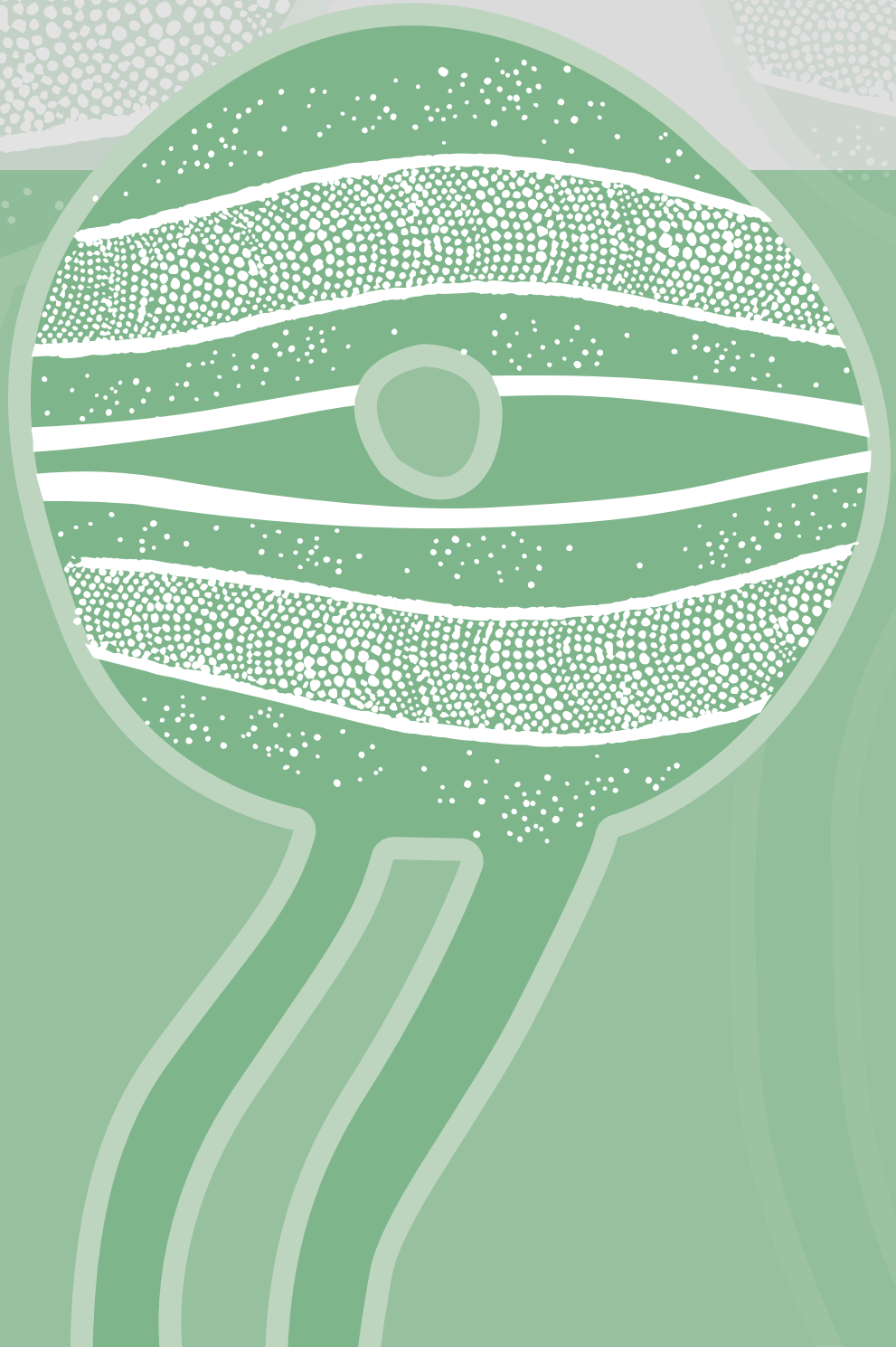
- ☐ Our quality management system is paper based.

**OR**

- ☐ Our quality management system is electronic.

# Chapter 10

## National Key Performance Indicators and ACCHOs



# National Key Performance Indicators and ACCHOs


## Summary

The national key performance indicator (nKPIs) are a set of mandatory indicators collected from primary health care organisations that receive Commonwealth goverment funding through the Indigenous Australian's Health Program to provide services primarily to Aboriginal and Torres Strait Islander peoples. These include predominantly ACCHOs but also mainstream primary health care services, Primary Health Networks and non-government organisations. The nKPIs were introduced in 2012 and include 24 indicators that collect information on clinical processes and health outcomes with a focus on chronic disease management, preventive health, and child and maternal health. The development and implementation of the nKPIs has been challenging for the ACCHO sector. Effective governance, internal communication and staff capacity enables ACCHOs to utilise relevant nKPIs in continuous quality improvement activities alongside other data. There are considerable improvements that could be made to the nKPIs to make them more useful for the ACCHO sector.


The content of this chapter was drawn from the PhD project *Understanding the impact of the national key performance indicators on the Aboriginal Community Controlled Health Organisations.*

## What we cover in this chapter:

## Introduction

Monitoring system performance through routine data collection has become a significant area of policy development in Aboriginal and Torres Strait Islander primary health care services and specifically in the ACCHO sector. Since 2008, there has been an increased focus on improving Indigenous health outcomes through the *Closing the Gap* Framework. One monitoring mechanism is the national key performance indicator (nKPIs). The nKPIs are defined as:

> *A set of indicators that monitor the major health issues of the regular client population of Indigenous-specific primary health care services (p. 128)*[1]

The nKPIs are mandatory indicators collected from primary health care organisations receiving Commonwealth goverment funding through the Indigenous Australian's Health Program to provide services primarily to Aboriginal and Torres Strait Islander peoples. These include predominantly ACCHOs but also mainstream primary health care services, Primary Health Networks and non-government organisations. The nKPIs were introduced in 2012 and include 24 indicators that collect information on clinical processes and health outcomes with a focus on chronic disease management, preventive health, and child and maternal health.

