**Refugees and Primary Health
(RaPH) Project**

**Evaluation Report (Final)
25.5.11**

**Prepared by
Mater/UQ Centre for Primary Health Care Innovation**

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Executive Summary

Project Background

The Refugee and Primary Health (RaPH) project was developed in response to research indicating refugee populations were at greater risk of experiencing poor health and chronic diseases than Australian born residents. Language, cultural differences and psychological difficulties as a result of trauma or torture and social disadvantage were also identified as potential barriers to accessing primary health care by refugee populations. With Brisbane's significant and growing number of new refugees in mind the RaPH project was designed in collaboration with a number of key stakeholders including representation from refugee health services, settlement support services, refugee communities, Queensland Health services, primary health care services and research institutions.

The Project

The RaPH project was established with funding of $301,097 from Connecting Health In Communities (CHIC) Chronic Disease Strategy, a state-wide initiative of Queensland Health. The project was auspiced by Mater UQ Centre for Primary Health Care Innovation, Mater Health Services for the duration of the project January 2009 – March 2011.

Project Aim

Develop and implement a sustainable primary care model which will support the clinical management of chronic disease, including health promotion and prevention in refugee populations.

Project Objectives

Five project objectives focussed on the following areas:
1. Clinical
2. Information sharing
3. Education and professional development
4. Community engagement/partnership approach
5. Context evaluation

Evaluation Process

The evaluation utilised qualitative and quantitative methods to gather and analyse evaluation data. Methods included survey, document review and audit. Sources included but were not limited to: periodical funding reports, meeting minutes, satisfaction survey reports, communication logs, presentations, training resources and research documents.

Summary of Outcomes

Process Objective 1 Clinical Care & Information Sharing
1. The broad consultation process used to perform a local mapping activity provided valuable information relating to current service gaps.
2. The project facilitated and contributed to many forums whereby strategies were identified to improve access for refugees to health services.
3. The project facilitated the collaboration of project partner's in relation to the development of clinical guidelines and referral protocols.
4. Input to and facilitated circulation of the 'Desk Top Guide' to local general practices provided access to quality information to assist clinicians in their decision making.
5. The projects assistance in developing the Materonline refugee health website which contains information about Refugee Health Queensland's (RHQ's) and the Mater Refugee Maternity Service also assisted clinicians and other health providers to have access to relevant information relating to refugee health and services.
6. Contribution to newsletters enabled information to be circulated through existing health provider networks.
7. Successful application for funding to the Sidney Myer Foundation with matched funding from the Mater Foundation enabled RHeaNA (Refugee Health Network Australia) to develop a strategy to strengthen its capacity to facilitate national information sharing with respect to

refugee health issues at both a clinical and advocacy level.

Process Objective 2 Education& Professional Development
1. The RaPH project devised training materials and hosted two information events for general practice and allied health staff.
2. The September 2009 information event gained high levels of satisfaction from participants relating to increased knowledge, meeting of learning needs and relevance to practice.
3. The April 2010 information event gained moderate levels of satisfaction relating to increased information and high levels of satisfaction relating to meeting of learning needs and relevance to practice.
4. A DVD and booklet was developed from the recording of the April 2010 information event and is available from Materonline as well as hard copies through RHQ.
5. The inclusive approach of the RaPH project in relation to involving a wide range of individuals and organisations in the planning, facilitation and participation of its educational events and forums increased inter-professional linkages.
6. Through three research activities the project facilitated opportunities for stakeholders to collaborate.
7. The project utilised many opportunities to inform general practice and allied health services about the role of RHQ.

Process Objective 3 Community Engagement / Partnership Approach Objectives
1. Key stakeholders were invited and encouraged to be involved in a number of critical project activities these included membership in the management group and three working parties.
2. Through surveying the members of the projects management group the project was able gain important insight that facilitated a shared understanding of the significance of partnership to the RaPH project and refugee health service delivery. Results from the survey also highlighted partner's willingness to commit time and energy for the future benefit of refugee population's health.
3. The project engaged successfully with many existing initiatives and projects to increase understanding and improve service delivery to refugee populations.

Process Objective 4 Context Evaluation
1. The project successfully hosted a broadly attended interactive forum which examined the need to extend existing frameworks for working with refugee populations.
2. The project has built on existing knowledge to develop an enhanced model of health care for refugee populations. This has been communicated through presentation and will be further explored in the future publication of a discussion paper.

Process Objective 5 Develop Evidence Base
1. The project developed linkages with three tertiary institutions which enabled the completion of three research studies and contribution to a forth.
2. The research studies have provided new insight into the prevalence of chronic disease in refugee populations in addition to the experiences of providers of health care to refugee populations and the experiences of refugee populations in accessing health care.
3. Broad circulation of the research findings has occurred through oral presentation, poster presentation and publication.

Conclusion
Based on the data available the findings indicate that the RaPH project has successfully delivered on all of its objectives and has been able to go beyond the original expectations in a number of significant areas. It has developed a model of primary care as described in the project's original statement of intent. With regard to implementation of the model, the project has acknowledged that current policy gaps contribute to fragmentation in the refugee health sector thus making it difficult for services to undertake coordinated and sustainable work. For the implementation of the expanded chronic care

model within a primary care context more work needs to be undertaken with key service providers and supported by a refugee health and wellbeing policy framework. The legacy of the project will be the contribution to the evidence base through the research outcomes and the ensuing dialogue from the discussion paper.

