NHMRC CREATE
The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange

CREATE Leadership Group Meeting

SAHMRI, Level 8, North Terrace, Adelaide

9:00-4pm, Thursday and Friday 7 & 8 April 2016

MINUTES

Day 1 – 7th April 2016

1. Meeting Attendance

Meeting attendees and apologies are presented in (Appendix A). (Please follow hyperlinks to all appendices).

2. Welcome to Country

Karen Glover welcomed everyone and acknowledged Country.

3. CREATE overview and Introduction for new members

Carol provided an overview of the CREATE project and outlined the Leadership Group structure and purpose as an induction for the new Leadership Group members. Slides are in (Appendix B) (separately attached due to the size of the document) and the discussion notes are at (Appendix C).

4. Minutes of previous meeting and actions arising

Minutes from the previous meeting of 11 December 2015 were accepted by John Gregg and Louise Lyons and agreed unanimously, the action items arising from the previous minutes were addressed at (Appendix D).

5. Action Items

A summary of Action Items is presented at (Appendix E). The list contains outstanding action items, new actions arising from this meeting and completed action items.

6. Overview meeting of CREATE and NACCHO

John Gregg provided an update on discussions between the CREATE team and NACCHO. Discussion notes are in (Appendix F).

7. Overview of CREATE Outcomes

Refer Summary slides at (Appendix G) and discussion notes at (Appendix H).

8. Collective

Stephen Harfield discussed who The Collective is, The Aboriginal and Torres Strait Islander staff at SAHMRI, what they do and how the meetings are used as an opportunity to learn from each other and support each other. The

Collective started as a support group but has since progressed to a group of people who want to ensure that Wardliparingga and SAHMRI do things the right way, taking account of Aboriginal and Torres Strait Islander ways of doing business first and foremost. The meeting last Friday, went through the Collective work plan, the cultural protocol process currently being developed, and discussed what the Collective should work on and what SAHMRI as an Institute is responsible for. Currently over 50% of Wardliparingga staff are Aboriginal and Torres Strait Islander people; all of these people and any other Aboriginal and Torres Strait Islander people in SAHMRI are invited to attend The Collective. One of the Collective's roles is to meet all reference groups and visiting Aboriginal and Torres Strait Islander people from Australia and other indigenous peope from overseas, hence the Collective joined the Leadership Group for lunch.

9. Presentation: Updates on Current Projects

The CREATE team (Stephen Harfield, Judith Gomersall and Carol Davy) presented brief updates on Service Delivery, Funding Projects, Aged Care and Health Promotion. Refer Summary slides (Appendix I) and discussion notes (Appendix J) for further information

John Gregg requested a formal note of thanks be made to Pam Fletcher for her assistance with organising travel and setting up of the meeting.

Day 2 – Friday 8th April 2016

Carol officially welcomed John Singer and Yvette Roe and congratulated Yvette on her doctorate.

10. Feedback from Leadership Group Sessions

A brief update was provide for John and Yvette, then the group discussed a number of areas of concern. See discussion notes at (Appendix K).

11. Presentations, discussions and feedback on Post Graduate Studies

Refer Summary slides (Appendix L) and discussion notes (Appendix M) for further information.

12. Planning for case studies

Refer Summary slides (Appendix N) and discussion notes (Appendix O) for further information.

13. Planning for Master Class and fellowship sustainability

Refer Summary slides (Appendix P) and discussion notes (Appendix Q) for further information.

14. Planning for increased Knowledge Translation

Refer Summary slides (Appendix R) and discussion notes (Appendix S) for further information.

15. 2016 Meeting dates and venues

See (Appendix T)

16. Closing remarks

Carol thanked everyone for their attendance and advised the information will be sent out in a few weeks.

Meeting closed at 3pm.

Appendix A – Attendance and Apologies

Attendees

Alex Brown (Chief Investigator) – Wardliparingga, South Australian Health and Medical Research Institute
Annette Braunack-Mayer (Chief Investigator) – University of Adelaide, School of Population Health
Carol Davy (Senior Research Fellow) – Wardliparingga, South Australian Health and Medical Research Institute
Elaine Kite (CREATE PhD Candidate) – Wardliparingga, South Australian Health and Medical Research Institute
Edoardo Aromataris (Chief Investigator) – University of Adelaide, Joanna Briggs Institute
John Gregg - National Aboriginal Community Controlled Health Organisation
John Singer – Nganampa Health (Friday only)
Judith Gomersall (Research Fellow) – University of Adelaide, Joanna Briggs Institute
Karen Glover - CREATE Program Manager, Wardliparingga, South Australian Health and Medical Research Institute
Karrina DeMasi – Danila Dilba
Louise Lyons – Victorian Aboriginal Community Controlled Health Organisation
Marianne Wood – Aboriginal Health Council of Western Australia
Ngiare Brown (Chief Investigator)
Stephen Harfield (Research Fellow) – Wardliparingga, South Australian Health and Medical Research Institute
Summer Finlay – CREATE PhD Candidate
Tracey Brand – Central Australian Aboriginal Congress
Yvette Roe – Institute for Urban Indigenous Health (Friday only)

Pam Fletcher (Administration Assistant) – University of Adelaide, Joanna Briggs Institute
Karen Laverty (Administration Assistant) – Wardliparingga, South Australian Health and Medical Research Institute

Apologies

Adrian Carson – Institute of Urban Indigenous Health
Barbara Henry – Derbarl Yerrigan Health Service
Brita Pekarsky (Research Consultant) – Wardliparingga, South Australian Health and Medical Research Institute
Damian Rigney – Watto Purrunna Aboriginal Primary Health Care Services
Eddie Mulholland – Miwatj Health Aboriginal Corporation
Julie Tongs – Winnunga Nimmityjah Aboriginal Health Services
Karla Canuto (Research Fellow) – Wardliparingga, South Australian Health and Medical Research Institute
Marion Scrymgour – CEO Tiwi Islands Regional Council
Olga Havenen, Danilla Dilba, Karina attended as proxy.
Sandy Davies – Geraldton Regional Aboriginal Medical Service
Shane Mohor/Amanda Mitchell – Aboriginal Health Council of South Australia
Suzi Berto – Wurli Wurlingjang

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Appendix B. CREATE overview slides

See CREATE OVERVIEW slides in the presentation sent out separately.

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Appendix C. CREATE overview and induction for new members discussion notes

The CREATE is an NHMRC CRE funded grant and that we have 5 years' worth of funding, which is flexible so we can shift and change over time. Currently in year two, end date is October 2018. Anticipated that at the October meeting we should be able to start discussions about the CREATE projects going into the future. The Leadership Group is an important part of the future planning.

Further discussion about CREATE collaborations with other Universities in South Australia and Australia and how evidence is collected for example through Systematic Reviews eg. James Cook around the methods work.

In addition CREATE works with people overseas, such as Josee Lavoie in Canada, and Maui Hudson in New Zealand. Keen to work with other people but nothing formal at this point.

Copies of the ACCORD were discussed and distributed during the break.

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Appendix D. Minutes and review of action items from previous meeting

Review of Previous Action Items

2, 3 and 4. Complete

5. Complete.

6 and 7. Complete – Carol Davy met with Julie Tongs and will keep her informed of any progress about ageing projects. Currently discussing how to incorporate Primary Health Care. Ngiare Brown advised on Winnunga's behalf, currently not funded and not acknowledged but are very interested providing aged care does not create an additional burden. Carol working with Graham Aitken in SA about aged care policy changes and impacts on Aboriginal and Torres Strait Islander communities.

8. On hold.

10. In progress.

11 and 12. Communication Strategy distributed. Twitter is currently being managed by Summer Finlay, we have increased from 55 to 250 followers since the start of the year. Alex suggested we should have a list of what we want to communicate and add to the Tweet deck so it can be readily scheduled.

13. Carol will arrange for the link to the Aged Care Webinar to go up shortly. John Gregg suggested to make contact with VACCHO around work in this space.

14. Information was distributed. Second round of opportunities to follow. The costs of the Fellowships are only for Aboriginal and Torres Strait Islander people. It was clarified that people with the Fellowship can still hold their current jobs.