ACCHOs provide the Commonwealth government with nKPI data every 6 months. They also provide the Commonwealth government with data on service provision and workforce through Health Care Provider data and an Online Services Report which is submitted once a year. A brief description of the nKPIs is provided in Table 13, over page. A full description of the nKPIs is provided in Table 15 on page 188 at the back of this chapter.

## Purpose of the nKPIs

The nKPIs were introduced to assist services to monitor the health of their clients and to improve services through continuous quality improvement processes. The nKPIs were also introduced to assist governments in measuring Aboriginal and Torres Strait Islander health to inform policy.

## Coordination and reporting of nKPIs

The nKPIs are collected and managed by the Commonwealth Department of Health (DoH) with reports produced by the Australian Institute of Health and Welfare (AIHW). While the DoH and AIHW collect and report on the data, each individual service still owns the data they submit.

There are two different reports produced using the nKPIs; individual service reports and national reports. The individual service reports are specifically produced for each service and are not shared with anyone else. The nKPIs have been collected from around 230 primary health care services since June 2012 and the AIHW has produced national nKPI reports since May 2014.[2]

The reports include:

- nKPI results from the previous reporting period
- Trends over time (i.e. a comparison of each reporting period submitted)
- Comparison with services in the same state/ territory
- Comparison with services in the same remoteness bracket

[1]Australian Institute of Health and Welfare. (2018). *National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results for 2017*. Series no. 5. Cat. no. IHW 200. Canberra: AIHW.
[2]Department of Health. (2018). *Aboriginal and Torres Strait Islander Health Reporting Background*. Accessed on January 17, 2020 at: www1.health.gov.au/internet/main/publishing.nsf/Content/indigenous-reporting-lp

**Table 13: A brief description of the National Key Performance Indicators***

| nKPI | Indicator |
|---|---|
| PI01 | Birthweight recorded |
| PI02 | Birthweight result (low, normal or high) |
| PI03 | Health assessment (MBS item 715) |
| PI04 | Fully immunised children |
| PI05 | HbA1c test recorded (clients with type 2 diabetes) |
| PI06 | HbA1c result (clients with type 2 diabetes) |
| PI07 | GP Management Plan (MBS item 721) |
| PI08 | Team Care Arrangement (MBS item 723) |
| PI09 | Smoking status recorded |
| PI10 | Smoking status result |
| PI11 | Smoking status results of women who gave birth |
| PI12 | BMI (overweight or obese) |
| PI13 | First antenatal care visit |
| PI14 | Influenza immunisation (aged 50 and over) |
| PI15 | Influenza immunisation (type 2 diabetes or COPD clients) |
| PI16 | Alcohol consumption recorded |
| PI17 | Alcohol consumption (AUDIT-C) result |
| PI18 | Kidney function test recorded (type 2 diabetes or CVD clients) |
| PI19 | eGFR and ACR results |
| PI20 | Necessary risk factors assessed to enable cardiovascular risk assessment |
| PI21 | Absolute cardiovascular risk assessment result |
| PI22 | Cervical screening recorded |
| PI23 | Blood pressure recorded (clients with type 2 diabetes) |
| PI24 | Blood pressure less than or equal to 130/80 mmHg (clients with type 2 diabetes) |

*Note: See Table 15 on page 187 for a full description of the nKPIs

## ACCHO approaches to the nKPIs

ACCHO extract data related to the 24 nKPIs from the patient information management system. ACCHOs use a range of different systems such as MMEX, Best Practice, Communicare and Medical Director. The data is extracted using an inbuilt data extraction tool or an external data extraction tool and directly uploaded to the Health Data Portal.

The Health Data Portal is a:

> *'web based tool used by all Health Services funded by the Indigenous Australians' Health Program (Health Services) to submit National Key Performance Indicators (nKPIs), Online Services Report (OSR) and Health Care Provider (HCP) number report data'*[3]