The experienced Project Managers have been instrumental in engaging with a wide variety of passionate and knowledgeable individuals and organisations who strive to make a positive difference in the health care experience of refugee populations. By focusing much attention on the importance of partnership agencies and organisations have become used to working together to create benefits for all. The project has also been mindful to ensure it does not create a vacuum when it ends and has instigated various activities to ensure that momentum is sustained.

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Project Background

Service Need
Project Background
The Refugee and Primary Health (RaPH) project was developed in response to research indicating refugee populations were at greater risk of experiencing poor health and chronic diseases than Australian born residents. Language, cultural differences and psychological difficulties as a result of trauma or torture and social disadvantage were also identified as potential barriers to accessing primary health care by refugee populations. With Brisbane's significant and growing number of new refugees in mind the RaPH project was designed in collaboration with a number of key stakeholders including representation from refugee health services, settlement support services, refugee communities, Queensland Health services, primary health care services and research institutions.

The Project
The RaPH project was established with funding of $301,097 from Connecting Health In Communities (CHIC) a state-wide initiative of Queensland Health. The project was auspiced by Mater University of Queensland Centre for Primary Health Care Innovation (MUQCPHCI) Mater Health Services for the duration of the project January 2009 – March 2011.

Project Aim
Develop and implement a sustainable primary care model which will support the clinical management of chronic disease, including health promotion and prevention in refugee populations.

Project Objectives
The project objectives from the original project submission were as follows:

1. Clinical Objectives
1.1 To develop and implement clinical tools and guidelines in relation to: care pathways, refugee complexity assessment tools and complement existing guidelines such health prevention and promotion by building in culturally specific and refugee related perspectives and linking with work already undertaken in other states
1.1 To provide access for general practice staff and allied health to evidenced based knowledge, skills and cultural competencies required to undertake refuge health work in a community primary health care setting eg specific advice on immunisation, infectious diseases and conditions particular to some refugee communities like sickle cell anaemia which may contribute to chronic health conditions

2. Information Sharing Objectives
2.1 In collaboration with key stakeholders develop referral protocols /guidelines to facilitate transfer of quality information necessary for decision making by clinicians
2.2 In collaboration with key stakeholders develop referral templates
2.3 To facilitate access to appropriate and culturally relevant information, options and processes – development of a website

3. Education and professional development Objective
3.1 Education regarding protocols and tools is made available to general practice staff and allied health
3.2 Practice staff and allied health education regarding protocols and tools improves clinical knowledge and skills
3.3 Refugee Health Advisory Committee (RHAC) / Queensland Integrated Refugee Community Health Clinic (QIRCH) / Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT) specialist education with a focus on building links with tertiary institutions for research and training development
3.4 To promote an ethos of RHAC/QIRCH supporting primary care within and external to general practices

4. Community engagement/partnership approach objectives
4.1 NGOs, allied health and practice staff are satisfied with the partnership approach
       Partnership approach will include linkage with existing initiatives

5. Context Evaluation
5.1 A sustainable transferable model of care is described

Project Management
Two project managers were recruited in a job share position for the length of the project. The project managers had worked together in the past and had extensive experience working with refugee communities and the service sector that served this community in Brisbane.

Evaluation Methodology

An evaluation plan was initially scoped in March / April 2009 by Mater / UQ Centre for Primary Health Care Innovation (Appendix 1) in consultation with RaPH Project Management Group. The evaluation plan was successfully submitted for sign off by the Research and Evaluation working Group on the 25/6/2009.

Process Objectives
The RaPH project was designed with 5 project objectives. Through the development of the evaluation plan these were translated into evaluation process objectives.

Process Objective 1 Clinical Care & Information Sharing

1.1: In collaboration with key stakeholders develop and implement clinical tools and guidelines in relation to providing quality care to refugee populations *(Project Objective 1.1)*

1.2: In collaboration with key stakeholders facilitate access for general practice staff and allied health to specialist services and evidence based knowledge, skills and cultural competencies required to undertake refugee health work in a community primary health care setting. *(Project Objective1.2)*

1.3: In collaboration with key stakeholders develop referral protocols to facilitate access and transfer of quality information necessary for decision making by clinicians. *(Project Objective 2.1)*

1.4: In collaboration with key stakeholders develop of referral templates for RHQ *(Project Objective 2.2)*

1.5: Support and develop appropriate mechanisms to facilitate access to culturally relevant information, referral options and processes eg RHQ website, project newsletter *(Project Objective 2.3)*

Process Objective 2 Education & Professional Development

2.1: Make education regarding protocols and tools available to general practice staff and allied health *(Project Objective 3.1)*

2.2: Improve knowledge and skills of general practice staff and allied health through education regarding protocols and tools *(Project Objective 3.2)*

2.3: Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and training development *(links with Project Objective/Outcome 3.3)*

2.4: Promote RHQ as supporting primary care within and external to general practices (Project Objective 3.4)

Process Objective 3 Community Engagement / Partnership Approach Objectives

3.1: Key stakeholders are engaged effectively in partnership (Project objective 4.1)

3.2: Link with existing initiatives to maximise project outcomes (project objective 4.2)

Process Objective 4 Context Evaluation

4.1 Describe a sustainable transferable model of care (Project Objective 5.1)

Process Objective 5 Develop Evidence Base

5.1: Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and development

5.2: Collect base line prevalence data which will contribute to evidence based best practice and inform policy

Each process objective has one or more evaluation 'indicators' which are the measure of output against each objective.