15. Due November.

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Appendix E. Action Items

Action Item No.	Raised at Meeting	Topic	Action	By Who	By when	comments
14a	11/12/15	Annual Brief	To be prepared	Karen Glover	Nov 2016	
15	8/4/16	Leadership/ NACCHO	Document "Rapid Response" process for John Gregg.	Karen Glover	May 2016	Completed
16	8/4/16	Leadership / Health Promotion	Provide an evidence "brief" for Senior public servants, about ACCHOs; give to John Gregg	Stephen Harfield / Carol Davy	Aug 2016	
17	8/4/16	Case Studies	Present to CIs re: Case study on SDOH also discuss with Judith Dwyer and investigate if other countries have similar SDOH.	Carol Davy	Aug 2016	
18	8/4/16	Leadership Group	Investigate including someone from Tasmania on the Leadership Group to make it truly national. John Gregg can assist with contacts (TACINC, plus 4 others)	Karen Glover	April 2016	
19	8/4/16	Aged Care	Discuss residential aged care with Louise Lyons and Vicki Wade	Carol Davy	June 2016	completed
20	8/4/16	Aged Care	Identify some good examples in SA of	Carol Davy	June 2016	completed

Action Item No.	Raised at Meeting	Topic	Action	By Who	By when	comments
			Aged care			
21	8/4/16	Case Studies	Conduct a quick environmental scan / investigation around what other CREs are doing around Social Determinates of Health to determine if there is any overlap.	Carol Davy	May 2016	
22	8/4/16	Case Studies	Ngiare Brown requested information on homelessness and if we could do a brief scan of policy documents.	Carol Davy		
23	8/4/16	Case Studies	Discuss case study checklist with Louise Lyons and Yvette Roe prior to distribution to Leadership Group.	Carol Davy	May 2016	Completed
24	8/4/16	Case Studies	Create a case study pack which includes the case study template, case study tool, semi structured interview questions, etc. Distributed to Leadership Group.	Carol Davy	April 2016	Completed
25	8/4/16	KPIs	Map the Best Practice framework and priciples back to the KPIs to see what is missing.	Summer Finlay	Aug 2016	

Action Item No.	Raised at Meeting	Topic	Action	By Who	By when	comments
26	8/4/16	Case Studies	Suggest and provide guidance on sites and timing for case studies.	Leadership Group	Aug 2016	
27	8/4/16	Case Studies	Discuss case study plans with John Singer	Carol Davy	May 2016	
28	8/4/16	Master Classes	Look at strategy for increasing availability of master classes	Carol Davy	May 2016	Completed
29	8/4/16	Master Classes	Need a contact person on website and reflective points	Carol Davy	June 2016	
30	8/4/16	Master Classes	Develop and distribute capacity strengthening program to peak bodies	Carol Davy	Aug 2016	
31	8/4/16	Fellowships	Contact Carol if you have anyone interested in a PhD or Masters.	Leadership Group	Aug 2016	
34	8/4/16	Health Promotion / Master Classes	Investigate the IP legalities and then design a process that allows CREATE specific documents to be utilised by local groups, who can then put their artwork etc. on these documents.	Carol Davy	Aug 2016	

Appendix E (cont)

Completed Action Items

Action Item No.	Raised at Meeting	Topic	Action	By Who	By when	comments
1	11/12/15	Leadership Portal	Send log on information and password to John Gregg	Karen Laverty	Jan 2016	completed
2	11/12/15	Environmental scan	Discuss ways forward with Barbara Henry – possibly set up sub group and adapt existing template	Karen Glover	Ongoing	Completed
3	11/12/15	Holman Review	Feedback discussion to Barbara and John to prepare for a meeting	Karen Glover	Ongoing	Completed
4	11/12/15	Holman Review	Meeting to discuss review and develop ways forward	Barbara Henry and John Singer	Ongoing	Completed
5	11/12/15	Income management	Discussion and update to Barbara Henry	Brita	May 2016	
8	11/12/15	Childhood trauma and chronic disease	Work with Ngiare Brown to further investigate – identify trauma and chronic disease early intervention and prevention, 0 – 3yrs, where and what is emerging evidence? Refer systematic	Karen Glover	On hold till October	

			review Leonie Segal NT/SA data link			
12	11/12/15	Communications strategy	To also 'stream on apps'	Summer Finlay	Apr 2016	Completed
14	11/12/15	Fellowships	Send information out about the Fellowships in mid-January	Karen Glover	Jan 2016	completed
32	8/4/16	Leadership Portal	Send logon information and password to new Leadership Group members	Karen Laverty	April 2016	Completed
33	8/4/16	Master Classes	Need to record on all study guides etc. that this project has been funded by NHMRC.	Carol Davy	April 2016	Completed
33a	8/4/16	Leadership Portal	Information on the Leadership Group Portal to be appropriately watermarked as either a) For your information only or b) Share widely within the sector.	Carol Davy	June 2016	Completed

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Appendix F. Overview meeting of CREATE and NACCHO

John Gregg confirmed commitment to the collaborative arrangement and the importance of working with CREATE to support the ACCHO sector. Key items from the meeting were funding, competition, PHN transaction costs. John met with the Deputy Secretary yesterday and as a result of the small piece of work from the CREATE team a directive was issued that PHN's can now only charge a max of 7% for overheads. This is an example of how valuable this research work can be to provide support towards positive policy and/or program impact.

This resulted from a specific question from our industry to CREATE, who provided the information and then John and the sector were able to use this to make changes. It is important that we can take bits of research quickly and use it to give support for positions the sector wants to take. Drawing on independent evidence (ie. Work of the CREATE research team). John's people collect a lot of data, we need to ensure we can pick out the good bits and use them wisely.

Dingo bingos, ningos – Carebears are able to access what was previously specific identified Aboriginal and Torres Strait Islander money and using it - including overhead costs – thus reducing the service delivery to our community.

It was agreed that CREATE has the capacity for a "quick response" process and Karen Glover to write up and disseminate. The request to include context, issues, questions, timelines and thoughts. (Action Item 15)

It is important that CREATE researchers continue to move with the changes and translate the research into knowledge. The group discussed how things have changed 3 times, from Divisions of GPs to Medicare locals and now PHNs.

Funding domain was set as a priority by the Leadership Group so we had already done the work on this. If we don't have the information we can't give an immediate response, like we could do with the funding area. Important to check that the information was publicly available information. We will respond to requests a number of ways – yes we have information, no we don't have it but could do it, or no we don't have the information and it will be hard to get and we cannot do it.

All agreed the meeting was a good day well spent. The key things was an absolute commitment from the research team – ask and we will try to provide digestible information. The briefs should be able to be read by everyone.

PHNs are loved by Minister Lee. All government are committed to Closing the Gap. Procurement policy – 4% - can't we place ourselves in this space. Need to be a few steps ahead.

There is a pressing need to have a document about why we are the preferred provider. Need to have something that says if not using us, than why not, rather than us having to justify ourselves. Create an evidence "brief" for Senior public servants, about ACCHOs for John Gregg. (Action Item 16).

Short focus. We are currently in "Care Taker" mode – so use this time to prepare the document that supports ACCHOs being the preferred supplier for delivery of wellness focussed service for Aboriginal and Torres Strait Islander people. We could do some modelling work that is able to identify the best practice case studies – very diverse areas so will be nuances – but still be able to show some consistency. Fiona Nash loves this stuff.

Case studies to address how the sector can assist with unpacking our unique model of care, specifically how best to articulate what it is?