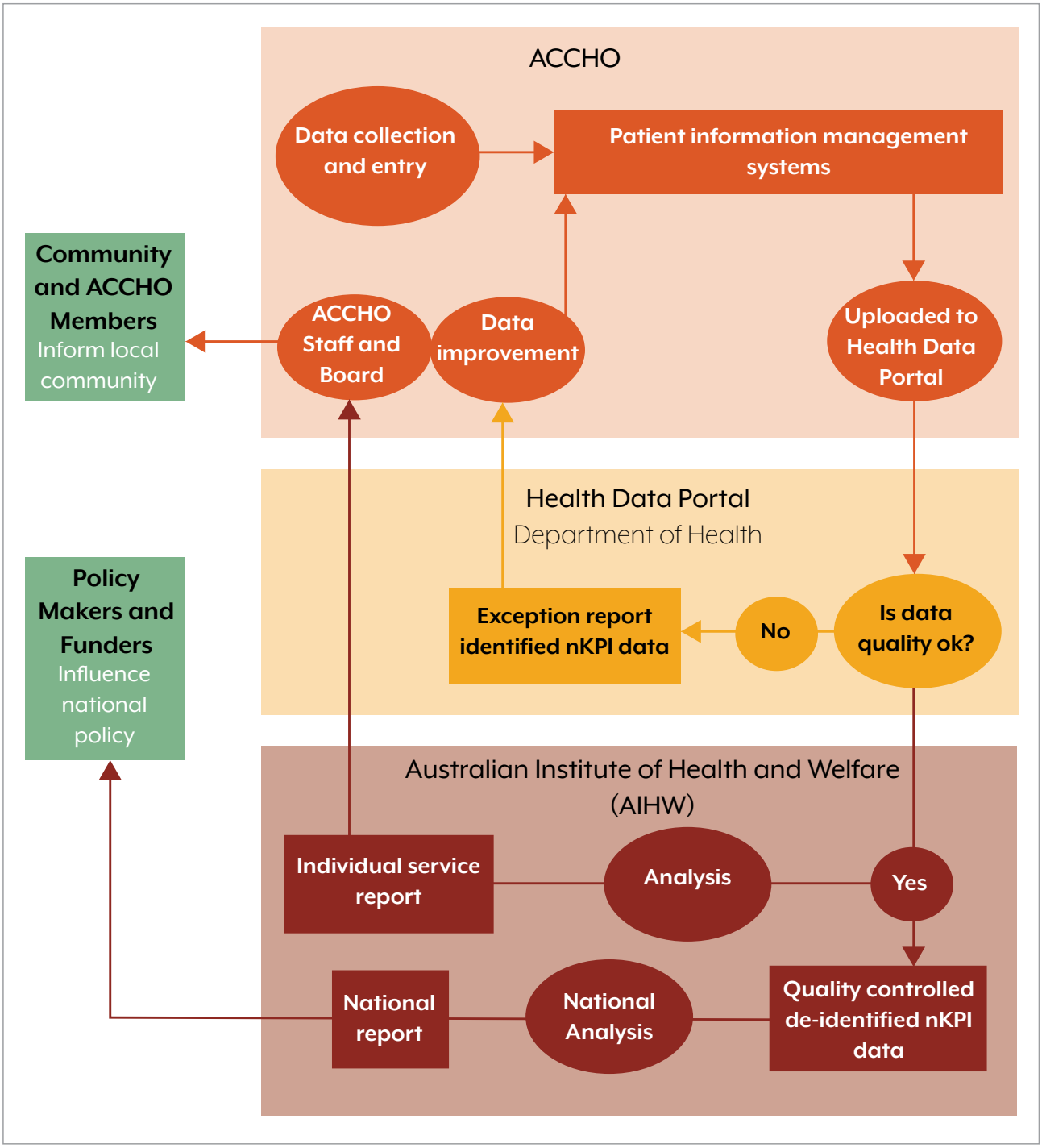
Within the Health Data Portal, data is checked for completeness and accuracy, and to see whether there are significant differences from the last reporting period. If there are any issues, an "exception" report containing the errors is produced and sent back to the ACCHO to check[4]. Once the data is correct, the Australian Institute of Health and Welfare produces a service report and de-identifies data to include in national nKPI reports.

Image 11 (over page) describes the processes undertaken to produce nKPI data, including ACCHO responsibilities, the Health Data Portal, and reports generated by the Australian Institute of Health and Welfare.

[3]Department of Health. (2019). *Aboriginal and Torres Strait Islander Health Reporting Transition to the Health Data Portal - Fact Sheet.* Accessed on January 17, 2020 at: www1.health.gov.au/internet/main/publishing.nsf/Content/D9154F83043FCBBDCA2581CB007F3616/$File/Heath%20Data%20Portal%20Fact%20Sheet%20March%202019.pdf

[4]Department of Health. (2019). *IHDR in the health data portal for health services.* Accessed on January 17, 2020 at: dataportal.health.gov.au/wps/wcm/connect/dataportal/9697fb10-c461-43f7-980c-fde7c6c40b39IHDR+in+the+Health+Data+Portal+for+Health+Services+User+Guide.pdf?MOD=AJPERES

**Image 11: nKPI data management and reporting**




This image was adapted from a figure developed by the Australian Institute of Health and Welfare (2015, page 7)[5]. The adaptation was informed by Doctor of Philosophy research on the nKPIs undertaken by Summer May Finlay, funded through the CREATE project.

[5]Australian Institute of Health and Welfare. (2015). *The nKPI data collection: data quality issues working paper 2012–2014*. Cat. no. IHW 153. Canberra: AIHW.

## ACCHO utilisation of the nKPIs

ACCHOs can use nKPIs in continuous quality improvement activities including identifying relevant nKPIs with good data quality to track clinical processes over time.

At the *Metro ACCHO* all staff are aware of nKPI processes and how the service is performing against the nKPIs. The service uses relevant nKPIs in continuous quality improvement activities, including data related to health assessments, GP management plans and Team Care Arrangements.

## Enablers

A range of enabling factors supported the collection, reporting and usefulness of the nKPIs:

- Stability in ACCHO governance and workforce: ACCHOs with effective governance and long-term workforce are better positioned to effectively collect, report and utilise the nKPIs.
- Staff capacity and understanding of the nKPIs.
- Regular staff training in the patient information management system.
- Staff supported to correctly enter data within the patient information management system.
- Clear and transparent communication with staff regarding nKPI processes and outcomes.

During inductions, the *Metro ACCHO* assesses the skills and knowledge of new staff related to the patient information management system, and provides training and capacity strengthening opportunities if needed. All clinical staff are aware of what data needs to be collected for the nKPIs. The service has processes in place to ensure that data is correctly entered into the patient information management system to enable effective data extraction for the nKPIs.

## Challenges

### Principles and approaches related to the nKPIs

- **nKPIs were imposed on the ACCHO sector**

The nKPIs were imposed on the ACCHO sector with a top-down approach rather than with ground-up self-determination, Aboriginal community control and local data sovereignty principles.

- **National benchmarking and jurisdictional comparisons**

The use of nKPIs for national benchmarking and comparison of performance across jurisdictions is challenging for the ACCHO sector due to its heterogeneous services, contexts and populations.

- **Inequitable accountability requirements**

There are differing (and therefore inequitable) accountability requirements for Indigenous and mainstream primary health care services providing services to Aboriginal and Torres Strait Islander clients, with more rigorous reporting required of ACCHOs.

### Development of the nKPIs

- **Tokenistic nKPI consultation**

The tokenistic nature of the nKPI consultation led to lack of engagement and consequently a lack of ownership of the nKPIs by the ACCHO sector. The nKPIs are often seen as another reporting requirement for the sector.