Evaluation methods:

A number of data collection methods have been utilised to evaluate the RaPH project. These included quantitative and qualitative methodology.

a. Surveys
Purpose: To collect information from a sample of individuals in a systematic way. With respect to this project both open and closed questioning techniques were utilised.
Examples:
- Partnership evaluation surveys
- Education event evaluation surveys
- Forum evaluation surveys

b. Document review
Purpose: Designed to assess the relevance and/or responsiveness of documents in relation to the project objectives.
Examples:
- Clinical tools
- Web site
- Formal communications
- Training materials
- Research protocols
- Ethics submissions
- Research papers
- Meeting agendas and minutes

c. Audit
Purpose: To ascertain the validity and reliability of information relating to the project objectives.
Examples:
- Number of visits / meetings
- Number of participants involved in training
- Number of presentations

Findings

1A: Clinical Care

Process objective 1.1:
In collaboration with key stakeholders develop and implement clinical tools and guidelines in relation to providing quality care to refugee populations *(Project Objective 1.1)*

Indicator 1.1.1
Clinical tools/guidelines developed

"Refugee Care Pathway"
The RaPH Clinical Access and Training Working Group of the RaPH project used the Victorian resource "Refugee Care Pathway" to map the patient journey locally.

Gap Identification
Current gaps in clinical tools and guidelines for primary health care of refugee populations were established by broad consultation with stakeholder groups (see 1.2 below). A number of key issues were identified from this consultation process.

QPASTT & RHQ
Collaboration between QPASTT and RHQ that was facilitated by the RaPH project enabled the commencement of clinical guidelines for identifying refugees who have torture and trauma issues.

Indicator 1.1.2
General Practice and Allied Health practitioners are aware of available guidelines

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Desk top guide:
The project managers worked with the Forum of Australian Services for Survivors of Torture and Trauma in the revision and reprinting of the desk top guide 'Caring for Refugee Patients in General Practice (3rd edition) Queensland. The project managers worked with QPASTT, RHQ and Divisions of General Practice to circulate 500 copies of the desk top guide to general practices, priority was given to practices with high numbers of refugee patients. The project managers also promoted online access to the desk top guide to Divisions of General Practice who had been involved in the project. These Divisions were able to provide a link on their websites to the resource.

The desk top guide will be updated and reprinted this year by the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) with QPASTT responsible in managing the production and circulation.

Online resources:
A website (see 1.2.3 below) was developed as part of the project with assistance from Mater Marketing and is accessible through Materonline by the general public and service providers including general practice and allied health practitioners. This provides access to recourses relating to refugee health including the Desk Top Guide.

Information sessions:
Information sessions for general practice and allied health providers organised by the project managers (see process Objective 2 below) promoted discussion, exploration and education in relation to resources available for working with refugee populations.

Process objective 1.2:
In collaboration with key stakeholders facilitate access for general practice staff and allied health to specialist services and evidence based knowledge, skills and cultural competencies required to undertake refugee health work in a community primary health care setting.   (*Project Objective1.2*)

Indicator 1.2.1:
Map current processes and identify gaps

Broad Consultation
Current gaps in clinical tools and guidelines for primary health care of refugee populations were established by broad consultation with stakeholder groups including representatives form two general practices, three Divisions of General Practice (SEA-GP, Brisbane South and GP Partners), Refugee Health Queensland (RHQ), Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT), Community Health Primary Health Services and the Brisbane Refugee Health Network (also see 1.1 above).

Indicator 1.2.2:
Identification of strategies to improve access

GPQ
Through discussions with General Practice Queensland (GPQ) it was agreed that GPQ would facilitate the dissemination of resources relating to refugee health management to general practice state wide and in turn they would ensure the RaPH project were informed of developments across Queensland relating to refugee health and chronic disease strategy.

CHAG & Multicultural Health Network
The project participated in two networks which focused on identifying barriers to information exchange on refugee health matters and developing ideas for new processes to facilitate better access. The forums were the Community Health Action Group (CHAG) and the Multicultural Health Network.

RHeaNa
Through successful application for funding to the Sidney Myer Foundation and matched funding from the Mater Foundation (funds raised by QIRCH conference 2008) the project was able to facilitate the appointment of a project officer for the Refugee Health Network Australia (RHeaNA) to establish RHeaNA's capacity to facilitate sharing of clinical skills, cultural information and referral protocols. Through RHeaNA the project also provided input to the Primary Care Strategy, national policy discussions and development of collaborative research opportunities.

Indicator 1.2.3:
Access to information is made available (eg website, newsletter)

Web Site:
A web site providing information on refugee health and relevant resources was developed in collaboration with Mater Marketing, RHQ and Mater Refugee Maternity Service. The website was launched in September 2009 at the first information evening facilitated by the project. The website can be accessed through Materonline at: http://.materonline.org.au/Home/Services/Refugee-health . The website has links to the Victorian Health Network, SEA-GP and other divisions of general practice. Mater Marketing provides ongoing web support. The project managers have promoted the website through stakeholder networks and education events.