The focus from NACCHO for the ACCHO sector moving forward is to be specific in some cases, for example:

- Most vulnerable – young Aboriginal males.
- Mental health key area to focus on.
- Social and Emotional Wellbeing
- Youth and older people prioritise.
- The recently reported 35% contribution that the social determinants of health make to the burden of disease in Aboriginal and Torres Strait Islander communities is a significant underestimate.
- Story about wellness.
- Communities pursuing wellness
- Resilience and capacity to respond and deliver
- Skilled and nimble workforce / technologies
- Maximising opportunities through NDIS and Aged Care reforms

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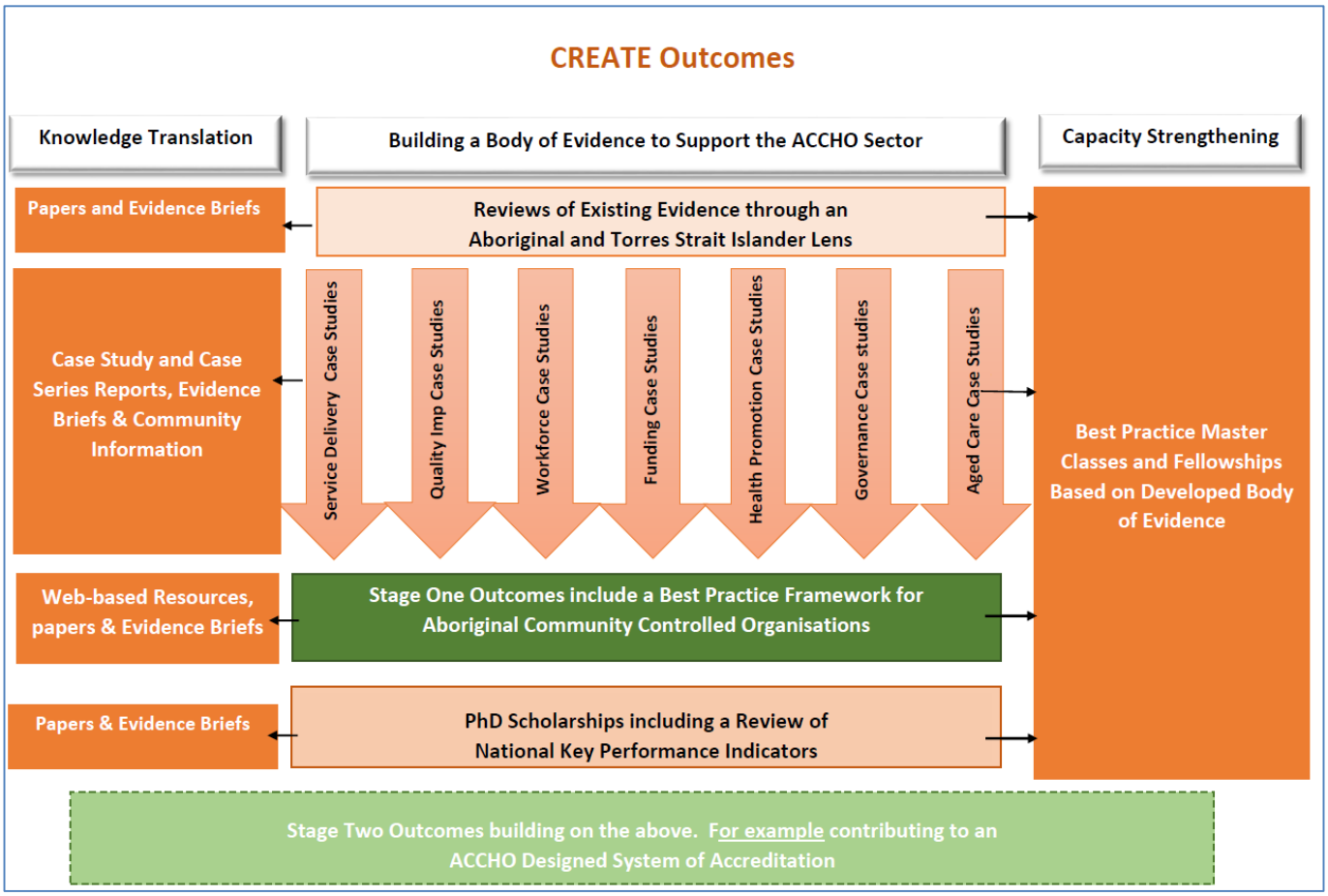
Appendix G. Overview of CREATE Outcomes



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Appendix H – Overview of CREATE Outcomes – Discussion notes.

Carol Davy explained the CREATE outcomes diagram and the associated program of work, it is being called a framework as each organisation will develop their basic model based on the framework. The plan is to review existing evidence, to ensure the team do not repeat work that has already been done. The review will be looking at existing evidence from an Aboriginal and Torres Strait Islander lens. Odette Gibson and others have reviewed the plan. The plan is to do case studies around each of the downward arrows. Miwatj will be the first case study and will focus on leadership as it is considered an area of strength for them.

The team is aiming to complete six case studies by the end of 2016. We are working toward up to 20 all together, It will probably take 2 years, with 4-5 big ones that will cover all domains, the rest will be smaller and about specific domains. We need to articulate the differences between a western model of care and the Aboriginal and Torres Strait Islander models. There is work happening around Summer's, Key Performance Indicators work and Elaine's wellbeing work that will be discussed later. Also plan to start development of Master Classes around each of the domains, such as health promotion, best practice and funding. Also hope to do a Systematic Review Synthesis Master Class later this year. The aim is to build this into a professional development program.

Case studies – each site will negotiate its documents required at the beginning, for example: each site will receive a case study report other documents required and how they will look may differ from site to site eg information targeting the local community as the primary audience. It will all be web based and contain the framework, case studies, and various resources gathered along the way. For those areas without reliable internet access, paper information and USB will also be available.

Further information on Case studies will be discussed tomorrow. Alex advised that we will look to the Leadership Group for advice on site locations because the Leadership Group should be able to identify those areas that are doing certain things well.

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Appendix I – Presentation – Discussion and feedback on current work- Slides

See BUILDING A BODY OF EVIDENCE slides in the presentation sent out separately. The slides covered:

- Best Practice Service Delivery
- Funding
- What keeps you strong?
- Health Promotion (limited discussion)

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Appendix J – Discussion and feedback on current work

Service Delivery (Stephen Harfield)

Key points from the Service Delivery discussion were:

- Most of the studies are from Australia, some from the US and Canada.
- A community reference group to be formed to assist with Phase 4 (Developing a draft Service Delivery Framework).
- Phase 2 (Learning from other Indigenous service delivery) - the 10 characteristics are what are available from the literature. Considered comparing this to the Chronic Care Model but since this morning's discussions will now compare to ACCHO preferred supplier.
- ACCHOs only deal with 40% of the population, we only exist where 30% of the population are. Aboriginal and Torres Strait Islander people have the same right as everyone to choose but sometimes there is no other option.
- Need an opening statement – where there is a choice the preferred choice is ACCHO, create Evidence brief. (See action Item 16)
- John Gregg suggested we look at the report from last year. Data is incorrect – as people move so they may be counted multiple times. They move due to sorry time, etc. The reports often have caveats that should be read. We need to use caveats too.
- We are the preferred choice in a lot of places.
- All social determinates of health – the ACCHOs do a lot of other things that are not captured ie. Running people around, taking people to visit family in jail, the driving takes up a lot of time. VACCHO has done a map showing multiple pillars of service – not just doing health services. Possibly out of scope but should acknowledge that it is more than just a health service.
- Carol Davy reminded the group the reviews are not just from Australia, they include, New Zealand, Canada, etc.
- Marianne would like the work to be comprehensive.
- Odette Gibson's work with Aboriginal and Torres Strait Islander State government services identifies those that provide extra services that address social determinates as best they can – they identify that they are not getting funded and they have limited staff.
- Karrina - Lots of things to consider, homeless people the GP practices will not do some of this work. We are a comprehensive provider, but the government doesn't recognise the extra work we do. ACCHO systems are so stretched, the case studies are very important. They will show what we do beyond traditional services.
- John Gregg – AIHW draft on burden of disease for Aboriginal and Torres Strait Islander people is around 30%. This seems low. Doesn't consider the impacts of social determinants of health (SDOH) on the burden of wellbeing. We need to know if these other countries have similar SDOH or not. Do they speak about it in their reviews? Perhaps speak to Judith Dwyer. Professor Voss has done a lot of work on SDOH. AIHW – has two A4 pages that address SDOH. Canada is better. We could do a case study around SDOH. Carol Davy requested and received permission from the group to present to Alex, Ngiare and Annette Braunack-Mayer on doing a case study on SDOH. (Action Item 17) Ngiare suggested we revisit the Closing the Gap work. Winnunga has a social health team that deals with the other supporting items

ie. Housing, finding jobs, child protection, transitioning from jail, etc and they are one of the hardest working teams in Winnunga.

- Marianne raised mental health and believes all of the money allocated for mental health work has gone to PHNs.
- Further discussions to be held tomorrow on case studies. They should cover ACCHO diversity, including geographic, size, and domain and will need to go to 7 ethics committees across Australia – NT, SA, WA, NSW, and Queensland different for each place. Vic they tend to go to VACCHO. (See action Item 17)
- It was raised that we talk nationally but often miss Tasmania. John Gregg offered to help make contact with the TAC (Heather is the contact), need to be aware there are 4 others and they operate as a cooperative model. (Action Item 18)

Funding (Judith Gomersall)

- Acknowledged input from Odette Gibson
- Evidence specifically about Australia and ACCHO care.
- 9 people involved – half Aboriginal, led by Odette. Others doing the work, Judith is just collating the work.