### Implementation of the nKPIs

- **Numerous data extraction tools and data management systems imposed on the sector**

Since the introduction of the nKPIs in 2012 the sector has experienced a number of changes in data extraction and management approaches. First, data extraction was undertaken manually, then using the PEN Clinical Audit Tool and the Canning Tool. There have also been changes in relation to data management by the Improvement Foundation and then the establishment of the Health Data Portal. These changes to data extraction and management have negatively impacted data quality and the ability to compare data over time. They have also burdened the ACCHO sector with change management processes and data challenges (e.g. increased number of exception reports).

### Utility of the nKPIs

- The nKPIs have a biomedical focus and do not capture the comprehensive primary health care undertaken by ACCHOs.
- The client definition is inappropriate for some ACCHOs especially those with transient populations.
- Immunisations and cervical screening data is better collected through national registers than through the nKPIs.
- There are concerns with the accuracy and utility of nKPIs related to smoking and pregnancy (PI11) and cardiovascular disease risk assessment (PI20).
- Relevant indicators are missing (e.g. health checks for 6-24 year olds, sexually transmitted infections, mental health, oral health, social determinants of health activities).

### Workforce capacity and governance challenges

- ACCHOs face staff capacity challenges in relation to nKPIs and data (i.e. patient information management system data entry and extraction, and interpretation of nKPI reports).
- ACCHOs who face difficulties in attracting and retaining GPs find it difficult to meet nKPI targets.
- ACCHOs facing instability in governance are more challenged in utilisation of nKPIs in CQI processes.

## Recommendations

### Recommendations for ACCHOs

- During new staff inductions, assess skills and knowledge relating to the patient information management system and understanding of the nKPIs. If a gap in skills and knowledge is identified, provide training and capacity strengthening opportunities.
- Upskill all existing clinical staff on what data needs to be collected for the nKPIs.
- Make sure that the nKPI data is correctly entered into the patient information management system (and not within free notes).
- Communicate with all staff regarding progress towards nKPIs and outcomes of nKPI reports.
- Include relevant nKPIs in CQI processes to understand performance against indicators including areas for improvement.
- Advocate to jurisdictional peak bodies regarding relevant indicators that could benefit CQI processes in your organisation.

### Recommendations for policy makers

#### nKPI monitoring and redevelopment

- Engage the ACCHO sector as equal partners in the leadership, development and ongoing implementation of relevant nKPIs such as through an ACCHO advisory group.
- Ensure nKPIs align with ACCHO principles and Aboriginal and Torres Strait Islander ways of being, knowing and doing.
- Ensure there are equitable accountability requirements for both Indigenous and mainstream primary health care services receiving funding for Aboriginal and Torres Strait Islander peoples including funding through the MBS.
- Align nKPI definitions with other data sets to make them comparable.
- Engage the ACCHO sector in the design of all nKPI reviews and evaluations and ensure there is transparency in the approach, interpretation and dissemination of outcomes.

#### nKPI data set

Undertake a co-design process led by the ACCHO sector that considers the following:

- an agreed client definition
- nKPIs should reflect the heterogeneity of the ACCHO sector and include qualitative indicators
- organisations should report data on services they offer (i.e. establish a process whereby ACCHOs can select relevant indicators from an agreed, standardised, national indicator set)
- remove specific nKPIs related to immunisation and cervical screening and review nKPIs related to cardiovascular disease and pregnancy and smoking
- develop indicators related to health checks for 6-24 year olds, sexually transmitted infections, mental health (e.g. a process indicator related to the proportion of Aboriginal and Torres Strait Islander people with a mental health plan[6]), oral health and social determinants of health activities
- consider how the nKPIs disadvantage smaller ACCHOs facing workforce supply shortages
- develop a mechanism to exclude data for indicators where clients have sought services elsewhere

#### nKPI capacity building

- Resource the ACCHO sector (including NACCHO jurisdictional affiliates and member services) to build staff capacity in relation to nKPIs including training on patient information management systems and on collecting, reporting and using the nKPIs in CQI activities.
- Provide external supports to build capacity in ACCHO workforce (e.g. network meetings, email and phone support, professional development training).

[6]Note: any nKPI related to mental health should be consistent with the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing- 2017-2023.

## Discussion

While the nKPIs represent the most recently developed indicators for Aboriginal and Torres Strait Islander health, several indicators sets have been attached to policies or commitments since 1969. The reason national indicator sets are not available pre-1969 is that prior to this time the Commonwealth Government, as per the Australian Constitution (British Parliament, 1900), could not make policies for Aboriginal and Torres Strait Islander people. Rather, state/territory governments were responsible for Aboriginal and Torres Strait Islander specific legislation (British Parliament, 1900). The 1967 referendum, titled 'Aborigines – Commonwealth Policy and Administration', enabled the Commonwealth Government to legislate and make policies for Aboriginal and Torres Strait Islander people, which became enacted in 1969 (Dow, & Gardiner-Garden, 2011). Since then, numerous Commonwealth initiatives have been aimed at improving the health and wellbeing of Aboriginal and Torres Strait Islander people, as listed in Table 14 (over page). Unfortunately, there has been very little investment in the collection and analysis of appropriate data that would aid in measuring the success or failure of successive policy imperatives (Hudson, 2017; Productivity Commission, 2012; Wronski, 1991).

Performance indicators for Aboriginal health services were first introduced in the mid-1980s (Anderson, Anderson & Smylie 2008). Since the mid-2000s, Aboriginal and Torres Strait Islander primary health care organisations have increasingly been undertaking continuous quality improvement (CQI) activities using indicators (Gardner et al, 2018). In 2007, the Office of Aboriginal and Torres Strait Islander Health, which was within the Commonwealth Department of Health and Ageing, funded Aboriginal and Torres Strait Islander primary health care services to incorporate CQI processes into their programs and reporting (Wise et al, 2013).