Newsletters:
Information about the RaPH project, RHQ and refugee health was distributed by the project through existing communication networks.
- Generally Speaking (Mater Health Services) May 2009 & September 2009

- SEA-GP and Brisbane South Division of General practice Faxflyer

1B: Clinical Information Sharing

Process objective 1.3: In collaboration with key stakeholders develop referral protocols to facilitate access and transfer of quality information necessary for decision making by clinicians. (*Project Objective 2.1*)

Indicator 1.3.1: Protocols developed

In addition to 1.1.1 the project contributed to the Brisbane Refugee Health network meetings which developed referral protocols and pathways for refugees.

Process objective 1.4: In collaboration with key stakeholders develop of referral templates for RHQ (*Project Objective 2.2*)

Indicator 1.4.1: Standardised referral templates developed

The project managers facilitated the circulation and discussion of referral protocols from the Victorian Refugee Health Network with key stakeholders. The mapping of the patient journey was also achieved with key stakeholders. These activities contributed to two agencies QPASTT and RHQ working together to develop clinical guidelines for refugees affected by torture and trauma.

Process objective 1.5: Support and develop appropriate mechanisms to facilitate access to culturally relevant information, referral options and processes eg RHQ website, project newsletter *(Project Objective 2.3)*

Indicator 1.5.1: Project newsletter disseminated

It was agreed by the Management Committee that a newsletter would not be produced by the project but that information would by circulated via meeting minutes, input into existing newsletters and the Materonline refugee health website.

Indicator 1.5.2: Newsletter items distributed through existing stakeholder networks

Stakeholder Networks
The project managers have contributed to SEA-GP and GPQ state-wide division newsletters. Additionally Mater Health Services newsletter 'Generally Speaking' was utilised to circulate information to primary health care providers.

Annual Report
The Mater Annual Report released July 2010 featured the RaPH project in an article entitled *'Refugee project links GPs and Services'* and can be viewed on http://2009.mater.org.au/News/2009/Refugee-project-links-GPs-and-Services.

Indicator 1.5.3: Website developed

See section 1.2.3

Table 1: Objective 1 Summary		
	Indicator	**Completed**
1.1 In collaboration with key stakeholders develop and implement clinical tools and guidelines in relation to providing quality care to refugee populations	1.1.1Clinical tools / guidelines developed	√
	1.1.2 General practice and allied health practitioners are aware of the guidelines	√
1.2 In collaboration with key stakeholders facilitate access for general practice staff and allied health to specialist services and evidence based knowledge, skills and cultural competencies required to undertake refugee health work in a community primary health care setting.	1.2.1 Map current processes and identify gaps	√
1.3 In collaboration with key stakeholders develop referral protocols to facilitate access and transfer of quality information necessary for decision making by clinicians.	1.3.1 Protocols developed	√
1.4 In collaboration with key stakeholders develop of referral templates for RHQ	1.4.1 Standardised referral templates developed	√
1.5 Support and develop appropriate mechanisms to facilitate access to culturally relevant information, referral options and processes eg RHQ website, project newsletter	1.5.1 Project newsletter disseminated	X
	1.5.2 Newsletter items distributed through existing stakeholder networks	√
	1.5.3 Website developed	√

2. Education and Professional Development Objectives

Process Objective 2.1:
Make education regarding protocols and tools available to general practice staff and allied health
(Project Objective3.1)

Indicator 2.1.1:
Training materials developed

Training materials were developed for two education sessions in September 2009 and April 2010 hosted by the RaPH project managers.

8th September 2009

The education event on the 8th September 2009 was awarded with 4 Royal Australian College of General Practitioners (RACGP) Category 2 Continuing Professional Development Points for the Quality Assurance and Continuing Education Program for the 2008–2010 triennium.

The event was attended by 43 people including 17 GPs.

The learning objectives were:

1. Increase knowledge about the clinical issues for newly arrived refugees from diverse cultural backgrounds.
2. Increase knowledge about the psycho-somatic issues for newly arrived refugees and how these are manifested in physical presentations.
3. Increase awareness of the cultural and social issues for newly arrived refugees especially new and emerging groups such as the Rohingya Community.
4. Build GP's capacity through increased knowledge of care pathways and clinical tools and resources available.

22nd April 2010

The education event on the 22nd April 2010 was awarded 4 RACGP Category 2 CPD points for the Quality Assurance and Continuing Education Program for the 2008–2010 triennium. Additionally the event was awarded 2 Continuing Nurse Education (CNE) points by the Royal College of Nursing Australia (RCNA).

The event was attended by 9 GP's, 8 Nurses and 16 Health workers from NGO, Government and Private sectors. Of the 33 participants evaluation forms were completed by 45% (n=15).

The learning objectives were:
1. Improve practice systems to best provide ongoing quality health care to refugee patients.
2. Build links and networks with refugee health service providers
3. Maximise access to health care and making the most of current Medicare arrangements.

DVD
Additionally the RaPH project produced a DVD and booklet from the recording of the April 2010 education event which can be used as a resource for doctors and nurses. This resource will be available to download from Materonline in addition to 100 hard copies of the DVD and booklet being made available to general practices and interested organisations.