Review 1

- Almost complete. Findings being used in Master Classes and an article in MJA.
- Value is holistic.
- Need a fundamental drive to make mainstream more useful and culturally appropriate but the key message is our model is the preferred item. The Government will want a 3 second video and check list so they can say yes we have made mainstream more useful and culturally appropriate but it is not that easy.
- The initial question came from the Leadership Group as not all places have access to ACCHOs, it is the responsibility of mainstream to do it better.
- Do not want a sole solution, ie. 1 Aboriginal person placed in mainstream services as this makes them unhealthy from having to deal with the community in isolation, where they are unsupported, which can be dysfunctional. Carol advised that all of this information is helpful in teasing out the issues for input into the case studies.

Review 2

- There is no existing systematic review that has pulled this together.
- Louise Lyons suggested there is a lot of missed opportunities via Medicare, people not knowing, ACCHOs need to know how to use these funding possibilities.
- 3rd element is the inadequacy of the services.
- John Gregg – tick and flick process – in some areas they are rounding people up, checking them, and gathering the funding, but not delivering a good service. This misses the people with multiple comorbidities.
- Marianne – advised of instances where GP management is done on the tarmac for a person who is being picked up by RFDS so they can get their funding.

- Ngiare advised that 8-10 years ago there was a big push around commonwealth funding, people became clever at finding the funding using the MBS number. Also using numerous aliases.
- Big issue around trust – they don't think that Aboriginal and Torres Strait Islander people are competent with their trust, possibly more racism.
- MBS item not suitable for Aboriginal and Torres Strait Islander people due to complex nature of SDOH.
- Medicare review was recently done with no Aboriginal people involved. Now they are thinking of an Aboriginal MBS review. John Gregg would like to use Ngiare or Mark Wenitong for this. Big ticket item.
- Aiming to present the findings at the PHCRIS conference in early June. Very good at providing support, including providing fellowship scholarships.

What keeps you Strong? (Aged care - Carol Davy)

- Carol discussed who was on the Expert Panel, Graham Aitken (Aboriginal Community Care SA), Jan Van Emden (Helping Hand), Jenny Hayes (ex Alzheimer's Australia) and Aunty Janice Rigney.
- Articles selected.
- Discussions with people around Australia – IUIH are interested in documenting their group, a proposal to be written. Also discussing with Winnunga but mainly with Graham Aitken.
- Tapping into the Older Aboriginals who are valuable members of their communities.
- Summer worked with the Elders in NSW.
- Ngiare discussed the importance of revitalisation of our culture
- Discussed what does cultural safety mean in an aged policy and practice setting. Ie. Collecting firewood, Graham Aitken discussing with TAFE – to ensure aged care places receive training on cultural safety.
- The slide with the diagram identifying the 5 areas, was developed by the Expert Advisory panel at their strategic planning day.
- Louise Lyons raised residential aged care, suggest we discuss with Vicki Wade who advised that older Aboriginal people in Victoria are traumatised so they struggle to pass on their experiences. (Action Item 19) Need a safe place for them to address it and to let them pass on their stories.
- Ngiare advised that it is difficult to capture some of these experiences, due to intergenerational trauma. Healing the older will transfer to healing the younger. Might be in a narrative, therapy place, or get them to help the elderly. Elevate our Elders and people as they age.
- Preserve and treasure human capital. Link different areas of the CREATE arm.
- There will be $50b spent on aged care in the next 10 years so plenty of opportunities. Need to come up with some examples in SA that are good. (Action Item 20) Graham is hoping to build something from the ground up in the Southern area.
- People from the age of 50+ are eligible for aged services. More people are identifying now as they feel more comfortable. Aboriginal people do not access residential aged care as much as non-Aboriginal people. Not looked at Palliative care. What sort of services available. Need to deliver decent meals.
- Carol advised that she has submitted a DECRA application around aged care which if she gets it will free up some of her salary costs.

Health Promotion

Karla an apology. They are currently pulling the literature together. Down to 120 articles, looking at book chapters, the running or implementation of it. Then we can pull out those on smoking cessation, alcohol, etc. Information helpful for Master Classes. There used to be a book that would give you all the index references of where you could get information from.

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Appendix K – Feedback from Leadership Group sessions

- Develop Master Classes around the tendering processes, draw on people experienced in this area.
- Capacity strengthening was around using own service data.
- Yvette discussed the need to look at the landscape in our model of care – patient journey, patient experiences, don't talk about nuance's, family stresses, social health team trying to manage this. Advocating to provide commercial resources. Contestability about what it costs to engage in long term health care. Currently written up very 1 dimensional. Lot of NGOs coming in, quality of service questionable, business cases need to be smarter and should discuss the terms of primary outcome.
- Already existing body of work. This is about surpassing the body of care that currently exists. Need to compare apples with apples. Can't just be a deficit model, needs to focus on wellness, innovation is important, it is about setting the benchmark.
- Need to push back to the Commonwealth on what have they done. Eg. Domestic violence.
- John Singer – important in how we engage in our community, the PHNs are tagging on to our community control and taking out our Aboriginality. Engagement is important. Shouldn't be a competition but it looks like it's going that way with tendering. Philosophy is the same even though it looks different. AMS/ACCHOs doing the best.
- Who's the biggest employer, building the workforce – we are.
- Important to build the Social Determinates of Health (SDOH) into this program.
- Discussion similar to yesterdays, not only about what we are producing but what we are doing.
- There are a range of CREs, we could be networking with or sharing information. We have done this stuff, this is what we have learnt.
- Look at what the other CREs are doing re: SDOH - do an environmental scan to see what is happening. (Action Item 21) We are looking at it in some way.
- The other CREs may not have the same leadership group – this is unique – opportunity to dig into the other CREs and offer this. Ie. The Poche centre, Lowitja, all part of knowledge translation.
- John Singer asked who will benefit, different angle of reports in terms of how it works. Something to support our work. We might put it in a folder but never use it. John Gregg re-shared his example re: funding and PHNs.
- Carol urged people to use the 1 page summary of evidence that are on the CREATE website that you can put on the table. Issues around policy – we will try and respond via rapid reviews – producing the evidence on the ground.
- South East Queensland has 18 clinics – aged care focus, our mob still needs this service, the needs are going to be the same. Money going to be smaller so we need to become smarter. How do we caucus.
- Ngiare – Being better connected at all of the levels, the politicians love this stuff. Often the jurisdiction have good relationship with the state and territory. They need information to be able to say I know here this happens and in this urban, rural centre etc this happens. This helps Ngiare in her relationships with the politicians.
- Karen G – confirm Carol Davy's CREATE outcome slide, does this cover everything. Looking at this stuff later in October as that's when we need the long term planning. The Leadership Group confirmed the slide represents the work accurately and it is relevant.
- Tracey – measure the impact and measurable outcomes.

- Yvette – What we can share and what do we do really well, ie. Around homelessness
- Ngiare – timeliness, while we are doing a systematic review can we do brief scans of policy documents. I need something on homelessness. Think tanks do this on policy briefs. (Action Item 22)
- Louise – CREATE outwardly focused on advocacy. John Gregg – do we have the capacity to help with application stuff via a rapid response to stuff that goes to tender. Take all of your knowledge to help move business models along. The keepers of knowledge in the sector is massive, can we pass some of this on and meet with the Politian's.
- Master Classes are knowledge translation.
- John Gregg advised that most senior Politian's don't know what ACCHOs are and may have never been to one or seen one. Two ideas:

    1) induction for senior public services (needs a different name).

    2) "how to" from a sector point of view, policy space. (See action Item 16)

- They get on the phone and ring peak bodies seeking assistance. How can we help provide information?
- Yvette's – Heart and mind story –people going to a funeral every week. Worth describing this – one has been done by Louise Lyon's site.
- Louise Lyon to provide case study information to Carol.
- Carol will put together a case study tool, capturing specific information about what each site does, then add these issues to the case study tool. ie. Analysing this across a lot of tools. Send tool to everyone with minutes. Carol to discuss case study tool with Yvette. Send out with minutes to get feedback from everyone. (Action Item 23 and 24)

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Appendix L – Presentation on Post Graduate Studies

See BUILDING A BODY OF EVIDENCE – Understanding the impact of national Key Performance Indicators on the Aboriginal Community Controlled Health Organisations - slides in the presentation sent out separately.