Since the nKPI introduction in 2012, there have been significant improvements in the quality of data housed within individual ACCHO patient information management systems (Finlay, 2020). However, the ACCHO sector does not consistently use nKPIs in continuous quality improvement activities due to concerns about data quality and the relevance of indicators. This raises the question regarding whether the nKPIs have achieved their objectives, since ACCHOs do not appear to be using the nKPIs for improving the health and wellbeing of their client base. Rather, the nKPIs are considered to be an accountability mechanism and reporting requirement rather than useful and relevant to CQI activities. The challenges faced by the ACCHO sector in relation to the implementation of the nKPIs are wide ranging. Firstly, there are concerns regarding data quality. Secondly, for many ACCHOs, the nKPI client definition does not meet their needs because they believe it does not accurately reflect who they consider to be their active client base. Thirdly, the nKPIs dataset does not measure health risks or outcomes of ACCHO clients because it does not take into consideration the ACCHO service delivery model. Meaningful consultation by governments with the ACCHO sector is needed to co-design relevant indicators that reflect the ACCHO comprehensive primary health care model and that can be used in ACCHO CQI processes.

A detailed description of the nKPIs is provided in Table 15 on page 187. Further reading and available resources related to the nKPIs is provided in the Appendix on page 192.

**Table 14: Timeline of national Aboriginal and Torres Strait Islander health policy, responsibilities and measurement**

| Year | Aboriginal and Torres Strait Islander policy or initiative |
|---|---|
| 1969 | Commonwealth Government priority to "raise the standard of health of the Aboriginals of Australia to the levels enjoyed by their fellow Australians" within 10 years |
| 1973 | National Plan for Aboriginal Health Statistics |
| 1979 | Standing Committee on Aboriginal Affairs into 1969 aim to raise health standards of Aboriginal Australians |
| 1981 | Aboriginal Public Health Improvement Program with a focus on unsatisfactory environmental conditions associated with inadequate water, sewerage and power systems |
| 1986 | Release performance indicators for Aboriginal Health Services |
| 1989 | National Aboriginal Health Strategy (NAHS) |
| 1991 | Targets for the NAHS were developed |
| 1994 | National Aboriginal Health Strategy: An Evaluation (NAHS evaluation)<br>National Commitment to Improved Outcomes for Aboriginal and Torres Strait Islander People<br>First National Aboriginal and Torres Strait Islander Health Survey was conducted |
| 1997 | Aboriginal and Torres Strait Islander Health Information Plan was developed |
| 2004 | The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 |
| 2006 | The Close the Gap campaign was established |
| 2009 | Closing the Gap Framework was launched by the Commonwealth |
| 2012 | National key performance indicator implemented for Aboriginal and Torres Strait Islander primary health care organisations |
| 2013 | National Aboriginal and Torres Strait Islander Health Plan was introduced |
| 2015 | National Aboriginal and Torres Strait Islander Health Plan Implementation Plan was introduced |

**Table 15: nKPI descriptions**[7]

| Indicator | Description |
|---|---|
| **PI01:** Proportion of Indigenous babies born within the previous 12 months whose birthweight has been recorded | Proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight has been recorded at the primary health care organisation. |
| **PI02:** Proportion of Indigenous babies born within the previous 12 months whose birthweight results were low, normal or high | Proportion of Aboriginal and/or Torres Strait Islander babies born within the previous 12 months whose birthweight results were categorised as 1 of the following:<br>• low (less than 2,500 grams)<br>• normal (2,500 grams to less than 4,500 grams)<br>• high (4,500 grams and over). |
| **PI03:** Proportion of regular clients for whom an MBS Health Assessment for Aboriginal and Torres Strait Islander People (MBS item 715) was claimed | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 0–4, for whom an MBS health assessment for Aboriginal and Torres Strait Islander people was claimed within the previous 12 months AND proportion of regular clients who are Aboriginal and/or Torres Strait Islander, aged 25 and over and for whom an MBS health assessment for Aboriginal and Torres Strait Islander people was claimed within the previous 24 months. |
| **PI04:** Proportion of Indigenous children who are fully immunised | Proportion of Aboriginal and/or Torres Strait Islander children who are regular clients, aged:<br>• 12 months to less than 24 months<br>• 24 months to less than 36 months<br>• 60 months to less than 72 months<br>and who are 'fully immunised'. |
| **PI05:** Proportion of regular clients with type 2 diabetes who have had an HbA1c measurement result recorded | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have type 2 diabetes and who have had an HbA1c measurement result recorded at the primary health care organisation within the previous 6 months AND proportion of Aboriginal and/or Torres Strait Islander regular clients, who have type 2 diabetes and who have had an HbA1c measurement result recorded at the primary health care organisation within the previous 12 months. |
| **PI06:** Proportion of regular clients with type 2 diabetes whose HbA1c measurement result was within a specified level | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have type 2 diabetes and whose HbA1c measurement result was recorded in the previous 6 months AND as recorded in the previous 12 months and categorised as one of the following (mmol/mol):<br>• less than or equal to 53 (7%)<br>• greater than 53 (7%) but less than or equal to 64 (8%)<br>• greater than 64 (8%) but less than 86 (10%) greater than or equal to 86 (10%). |

[7]Source: Australian Institute of Health and Welfare. (2019). *National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care: Results to June 2018*. Cat. no. IHW 211. Canberra: AIHW. Page 64. Viewed on 10 December, 2019 at: aihw.gov.au/reports/indigenous-australians/nkpis-indigenous-australians-health-care-2018