Process Objective 2.2:
Improve knowledge and skills of general practice staff and allied health through education regarding protocols and tools *(Project Objective 3.2)*

Indicator 2.2.1:
General Practice and Allied Health perceived knowledge, skills and attitude improved

Workshops in September 2009 and April 2010 were evaluated using paper surveys which included questions relating to learning objectives and satisfaction. Evaluation reports for the events can be located in Appendix 2 and 3. The following provides a summary of the findings relating to objective 2.2.

September 2009
The following is a summary of the findings from the workshop held in September 2009.

Table 2

**Evaluation of Learning Objectives
Refugees & Primary Health Care Workshop
8th September 2009**

	Clinical	Psycho-somatic	Cultural & Social	Care Pathways & Tools
Not met	0	1	0	0
Partially met	9	13	7	9
Entirely met	25	20	27	25
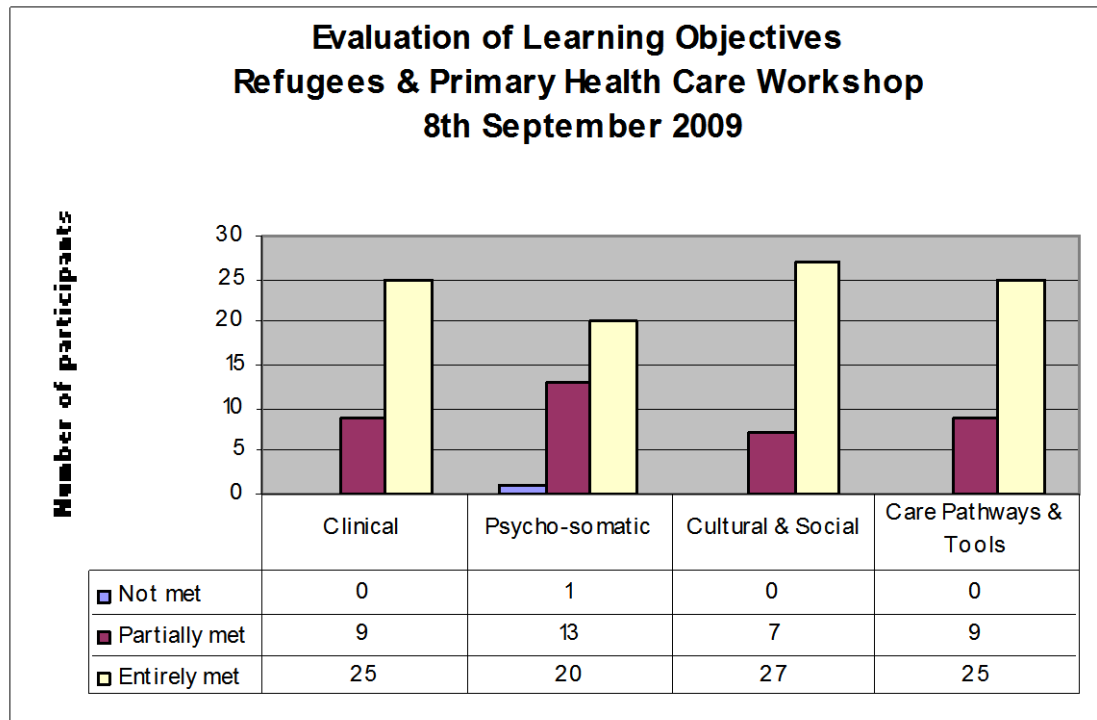
Table 2 above indicates that participants rated the workshop highly in meeting their learning objectives with regard to gaining knowledge and awareness of clinical, psycho-somatic and cultural and social needs of newly arrived refugees in addition to knowledge of care pathways and the availability of clinical tools.