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Appendix M – Discussion Notes from Post Graduate Studies

Summers' presentation

Summer presented her work which raised the following discussion:

- Yvette believes there are 3 PhDs in the work – very heavy workload.
- Need to be clear about definition of effectiveness as KPIs are just numbers.
- Systematic review will look at the gaps in the data. I.e. Improve life expectancy around KPIs – Challenge this.
- Ngiare questioned the relevance of KPIs? There are lots of KPIs some might go close to being useful but most are a huge imposition and just more work.
- Do they equate to quality of care in the sector. What is the effectiveness?
- Do they do what they are intended to do? Do they use them locally, what are the barriers and enablers?
- Different services with have different opinions. Have spoken with Jenny Hunt and Mark Wenitong. Would like to see what everyone's perspectives are.
- Draft background context paper due in November.
- Planning on doing four case studies, in different states and territories, different sizes, one that is using KPIs, one that is not. Ngiare advised that PHNOs are a resource they have been heavily involved.
- May identify what a quality service does – all this stuff (ie. Holistic stuff) which is not measured by KPIs.
- Expression of interest form will be sent out. Bit scared response might be too much – want a nice range and a good mix of areas involved in research and those that have never been.
- Selection panel to be setup.
- Carol suggested Summer to look at the Best Practice framework and principles and map them back to the KPIs and see what is missing. (Action Item 25) Hope to see this stuff through the semi-structured interviews.
- Also doing a survey of 136-150 ACCHOs. Hopefully the affiliates can assist during that process.
- Once published will want to start promoting it a lot. Will create a mini communication strategy around using social media etc.
- Yvette raised concerns that the question may shift. It is best if you have only 1 question that guides you.
- Summer does not believe the question will shift it is the tools that will change. Summer moving to Adelaide, to take the pressure off and to remove the level of isolation.
- Time frame – 2 years, data collection this year, analysis and write-up next year.

There are also two other students – Elaine Kite, Jasmine Gregory (Geraldton) – powerful women in leadership roles. Still have scholarship spots if people are interested.

PhDs are a traumatic experiences so supporting students very important and connecting them with other students helps. It's important that we think about the cohort of students and how they get together and how we can bringing them together regularly.

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Appendix N – Presentation - Planning for case studies

See PLANNING FOR CASE STUDIES slides in the presentation sent out separately.

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Appendix O – Discussion Notes - Planning for case studies

Planning for case studies

We are committed to do 20 case studies over two years. Four or five big ones that will cover all domains, the rest will be smaller and about specific domains. The plan is to put together templates for a report; examples of the types of evidence briefs and policy briefs; types of information we can put back to their services. Will negotiate with the site, get their agreement, and put together a service agreement for them to sign off on. We will work with local people on the ground.

Deidentification of data – data is deidentified, the service may be acknowledged and it might say an Aboriginal and Torres Strait Islander social and emotional worker said this, however, within the case study, to the service, it will only say a staff member said this. Will be signed off by CEO/board. The individual case studies will make a case series.

Possible things to consider in the selection matrix: (Included in action Item 24)

- Length of operation
- Type
- Rural, remote and very remote, consider the Victorian criteria or ABS definition or AIHW distance issue definition – ie. More than 60 minutes to access key services classified as remote. A lot of different way to cut it. Possibly consider if their incorporation status is listed.
- Focus on Health Promotion, but cover other things.
- What else do you do well, what else do you think you can do better given unlimited resources, time, etc, what works well, what doesn't, etc.
- John Singer advised they are the only health provider in his region. Funds go to our AMS but shift from one place to another regularly. Should be an easier formulae for funding these organisations.
- A different approach is required about how much funding is received.
- If they shutdown an AMS they have to go through a lot of work to justify funding for nothing. Is it cheaper for government to invest in us or to use NGOs?
- Linkages should be discussed. Ie. Working with the local football club, hospital, etc.
- Different in Victoria than remote areas. Two Aboriginal and Torres Strait Islander workers take 1 ½ days to get one Aboriginal and Torres Strait Islander person in for an appointment. Need a criteria to have the ability to describe it.
- Cultural construct – how are cultural needs being addressed?
- Recognition of environmental space – ie. access to specialist

Ngiare – it will vary, make sure people have safety and space to discuss and cultural experiences and know how to frame it. Geographically, if not specifically general. Explore in depth what led to a particular piece of information. Carol to put together a case study template of what it might look like. (Included in action Item 24)

Every case study will have specific information such as how many kms from service, how many staff on board, focus on particular areas and particular services ie. Great health promotion program so concentrate on that.

Need to be clear about the geography of where the case study comes from.

How to invite and identify the services. Summer hoping to send out an expression of interest through the affiliates and NAACHO for her project we could link in or follow this process. Hoping people will self-identify like Winnunga and Miwatj have done.

Carol suggest we have a separate link up with each of the key peak bodies, would like the Leadership Group to identify appropriate or inappropriate times. (Action Item 26) Have spoken with AMSANT and they are very keen.

Capture things around each of the states and territories, size, location. John Singer mentioned that we all live in very different areas, context of urban, rural, remote, etc not entirely correct for his area. So how do we do it? Relationships and competitive advantage – relationships are diverse and communications methods are different for the young – technologies, older – not so much down this path. The hard mob (homeless, addicts, chronic disease, etc) – difficult to engage with but when they come in we are doing a good job with them.

Yvette suggested we look at what brings people together not what separates them.

Discuss case study plans with John Singer after meeting. (Action Item 27)

Karen Glover summarised case study information as follows:

- Who –ask for suggestions
- Coverage/ ACCHO size, age, specialities
- Matrix – context
- Urban, rural, remote, regional, very remote
- Size of service
    - Programs, specialists, workers
    - Number of FTEs
    - Number of Clients
- Each state and territory represented
- Remoteness and very remote (ABS definition)
- Distance – AIHW define access (60 minutes from a health service)
- Incorporation status and legislation
- Diversity – describe
- BTH workers - describe
- Cultural, social experiences
- Funding features eg. NTs
- Reporting burdens/patterns/community movement and levels of stress for ACCHOs at times (sorry business and festivals)
- Remote areas / only service in the area. Dollar formula
- Partnerships and linkages
- What brings the "natural group of people together"
- Infrastructure
- Diversity – describe this
- Culturally construct – how are cultural needs being addressed?

- Recognition of environment – access to specialist eg Victoria 1.5 days travel x 2 staff (Work Health and Safety)
- Health outcomes access, workforce
- Access – homeless difficult to reach, threads bringing us together
- Resilience and cultural strengths
- Selection process – NACCHO and Affiliates in the first instance and also through the Leadership group membership – phone calls to NACCHO and Affiliates

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Appendix P – Presentation - Planning for Master Class and Fellowship sustainability

See PLANNING FOR SUSTAINABILITY OF MASTER CLASSES AND FELLOWSHIPS slides in the presentation sent out separately.