| Indicator | Description |
|---|---|
| **PI07:** Proportion of regular clients with a chronic disease for whom a GP Management Plan (MBS item 721) was claimed | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have a chronic disease and for whom a GPMP was claimed within the previous 24 months. |
| **PI08:** Proportion of regular clients with a chronic disease for whom a Team Care Arrangement (MBS item 723) was claimed | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have a chronic disease and for whom a TCA was claimed within the previous 24 months. |
| **PI09:** Proportion of regular clients whose smoking status has been recorded | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15 and over, whose smoking status has been recorded at the primary health care organisation within the previous 24 months. |
| **PI10:** Proportion of regular clients with a smoking status result | Proportion of Aboriginal and/ or Torres Strait Islander regular clients, aged 15 and over, whose smoking status has been recorded within the previous 24 months as one of the following:<br>• current<br>• smoker ex-smoker<br>• never smoked. |
| **PI11:** Proportion of regular clients who gave birth within the previous 12 months with a smoking status of 'current smoker', 'ex-smoker' or 'never smoked' | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15 and over, who gave birth within the previous 12 months and whose smoking status has been recorded within the previous 12 months as one of the following:<br>• current<br>• smoker ex-smoker<br>• never smoked. |
| **PI12:** Proportion of regular clients who are classified as overweight or obese | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 25 and over, who have had their BMI classified as overweight or obese within the previous 24 months. |
| **PI13:** Proportion of regular clients who had their first antenatal care visit within specified periods | Proportion Aboriginal and/or Torres Strait Islander regular clients, who gave birth within the previous 12 months and who had gestational age recorded at their first antenatal care visit, with results either:<br>• less than 13/40 weeks<br>• 13/40 weeks to less than 20/40 weeks<br>• at or after 20/40 weeks<br>• no result<br>• did not attend an antenatal care visit. |
| **PI14:** Proportion of regular clients aged 50 and over who are immunised against influenza | Proportion Aboriginal and/or Torres Strait Islander regular clients, aged 50 and over who had an influenza immunisation within the previous 12 months. |
| **PI15:** Proportion of regular clients with type 2 diabetes or chronic obstructive pulmonary disease (COPD) who are immunised against influenza | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15–49, who have type 2 diabetes or COPD and have had an influenza immunisation within the previous 12 months. |

| Indicator | Description |
|---|---|
| **PI16:** Proportion of regular clients whose alcohol consumption status has been recorded | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15 and over, who have had their alcohol consumption status recorded at the primary health care organisation within the previous 24 months. |
| **PI17:** Proportion of regular clients who had an AUDIT-C with result within specified levels | Proportion of regular Aboriginal and/or Torres Strait Islander clients, aged 15 and over, who have had an AUDIT-C result recorded in the previous 24 months with a score of either:<br>• high risk (greater than or equal to 4 in males and 3 in females)<br>• low risk (less than 4 in males and 3 in females). |
| **PI18:** Proportion of regular clients with a selected chronic disease who have had a kidney function test | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15 and over, who have type 2 diabetes and have had an estimated glomerular filtration rate (eGFR) recorded AND/OR an albumin/creatinine ratio (ACR) or other micro albumin test result recorded within the previous 12 months AND proportion of Aboriginal and/or Torres Strait Islander regular clients , aged 15 and over, who have cardiovascular disease (CVD) and have had an eGFR recorded within the previous 12 months. |
| **PI19:** Proportion of regular clients with a selected chronic disease who have had a kidney function test with results within specified levels | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 15 and over, who are recorded as having type 2 diabetes or CVD and who have had an eGFR recorded within the previous 12 months with a result of (mL/min/1.73 m2):<br>• greater than or equal to 90<br>• greater than or equal to 60 but less than 90<br>• greater than or equal to 45 but less than 60<br>• greater than or equal to 30 but less than 45<br>• greater than or equal to 15 but less than 30<br>• less than 15.<br><br>OR the proportion of regular clients who are male, Indigenous, aged 15 and over, who are recorded as having Type II diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):<br>• less than 2.5<br>• greater than or equal to 2.5 but less than or equal to 25<br>• greater than 25.<br><br>OR the proportion of regular clients who are female, Indigenous, aged 15 and over, who are recorded as having Type II diabetes and who have had an albumin/creatinine ratio (ACR) recorded within the previous 12 months with a result of (mg/mmol):<br>• less than 3.5<br>• greater than or equal to 3.5 but less than or equal to 35<br>• greater than 35. |

| Indicator | Description |
|---|---|
| **PI20:** Proportion of regular clients who have had the necessary risk factors assessed to enable CVD assessment | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 35–74, with no known history of CVD and with information available to calculate their absolute CVD risk recorded within the previous 24 months. |
| **PI21:** Proportion of regular clients aged 35 to 74 who have had an absolute cardiovascular disease risk assessment with results within specified levels | Proportion of Aboriginal and/or Torres Strait Islander regular clients, aged 35–74, with no known history of CVD, who have had an absolute CVD risk assessment recorded within the previous 24 months and whose CVD risk was categorised as 1 of the following:<br>• high (greater than 15% chance of a cardiovascular event in the next 5 years)<br>• moderate (10%–15% chance of a cardiovascular event in the next 5 years)<br>• low (less than 10% chance of a cardiovascular event in the next 5 years). |
| **PI22:** Proportion of regular clients who have had a cervical screening | Proportion of female regular clients who are Aboriginal and/or Torres Strait Islander, aged 20–74, who have not had a hysterectomy and who have had a cervical screening within the previous 2 years, 3 years and 5 years. |
| **PI23:** Proportion of regular clients with type 2 diabetes who have had a blood pressure measurement result recorded | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have type 2 diabetes and who have had a blood pressure measurement result recorded at the primary health care organisation within the previous 6 months. |
| **PI24:** Proportion of regular clients with type 2 diabetes whose blood pressure measurement result was less than or equal to 130/80 mmHg | Proportion of Aboriginal and/or Torres Strait Islander regular clients, who have type 2 diabetes and whose blood pressure measurement result, recorded within the previous 6 months, was less than or equal to 130/80 mmHg. |