Table 3

**Evaluation of Satisfaction Objectives
Refugees & Primary Health Care Workshop
8th September 2009**

	learning needs met	Relevance to practice
■ Not met	0	0
■ Partially met	11	7
□ Entirely met	23	27
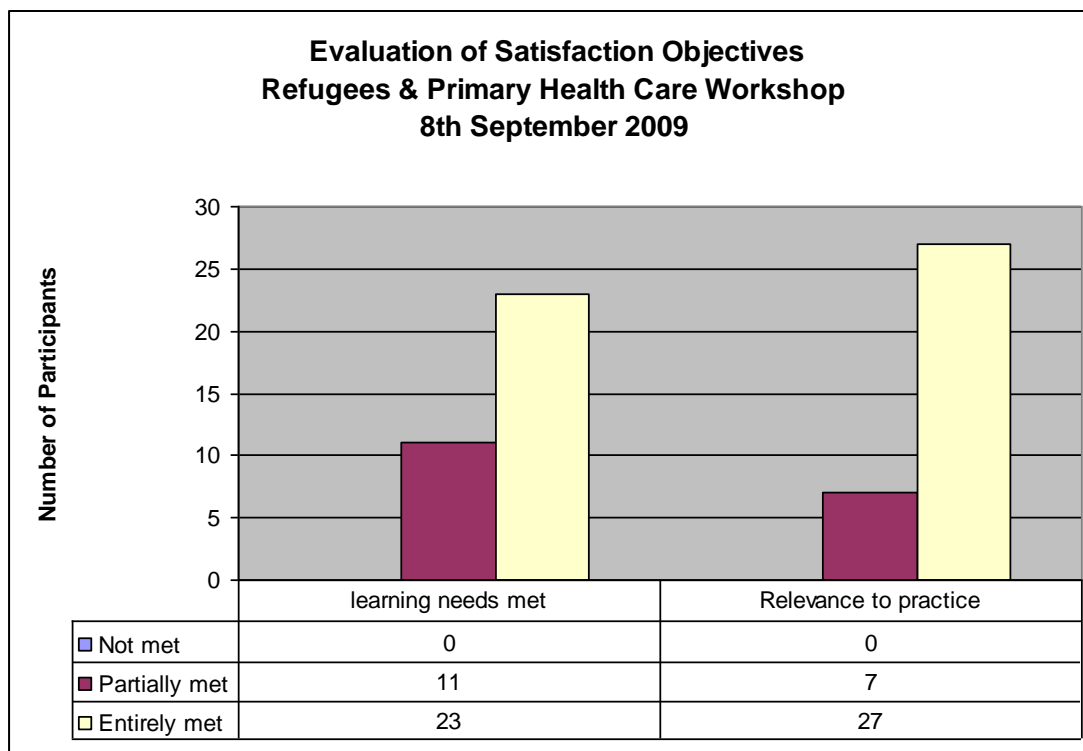
Table 3 above indicates that 68% (n=23) of participants felt that their learning needs had been met entirely in comparison to partially met (32% / n=11). Additionally 79% (n=27) of participants felt that the education activity was relevant to their individual practice, the remainder (21% / n=7) felt that it was partially relevant.

Appendix 2 provides detailed information relating to the additional topics that participants were keen to learn more about in addition to a host of comments of gratitude for organising such a well run event.

April 2010 Workshop
The following is a summary of the findings from the workshop held in April 2010.

Table 4

Evaluation of Learning Objectives
Refugees & Primary Health Workshop
22nd April 2010

	Management of patients	Care pathways and resources	Networks and support	Program changes	PHC Issues
Not met	0	0	0	0	0
Partially met	10	10	7	10	7
Entirely met	5	5	8	5	8
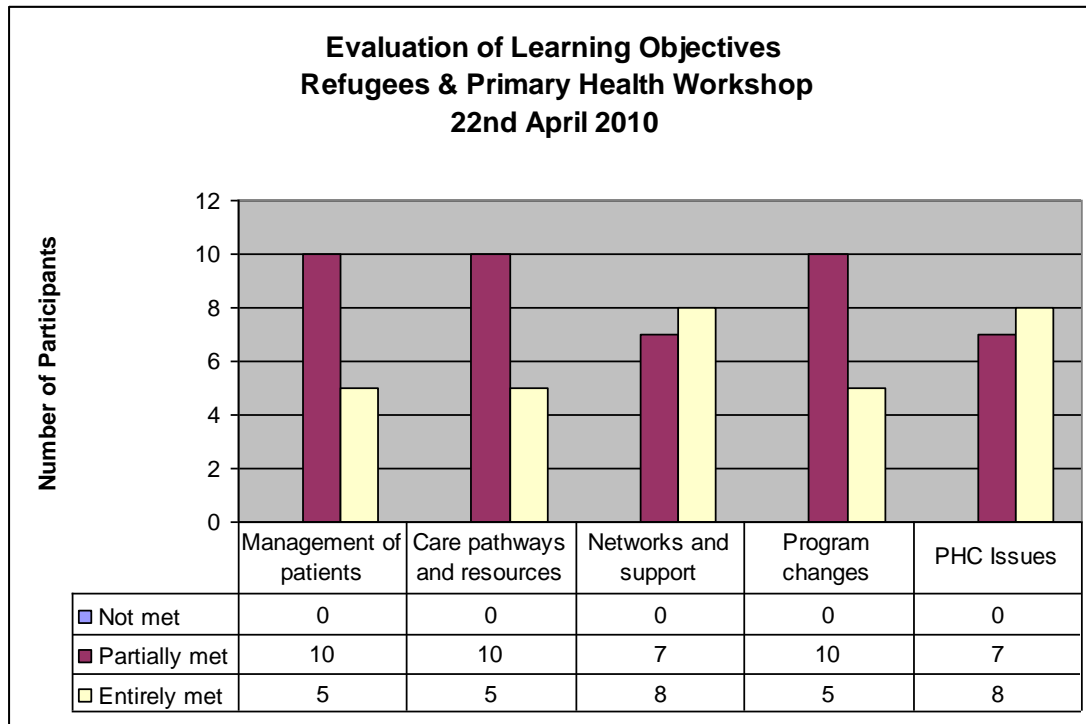
Table 4 above indicates that participants felt that their learning needs were partially met in relation to gaining increased knowledge and awareness of the management of refugee patients, care pathways and resources, and program changes. However in relation to increased awareness of networks, support services and primary health care issues, participants reported their learning needs were more evenly distributed between being partially and entirely met.

Table 5

Evaluation of Satisfaction Objectives
Refugees & Primary Health Workshop
22nd April 2010

	Learning needs met	Relevance to practice
Not met	0	0
Partically met	6	3
Entirely met	8	11

Table 5 above Indicates that slightly more participants felt that their learning needs had been entirely

met (53% n=8) in comparison to partially met (40% / n=6). Additionally 73% (n=11) of participants felt that the education activity was relevant to their individual practice, the remainder (20% / n=3) felt that it was partially relevant.