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Appendix Q – Discussion Notes - Planning for Master Class and Fellowship sustainability

Capacity Strengthening

Master Classes

- Carol advised that we were funded to produce 1 Master Class and present it twice. We now have 3 Master Classes and have presented to 150 people around Australia in 15 Master Classes.
- The Evaluation Master Class is finished. It is a 2 day Master Class, currently running at no cost to ACCHO's, but we ask if they could provide facility and the food.
- Thinking of longer term responsibilities, could stream in or podcast stuff, bluejeans video conferencing.
- Should be looking at Strategy, best practice, policy. Ie. The Carpa manual is a great example. (Action Item 28)
- Publications, evidence briefs, slides and presentaitons are important.
- Need a contact person on website and reflective points. (Action Item 29)
- Important to develop useful resources then distribute to peak bodies (Action Item 30)

Fellowships

- Contact Carol if you have anyone interested in PhD or Masters. (Two available – must be Aboriginal and/or Torres Strait Islander). Must study fulltime, allowed to work 1 day a week, $30k tax free plus whatever they earn at work. Additional funding available for visiting Adelaide to get support ie. Come to the Leadership Group meetings, then remain for the week. (Action Item 31)

How else to build capacity

- Training/ workshops – policy writing and activities
- Authors acknowledged
- Co-presentations at conferences of case studies – how to do it, public speaking
- See one, do one, train one
- Train the trainer
- Use vignettes
- Peer teaching
- Podcasting in one hour sessions
- Stream some and then group work
- Mixed mode
- Webinars
- Match to competencies in ACCHO, VACCHO, AHCSA RTO courses – collaboration and shared funding model
- Qualification pathways

- Professional development points through SAHMRI and other collaborations (not RTO)
- “Associate qualifications”
- Tender writing

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Appendix R – Presentation - Planning for Increased Knowledge Translation

Nil papers

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Appendix S – Discussion Notes - Planning for Increased Knowledge Translation

Knowledge translation

- What evidence
- What to do with it/ how is evidence useful
- How we take evidence and how we use it to inform best practice, strategy and policy
- Policy briefs – eg infrastructure during the tender process
- Political information
- Best practice
- Evidence briefs
- Evaluation Master Classes
- Tender writing Master Classes
- Best practice eg Carpa manual – evidence information to be robust, relevant and useable, measurable, purpose, eg advocacy document, process to ask questions, Tools
- Relevance and context

Strategy

- Evaluation works eg recommendations, where to next?
- Facility to ask questions eg. Feedback, webinar, discussion blog, online tutorial, contact person and interactive

Policy

- Brief format for "cut & paste"
- Slides for presentations
- Reflective document
- Vignette - learnings

Communication and dissemination plan

- Channels, audiences and messages
- Conference presentations PowerPoint – website and other means
- Feedback and presentations to communities (case studies)
- Diversity (eg. Twitter)
- Boiler plate model
- Fellowship project write ups
- Responsible for maintaining relevance
- Targeted tools with key messages
- Co-Branding and IP
- Naccho policy groups

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Appendix T – Future meeting dates, location and final discussion

Leadership Dates:

Thursday 4th and Friday 5th August 2016 – SAHMRI, Level 8, Adelaide

Thursday 20th and Friday 21st October 2016 – SAHMRI, Level 4, Adelaide

Friday 9th December 2016 – SAHMRI, Level 4, Adelaide

Final Discussion notes

Use Leadership Group Portal. Send link and password to the portal to new people. (Action Item 32)

Need to record that this project has been funded by NHMRC. (Action Item 33)

Information on the Leadership Group Portal to be appropriately watermarked as: (Action Item 33a)

- For your information
- Share widely within the sector.

Check with Lawyers if local mob can put their artwork on work we have produced, may be an issue with IP. (Action Item 34)

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Terms of Reference (Leadership Group)

Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange (CREATE)

1. Role/Purpose

The Leadership Group is to direct CRE researchers by providing strategic guidance to the CRE program and research and by maximising the applicability of the CRE outputs to achieve a positive impact on the health of Aboriginal and Torres Strait Islander people. It will also facilitate communication and relationships with key stakeholders within Aboriginal and Torres Strait Islander community controlled health sector to foster awareness of, and support for, the program. It will also be a vehicle for ensuring accountability back to the Aboriginal Community Controlled Health Service (ACCHS) sector.

2. Term

The Centre will be operational for five years. These Terms of Reference are effective from the commencement of the CRE (October 1st 2013) to completion of the five year program (September 30th 2018). Members will be appointed for a three year term with an optional two year extension.

3. Membership

The members of the leadership group will be invited by the Chief Investigators of the program and will be selected to reflect broad national coverage and expertise relevant to the goals of the CRE. The Leadership Group will consist of:

- The four chief investigators of the CRE (Prof Alex Brown, Prof Annette Braunack-Mayer, Prof Ngiare Brown, Assoc. Prof Edoardo Aromataris)
- Representatives from the Aboriginal and Torres Strait Islander community controlled health sector and communities

The exact composition of the Leadership Group is dependent upon the number of individuals who agree to participate in the Leadership Group, the needs of the program of work, and the availability of key individuals. A complete list of Leadership Group members will be available on the CREATE website http://create.joannabriggs.org/.

4. Roles and Responsibilities

The Leadership Group is responsible for:

- Selecting topics for systematic review and collation which have the greatest capacity to improve the health of Aboriginal and Torres Strait Islander peoples or those considered priorities by the ACCHSs and the community;
- Providing advice and feedback to the chief investigators regarding important outputs and initiatives of the CRE, including capacity development among ACCHSs, the community and Aboriginal researchers;
- Advising the CRE regarding the collaborations and relationships required with ACCHSs and Aboriginal and Torres Strait Islander communities to facilitate and maximise the success of the CRE;
- Establishing benchmarks for accountability to ACCHSs and community;
- Identifying key areas of strengths and best practice across the Aboriginal and Torres Strait Islander community controlled health sector to form part of the documentation and learning process within the program of work;
- To assist in the development of revised methodology for the conduct of research activities.

Members of the Leadership Group can expect:

- That each member will be provided with accurate and meaningful information in a timely manner;
- To be given reasonable time to make key decisions;
- To be informed of potential issues and risks which may impact the project as they arise;
- To have all CRE related travel costs covered for the duration of meetings;
- For those who are non-salary members, to be reimbursed $400 per day for their participation in Leadership Group meetings.

Members of the Leadership Group will commit to:

- Where possible, attending all scheduled Leadership Group meetings for approximately two full days per meeting, or to nominate a proxy who is a senior member with the authority to make contributions and decisions within the meeting setting if they are unable to attend;
- Make timely decisions so as not to delay the program;
- Notify members of the Leadership Group, as soon as practical, if any matter arises which has the potential to affect the Leadership Group and/or CRE;
- Identify key staff or partners to contribute to specific CRE activities or research;
- Other tasks, as agreed by members of the Leadership Group, which may arise over the course of the program.

5. Meetings

- All meetings will be chaired by either Prof Alex Brown or another CI in his absence;
- A meeting quorum will consist of no fewer than six members of the Leadership Group;

- Decisions are to be made by consensus (i.e. all members are satisfied with the decision even though it may not be their first choice). In those instances where this is not possible, the CIs will make the final decision;
- Due to the potential inability for all Leadership Group members to participate for the full sessions, the Group will endeavour to focus on discussions involving the most pressing matters when most members are present;
- Meetings will be held 2-3 times a year at the South Australian Health and Medical Research Institute (North Terrace, Adelaide).

6. Amendment, Modification or Variation

- These Terms of Reference may be amended, varied or modified in writing after consultation and agreement by Leadership Group members.
- A review of the Leadership Group membership and terms of reference will be conducted at the mid-point of the project, that being March 2016.

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Attachment 2 Characteristics of Indigenous Primary Health Care Models of Service Delivery

Characteristics of Indigenous Primary Health Care Models of Service Delivery as at 7th and 8th April

Access

- providing an **affordable** health care [30, 31] at either low cost or no cost.[32]
- ensuring a broad range of **available** services,[33] in a variety of locations and settings,[19, 31, 34-47] including increased opening hours, walk in appointments [40, 46, 48-51] and transport.[36, 46, 48]
- delivering **acceptable** care which focused on building trust with communities [31] ensuring patients feel supported [52] providing assurances in relation to privacy and confidentiality,[43, 52] and implementing a shared philosophy underpinned by cultural respect, social justice and equality.[46]
- ensuring **awareness** in the sense that communities know the service exists by providing outreach and mobile services,[34] participating in community events and holding screening days,[52] encouraging patients to share their positive experiences and promote the service to others.[41]

Approach to Care

- **tailoring approaches** to identify [33, 36, 53-55] and then meet the needs of the local community,[31, 33, 38, 40, 46, 51, 52, 56-62] delivering a range of services,[38] that are more relevant, appropriate and effective.[34, 53]
- providing a **holistic service**,[34, 35, 43, 63] which supports the health and wellbeing of not only the individual but also their family and community,[19, 32, 33, 37, 54, 58, 61, 64] including mental, emotion and spiritual needs alongside physical wellbeing,[42, 43, 48, 65] often with traditional healing and western medicine practices intertwined,[31, 32, 34, 36, 37, 43, 45, 66-70], and in some cases, incorporating programs which addressed the social determinants of health including housing, education and employment.[19, 34, 37, 38, 40, 43, 65, 71]
- **integrating health care** services,[39, 42, 43, 52, 58] with a multidisciplinary team approach,[19, 49, 50, 58, 72, 73] case management[36, 43, 74, 75] and continuity of care.[42, 45-47, 50, 56, 71]
- **partnering and linking with other services** to promote integration and cooperation between all support services, providing holistic care through a social view of health. [40, 43, 46, 64, 81]