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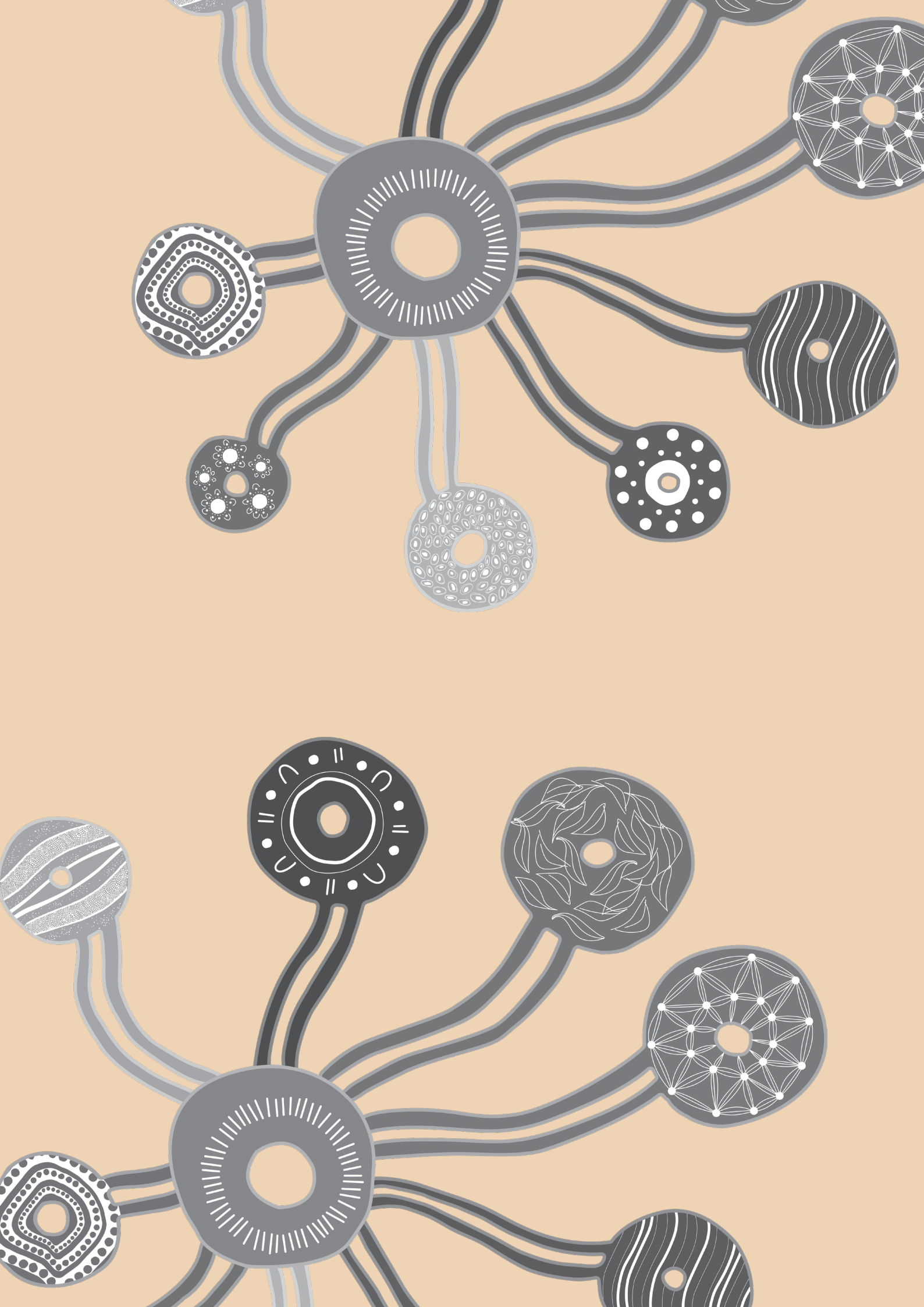
# Appendix: Further reading and available resources

There are a range of resources and reports to assist ACCHOs with the nKPIs. Some are Aboriginal and Torres Strait Islander specific, some are health specific and some are focused on both Aboriginal and Torres Strait Islander peoples and health.

**Table 16: nKPIs resources**

| Resource | Description |
|---|---|
| IHDR in the Health Data Portal for Health Services Users Guide July 2019 | The IHDR in the Health Data Portal for Health Services Users Guide July 2019 has been developed to assist different types of health services users interacting with the Health Data Portal with performing their required tasks within the Porta as part of the Indigenous Health Data Reporting (IHDR) process.<br><br>dataportal.health.gov.au/wps/portal/dataportalcontent/usersupport/userhelpihdr/!ut/p/a1/04_Sj9CPykssy0xPLMnMz0vMAfGjzOJNPb09DUwMjLwNfF1MDBwtTU0DLU09DSy8zYEKIoEKDHAARwNC-r2IsMCoyNfZN10_qiCxJEM3My8tXz-itDi1qLi0oCC_qATCyUjNKcjMSCnSD9ePAhuJx0kFuRFVPh4G6QBF0AU6/dl5/d5/L2dBISEvZ0FBIS9nQSEh/#UserGuides |
| Aboriginal and Torres Strait Islander Health Reporting Transition to the Health Data Portal - Fact Sheet | This Fact Sheet describes the Health Data Portal that is currently used to upload nKPI and other data.<br><br>www1.health.gov.au/internet/main/publishing.nsf/Content/D9154F83043FCBBDCA2581CB007F3616/$File/Heath%20Data%20Portal%20Fact%20Sheet%20March%202019.pdf |
| National key performance indicators for Aboriginal and Torres Strait Islander primary health care: results to June 2018<br>*Aboriginal and Torres Strait Islander health specific* | This report presents the nKPI data from June 2017, December 2017 and June 2018. These are the most recent periods for which data were available at the time of reporting.<br><br>aihw.gov.au/reports/indigenous-australians/nkpis-indigenous-australians-health-care-2018/contents/an-overview-of-nkpi-results-to-june-2018 |
| National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023<br>*Aboriginal and Torres Strait Islander health specific* | The National Framework for Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023 provides practical support for health care providers and policy makers to embed Continuous Quality Improvement into primary health care for Aboriginal and Torres Strait Islander People.<br><br>naccho.org.au/wp-content/uploads/NACCHO-CQI-Framework-2019.pdf |



# About the Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange

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## CREATE Collaborating Institutions

CREATE was a collaborative enterprise between the Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute, the Joanna Briggs Institute, University of Adelaide, the School of Public Health, University of Adelaide and the National Aboriginal Community Controlled Health Organisation.