Additional information and future education topics related to refugee health were highlighted in the evaluation as were levels of interest in participating in other activities most notably 60% (n=9) participants noting an interest in formal training or workshops in refugee health.

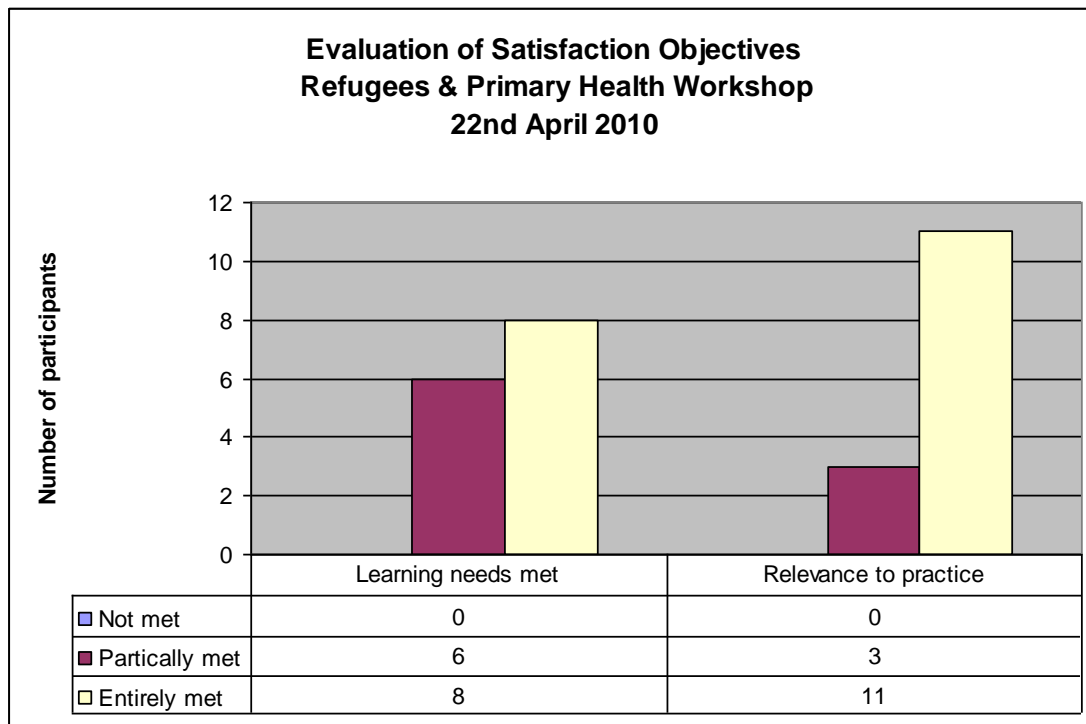December 2011 one of the RaPH Project Managers presented to the general practitioners at RHQ the findings of the research relating to refugee communities perception of the provision of primary health care. The feedback was positive and included comments that they had been 'enlightened' by the findings.

| **Indicator 2.2.2:** |
| Inter professional linkages are enhanced |

Inter professional linkages were enhanced through numerous activities within the RaPH project. Table 6 below indicates the range of organisations involved in 'presenting' (√) and 'planning' (P) with regard to the forum and two workshops.

Table 6 Organisations involved in presenting and planning events

Organisation	Event 1 Sep 09 Workshop	Event 2 Oct 09 Forum	Event 3 April 10 Workshop
Banyo Clinic			√
Community and Primary Health Services – Metro South (Queensland Health),		√ & P	
Discipline of GP (UQ)			√
Divisions of GP			√
ECCQ		√ & P	√
HealthWest Partnership Victoria		√	
Logan Natural Helper Partnership		√ & P	
Mater UQ Centre for Primary Care Innovation.	√ & P	√ & P	√ & P
MDA		√	√
Project Managers	√	√	√
QH Chronic Disease Strategy Unit		√	
QPASTT	√	√	√
Refugee Maternity Service (Mater Health Services)	√		
RHQ	√ & P	√	√ & P
Salisbury Medical Centre			√
TCMHQ			√
Victorian Refugee Health Nurse Program		√	

Additionally SEA-GP and Brisbane South Divisions of General Practice worked together on developing a business case for service provision for refugees which was a result of being involved in the RaPH project.

Process Objective 2.3:
Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and training development *(links with Project Objective/Outcome 3.3)*

Indicator 2.3.1:
Key stakeholders identify opportunities to collaborate

Research arm of the RaPH Project

The partnership established through the establishment of the RaPH project enabled the development of three projects designed to inform refugee health services. They included:

- ➢ Qualitative study - Exploring the experience of health seeking for communities
- ➢ Qualitative study -Exploring the experience of health provision with providers
- ➢ Refugee Health - Prevalence of chronic morbidities in newly arrived refugees: a preliminary study

The partnership provided the investigators with the opportunity to communicate with a range of people with experience and expertise in research, service delivery, and policy involved in the delivery of health care to the refugee communities. The partnership also involved members of the refugee communities and enabled the development of these research projects with members of the refugee communities. Their input from the inception of this project was vital and the partnership enabled their endorsement of the design and intention of the projects.