Community Participation

- ensuring **Indigenous ownership** of health services enables Indigenous peoples to own and manage their health service,[32] and ensures the service is accountable to the community.[61]
- establishing **Indigenous governance** [30, 34, 44, 48, 57, 59, 63, 76, 77] including board members from local community, was seen as community involvement and capacity

building for the community. [33, 40, 71]

- facilitating **community consultation, engagement and collaboration** in order to establish strong relationship with the community[42, 63] and facilitate sharing of information, [62, 68] which ensured that programs were appropriate, accessible, engaging and empowering, and were designed in line with the local context and needs.[31, 34, 43, 46, 60, 61]
- respecting the **role and status of elders**[53] and facilitating their involvement in the work and governance of services.[54, 66, 78]

Culture

- the **culture** of health services is underpinned by the **culture and values** of their community,[34, 37, 44, 58, 61] such as a strong focus on individuals, families and communities.[75]
- ensuring **cultural safety** and providing **culturally appropriate care** was achieved by: employing Indigenous staff,[40, 67, 75] respecting women's and men's business by having both female and male staff,[31, 36, 40, 52, 78] having staff that spoke the local language,[31, 36, 40, 52, 68, 70] non-Indigenous staff were learnt and understood about culturally appropriate care[42, 78] and receive cultural awareness training;[60] family were involved in aspects of care;[68] the physical, emotional, mental, and spiritual wellbeing of individuals and the community was maintained;[32, 33, 52, 67] local customs and beliefs were incorporated,[32, 34, 43, 52, 67, 68, 70, 71, 79] the local community were appropriately engaged;[32, 77] the service is community control;[32, 51, 67] and culturally appropriate health material was provide.[33, 35, 36, 66]
- the importance of **Language** for ensuring clients were able to receive care,[31, 43] was maintained by recruiting staff from the community,[30, 31, 40, 70] who spoke the language,[31, 36, 68, 70] and were able to act as an interpreter between clients and non-Indigenous health staff.[45]

Funding and Resources

- **funding and resourcing** services to ensure the sustainability of services that address the range of health issues in an integrated and comprehensive manner.[34, 39, 61, 63, 64, 75, 77, 80]
- **funding additional service activities outside of the traditional models of care**, such as outreach and offsite activities, traditional healing, transport and accommodation, and community events and advocacy.[34, 43, 48, 77]

Quality

- establishing an **accreditation** system to develop a skilled workforce of Indigenous health workers, and other non-health related areas.[33, 43]
- collecting and utilising **data** for a number of purposes including program evaluation[38] and quality improvement,[82] performance reporting purposes,[83] identifying clients

who require a specific service or follow-up visit and client tracking,[73] service planning and implementation,[34, 57, 84] and service impact.[84]

- **evaluating services** to measure health benefits for the community,[61] assess economic outcomes, baseline demographics in relation to increased service utilisation, health assessments and chronic disease care plans.[84]
- undertaking **research** to strengthen health systems with an emphasis on translating research findings into practice.[82]
- establishing **quality improvement** processes with a focus on chronic conditions, monitoring with preventive care as well as management and follow-up care,[73] and used as a the tools/framework to monitor progress and measure the impact of programs on health outcomes.[83]

Self-determination and Empowerment

- facilitating **self-determination and empowerment** of Indigenous communities in order to establish their own Indigenous Health Services,[44, 63] that meet the needs of the community, and are free from discrimination and racism;[53] and enabling clients to take control of their own health, at an individual and family level[58] as well as providing employment and training to promote the development of the local Indigenous health workforce.[77]

- **engaging and empowering Indigenous people** through programs, [31, 46, 77, 85] which build resilience,[71] enable clients to feel empowered,[62, 70] and help educate others.[62]
- providing **leadership opportunities** to ensure that staff form the community became leaders within their community[63] and positive role model and mentor for Indigenous people.[59, 63]
- promoting **community development** through the organisation of activities beyond health care,[19, 53] such as cultural days and camps, reconciliation events and other community activities enable communities to draw on culture, increase social connectedness, and have pride in their identity.[40]

Types of Services

- offering **a diverse range of services** to clients,[65] such as prevention and health promotion through to chronic disease care,[38, 40, 41, 65, 71, 73] maternal and child health,[19, 34, 40, 47, 65, 85] oral health,[33, 34, 57, 65, 71, 84, 86] ear health,[47, 57, 71] sexual health,[71] mental and social health,[39, 40, 47, 65, 85] alcohol and other drugs,[33, 34, 71] pharmaceutical services,[39, 43, 47, 58, 87] aged care,[38, 40, 53] and disability services.[34, 40]
- including **prevention and health promotion** initiatives developed and tailored to the needs of the local community, including general screening programs,[34, 36, 38, 52, 66, 70] healthy lifestyles programs[47] needle exchange programs,[34, 38, 47, 75] women's and men's health programs,[38] healthy eating, increase exercise and smoking cessation programs,[19, 41, 47, 51, 63, 70] oral health,[86] and supporting people to manage their

own health.[41]

- improving **health literacy** particularly in relation to early warning signs of suicide,[59] increasing HIV/AIDs awareness,[63] providing information about the harm that comes from alcohol, tobacco and other drugs,[37] understanding food labelling,[62] maintaining health and ensuring that people could detect early warning signs and understanding when to seek health care advice.[41, 62]
- preventing **illness and** promoting **health beyond the confines of services**, by working in collaboration with other organisations such as schools, youth groups, prisons, disability and aged care services,[38, 45, 63] and with councils, liquor outlets and grocers to reduce the supply of harmful products while increasing the availability of healthy options.[30, 38, 46, 53]
- providing **traditional healing** as one option within the health service.[34, 36, 42, 43, 51, 53, 57, 59, 66, 67, 70, 85]
- **advocating for clients and services**,[38, 51] and clients moving between other primary, secondary, tertiary, and other essential non-health services,[42, 48]
- advocating for the **social determinants of health** by supporting clients in accessing housing, employment, education, social security payments, and supporting people through the justice system.[33, 37, 47, 64, 71, 85] These programs were frequently developed specifically for or alternatively customised to meet the needs of the community they served.[42, 46, 63, 68]
- being involved in or providing advice in relation to **non-health related activities**, which are not within the normal scope of mainstream primary health care including sanitation system construction and maintenance, disease surveillance, environmental health, food distribution, and transportation.[85]

Welcoming Space

- creating **a welcoming space** which helps Indigenous peoples feel comfortable [40] by providing a cultural sensitivity and a family-friendly environment,[32, 36, 56] through, for example, the use of Indigenous artwork and Indigenous signage,[80] and employing Indigenous staff.[40, 53, 63]
- establishing **a community space**, where Indigenous peoples have strong social connections, and feel like 'a home away from home'.[44]

Workforce

- **employing arrange of staff** both health professionals and non-health personnel, including Indigenous and non-Indigenous people, and provide employment and training opportunities for Indigenous people.[19, 33, 40, 44, 53]
- establishing an **Indigenous workforce** comprising of Indigenous Health Workers, mental health workers, social workers, nurses, doctors, administration staff, managers and

traditional healers, all who provide arrange of services to meet the needs of the community.