## CREATE Investigators

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### CREATE Affiliate Researchers

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## CREATE Research Team

The CREATE research team changed over the life of the project. The team members listed below (in alphabetical order) contributed to systematic literature reviews and/or case studies. Those marked with * also contributed to the development of this resource.

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## CREATE Leadership Group and other contributors

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The CREATE Leadership Group (past and present) and other contributors are listed below. Those marked with an * were also involved in the development of this resource. The list includes only those people who provided permission to be acknowledged in this document. We would also like to extend our appreciation to those not able to be listed below who contributed to the project in meaningful ways.

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## Ethics

The research was conducted in alignment with the principles within the South Australian Aboriginal Health Research Accord[1] and in accordance with National Health and Medical Research Council's guidelines for ethical conduct: the National Statement on Ethical Conduct in Human Research (2007, revised 2018) and the Australian code for the responsible conduct of research, 2018). The CREATE Leadership Group guided the research process including recruitment, question development and analysis of the findings to ensure that cultural safety and respect was a priority.

Ethical approval for this research was granted by the:

- Aboriginal Health Research Ethics Committee (Protocol number 04-16-651)
- Aboriginal Health & Medical Research Council Ethics Committee of New South Wales (Protocol number 1123/15)
- Menzies School of Health Research Human Research Ethics Committee (Protocol number HREC 2015-2481)
- Central Australian Human Research Ethics Committee (Protocol number HREC-15-352)
- Western Australian Aboriginal Human Research Ethics Committee (Protocol number 680)
- University of Adelaide Human Research Ethics Committee (Protocol number H-2015-221)
- St Vincent Hospital Melbourne (HREC-A 110/16 and HREC/16/SVHM/136)
- University of Queensland Human Research Ethics Committee A (Approval number: 2017000181)

## Research Process

### Research Governance

Senior Aboriginal and Torres Strait Islander representatives from the ACCHO sector nationwide were invited to form the CREATE Leadership Group. The CREATE Leadership Group met twice yearly to oversee the work of the research team and guide the research process. They identified ten domains of interest: health service delivery, governance, funding, workforce, accreditation, continuous quality improvement, social determinants of health, health promotion, aged care and key performance indicators.

### Research Questions

Two research questions guided the work of CREATE.

1. What principles underpin best practices in Aboriginal Community Controlled Health Organisations?
2. How do Aboriginal Community Controlled Health Organisations develop and sustain best practice?

### Research Method

The research team undertook several scoping and systematic reviews of the literature to synthesise existing research evidence in relation to the ten domains identified by the CREATE Leadership Group. The CREATE Leadership Group then guided the research team to conduct case studies with ACCHOs to explore ways of working not yet described in published literature. The research team conducted case studies on workforce, accreditation, continuous quality improvement, social determinants of health, funding, health promotion and aged care. These case studies informed a meta-analysis of ACCHO ways of working in relation to ACCHO governance and ACCHO health service delivery. A funded PhD student also undertook a series of case studies on ACCHO experiences of the national key performance indicators.

The objective of the case studies was to capture practical examples of best practice service delivery within ACCHOs and articulate the principles that underpin the delivery of these services. Once ethics approval was obtained across all states and territories of Australia, the CREATE Leadership Group assisted with identifying and

[1]Morey K. (2017). *On behalf of the Wardliparingga Aboriginal Research Unit, South Australian Aboriginal Health Research Accord: Companion Document.* SAHMRI, Adelaide, South Australia.

inviting potential case study sites to participate. All work undertaken by the CREATE Research team was guided by a Case Study Handbook that was provided to potential sites and outlined the process to be undertaken including a draft case study report.

The key steps in undertaking case studies:

- **Identify and invite potential case study sites:** this included negotiating terms and conditions such as the focus of the case study, ethical approvals, timelines, provision of the Case Study Handbook, the potential appointment of an Aboriginal staff member to take up the role of an Aboriginal Research Fellow, and contractual arrangements such as completion of a Memorandum of Understanding or Scope of Works.

- **Initial engagement with the case study site:** this included an initial telephone conversation or site visit to introduce the Research team, identify potential participants for the interviews and begin to complete the Case Study Tool.

- **Collect the Best Practice data:** this included training the Aboriginal Research Fellow (where applicable), completing the Case Study Tool, providing potential interviewees with the Information Sheet and Consent Form and seeking informed consent to participate, and conducting interviews based upon the semi-structured interview guide.

- **Analyse the Best Practice data:** this included arranging for transcription of interviews, de-identification of transcripts and analysis of transcripts in NVivo software based upon a framework that described ways of working, benefits and outcomes, enablers, challenges and recommendations.

- **Draft Case Study Report:** the findings were presented in a draft Case Study report and sent to the participating ACCHO for their review.

- **Finalise and present the Case Study Report:** the draft Case Study report was updated based on feedback from the participating ACCHO with a finalised Case Study Report presented back to ACCHO staff and/or Board at a convenient time negotiated with the site.

### Research Translation

The Case Study reports were de-identified and the content was used to inform the development of chapters for this resource that described ACCHO ways of working across key domains of interest. The content within the chapters was refined to consider the experiences of the ACCHO sector nationwide through collective feedback from the CREATE Leadership Group. This collective feedback and refinement occurred over a two-year period through three face-to-face meetings (total days = 5) and five teleconferences.

## Other CREATE Outputs

For more information on other CREATE outputs and achievements, including published literature see the CREATE website: create.sahmri.org


SAHMRI
South Australian Health & Medical Research Institute
WARDLIPARINGGA
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CREATE
NACCHO
National Aboriginal Community Controlled Health Organisation
www.naccho.org.au
JOANNA BRIGGS INSTITUTE