- recognising that **Indigenous staff often had responsibilities and obligations** in relation to family and community, which were often conducted within the health service,[61] such as interpreting and acting as mediators.[39]
- **Indigenous Health workers** were central to the delivery of services, providing a diverse range of care,{Auclair, 2012 #54;Dawson, 2003 #34;DiGiacomo, 2010 #43;Freeman, 2014 #82;Gabrysch, 2009 #37;Murphy, 2012 #29;Poroch, 2007 #74;Tyree, 2007 #39} and within some service models, conduct the majority of the clinical work with clients.[52, 88]
- providing **training and development opportunities for staff**,[30, 46] in particularly Indigenous Health Workers,[19, 30, 33, 44, 59, 63] as capacity building,[68] and also a mechanism to empower and build the capacity of the community.[31, 40, 63, 77]
- developing and implementing **training programs**,[40, 57] such as cultural awareness training for non-Indigenous staff,[45, 52, 60] comprehensive training for staff working in remote areas or in isolation,[30] providing them will the skills and knowledge to deal with an array of simple and more complex needs.
- training **Indigenous Health Workers** to provide more specialised health care such as dental[75, 81] or maternal health[46], enhancing the capacity of workforce and often leading to staff to going on to further training or study.[63]
- recognising **the need to build and grow the Indigenous workforce of the future** by establishing long term strategies to mentor and recruit Indigenous students into health careers.[43]

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Attachment 3 Communication Strategy and Plan

CREATE Communications Strategy

Purpose

To communicate the progress, findings and activities from CREATE research to: influence Aboriginal and Torres Strait Islander health policy and service delivery; and, capacity strengthening Aboriginal and Torres Strait Islander health service providers and researchers to conduct and use evidence.

Our audiences

We have established who our partners and stakeholders are (our various audiences) in Table 1 below. Our different audiences have different relationships with CREATE and therefore provide and require differing levels of support and priority in assisting us with communicating our key messages. Each audience will have different communications requirements.

Secondary (consult)	**Primary (key players & partnerships)**
Aboriginal and Torres Strait Islander Communities, Elders	*Internal*
	NACCHO
	JBI Adelaide Uni
Affiliates	Leadership Group
	ACCHO's involved in projects
	Ethics Committees
	CREATE staff
	Project Advisory groups/ other experts
	CI's
	External
	Are there any external key players here?

	Other (monitor)	Secondary (keep informed)
Influence Upwards arrow along this axis	SAHMRI General community Potential Fellows/ Scholars	*Internal* Wardliparingga staff generally AI's *External* ACCHO sector, Other Universities Funders Governments Health Professionals

Importance
Arrow pointing towards the right

Our key messages

Our key messages are the messages about the CREATE project that we want our audiences to hear about and understand. As our audiences differ, so too do their communications needs and they will value different key messages.

Communication method

The communication methods, or channels we use for our various audiences are dependent on the activity, information or event that will be occurring.

These include

- Traditional media (Croakey, the Australian, Sydney Morning Herald)
- Indigenous media (Koori Mail, National Indigenous Times, NACCHO news, National Indigenous Radio etc.)
- NACCHO links, website, other
- Social media (Twitter and Facebook)
- Website
- Newsletter
- Peer reviewed journals
- Policy summaries (are these the Evidence Briefs? The summaries of publications?)
- Leadership Group meetings

- Face to face meetings with key stakeholders

Activities and materials
The communications activities and materials will be based on the communications needs of our audiences and the messages we are delivering. Refer to the Audience segmentation worksheet appendices.

Enhance and establish partnerships
Establish who else can help and support us with what we are doing and with the dissemination of our key messages.

Develop and implement communication plan
Develop the annual Communication plan flowing from the annual work plan and annual program plan. Develop action plans for any key events and activities. Include who, what we will do and what we will measure, when and how much.

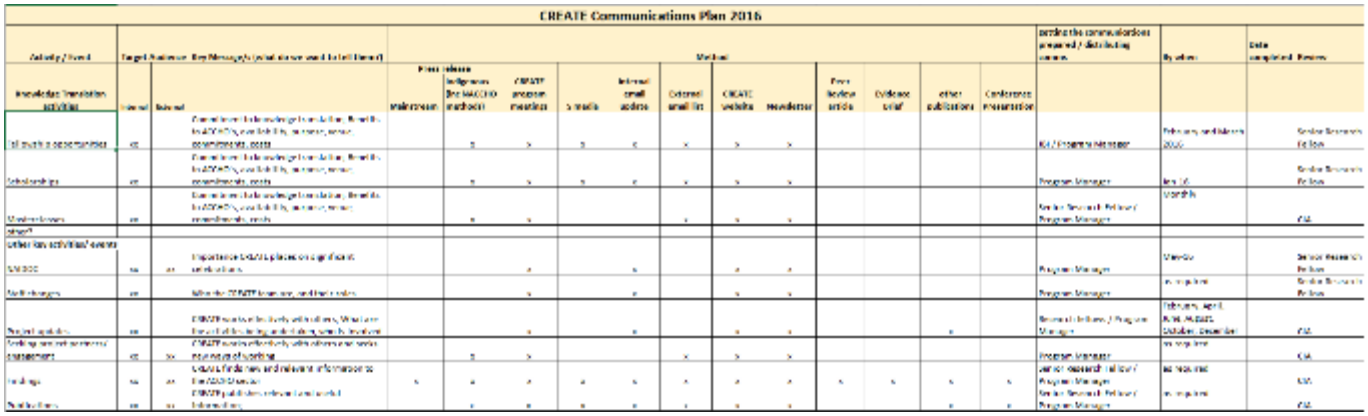
Evaluate/ Review
Monitor and evaluate the action plan and make improvements and corrections as required. Gather feedback from audiences in relevant and useable ways.

Performance Indicators could include:

- Increase twitter followers and reach (Twitter analytics)
- Increase Facebook followers and reach (Facebook analytics)
- Increase traffic to the website (google analytics)
- Number of Peer reviewed journal articles per year
- Number of press releases published in traditional media
- Increase the number of people who read the news letters
- Increase in the number of people requesting to be on mailing list from website

CREATE contact details:
Website
Landline phone number
Social Media
Email address KG

CREATE Communication Plan for 2016



CREATE Communication Plan for Meetings for 2016

	Fellowship opportunities	Scholarships	Master classes	NAIDOC	Staff changes	Project updates	Seeking project partners/ engagement	Findings
Leadership Group meeting								
CI meeting								
AI meeting Wardliparingga staff meeting Collective								
NACCHO meetings								
ACCHO meetings (identify which one)								
Elders annual Wardliparingga meeting								

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Attachment 4 Evaluation Master Class flyer

Refer below for content of the Master Class flyer

Master Classes For 2016

Wardliparingga Aboriginal Research Unit at the South Australian Health and Medical Research Institute has been funded by the Australian Primary Health Care Research Institute to develop Master Classes. The aim of these Master Classes is to strengthen the capacity of policy makers, managers and practitioners working within the Aboriginal Community Controlled Health sector, in order to improve healthcare for Aboriginal and Torres Strait Islander peoples.

The following three Master Classes are available to Aboriginal Community Controlled Health sector organisations from March 2016. The informal two day face-to-face format encourages participants to ask questions specific to their particular needs as well as develop practical skills which can be used within their organisation. All Master Classes are supported by study guides and links to further electronic resources.

1. Evaluation Master Class **New in 2016**

The **Evaluations Master Class** focuses on using evaluation as a tool for assessing and then improving healthcare services and programs. Participants in the Evaluation Master Class will gain a basic understanding of:

- benefits that arise from and pitfalls to avoid while evaluating healthcare services and programs;
- what to consider when selecting an evaluation design;
- how to develop an evaluation plan; and
- how to undertake an evaluation and ensure that the findings are used.

2. Understanding Research Master Class

The **Understanding Research Master Class** is not only designed to increase the awareness of how research can assist to improve health care for Aboriginal and Torres Strait Islander peoples but also about how to work with researchers in order to ensure that the needs of healthcare services are met. In particular, participants will gain a basic understanding of:

- research concepts and terminology;
- how research can help improve health services;
- how to find and assess existing evidence;
- what to consider when commissioning a new study; and
- how to ensure that research findings make a practical difference for Aboriginal and Torres Strait Islander peoples.

3. Undertaking Research Master Class

The **Undertaking Research Master Class** is also designed to increase the awareness of individuals about the use of research to improve healthcare for Aboriginal and Torres Strait Islander peoples. In particular, this Master Class is also focused on providing participants with a basic understanding of how they can develop their own research project in order to improve the quality of healthcare and patient safety for Aboriginal and Torres Islander peoples, and in doing so to gain a basic understanding of how to:

- develop a research question;
- develop a research proposal;
- develop an ethics application;
- conduct research ethically; and

- translate findings into practice.

Common features of the Master Classes include:

- These Master Classes are presented by senior researchers.
- Participants will receive a comprehensive Study Guide with links to further resources.
- Ongoing mentoring support will be available for those who wish.

Please email Dr Carol Davy for more information: Carol.Davy@sahmri.com

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