The RaPH project convened a series of Research and Evaluation meetings that assisted in guidance of the project as it developed. This guidance helped the investigators to negotiate their way through some initial technical difficulties with data collection. The meeting enabled regular feedback to the members of the RaPH group to ensure that the partners were well informed. The partnership also enabled the investigators to establish a way to feedback the information gathered during the project to the refugee communities once the data were gathered.

Without the partnership connecting these diverse groups involved in refugee health care, it would not have been possible to recognise the issues that needed to be addressed in these projects nor would it have been possible for such detailed input into the development and discussion of the outcomes of the projects.

Process Objective 2.4:
Promote RHQ as supporting primary care within and external to general practices (Project Objective 3.4)

Indicator 2.4.1:
General Practice report awareness of the role of RHQ

Representatives from RHQ presented information about their organisation at all three RaPH organised education and information events previously described where members from general practice were present. Additionally through the RaPH project the local divisions of general practice circulated information through their newsletters to general practice staff about RHQ and its work.

The RaPH project also presented at the National Diversity and Health Conference held in Melbourne in June 2010 and provided information about the role of RHQ. The audience included representatives from general practice.

Table 7 Objective 2 summary:		
	Indicator	**Completed**
2.1 Make education regarding protocols and tools available to general practice staff and allied health	Training materials developed	√
2.2 Improve knowledge and skills of general practice staff and allied health through education regarding protocols and tools	2.2.1 General practice and allied health staff perceived knowledge, skills and attitude improved	√
	2.2.2 Inter-professional linkages enhanced	√
2.3 Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and training development	2.3.1 Key stakeholders identify opportunities to collaborate	√
2.4 Promote RHQ as supporting primary care within and external to general practices	2.4.1 General practice report awareness of role of RHQ	√

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3. Community Engagement / Partnership Approach Objectives

Process Objective 3.1:
Key stakeholders are engaged effectively in partnership (Project objective 4.1)
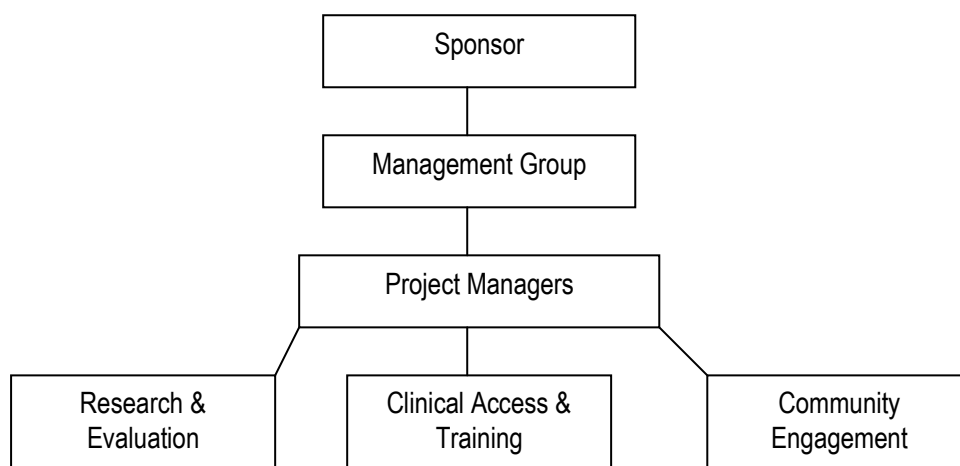
Indicator 3.1.1:
All key stakeholders (NGO's, Allied Health and Practice Staff) are satisfied with the partnership approach

Stakeholder involvement in project development

The structure of the RaPH project working and governance groups can be seen in Figure 1.

Figure 1 RaPH project structure

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                    ┌─────────────┐
                    │   Sponsor   │
                    └─────────────┘
                           │
                  ┌──────────────────┐
                  │ Management Group │
                  └──────────────────┘
                           │
                  ┌──────────────────┐
                  │ Project Managers │
                  └──────────────────┘
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    │  Research & │ │ Clinical    │ │ Community   │
    │  Evaluation │ │ Access &    │ │ Engagement  │
    │             │ │ Training    │ │             │
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The membership, purpose and frequency of meetings is recorded below. It is evident that stakeholders from a broad range of organisations and sectors were involved in the project in various capacities.

Management Group

Purpose:

The Management Group was created to provide advice and support in the following key areas:
- development of a project plan including governance structures and partnerships
- development and implementation of a model which addresses clinical issues, access and community engagement, data and evaluation
- policy development and system advocacy
- research

Table 8: Management group membership	
ACCESS Inc	QACC Inc
Brisbane South Division of General Practice	QH
ECCQ	QPASTT
Southeast Primary Health Care Network	RHQ
GP Partners	Refugee Health Research Centre – La Trobe
Griffith University	Refugee Primary Health Care Centre, Discipline of General Practice, University of Queensland
MUQCPHCI	SEAGP
MDA	TCMHQ
Multilink	

Meeting frequency: Bimonthly

Meetings occurred on the following dates:
2/2/2009, 2/3/2009, 5/5/2009, 14/7/2009, 6/10/2009, 24/11/2009, 16/2/2010, 13/4/2010 with a final meeting scheduled for 7.6.11.

Clinical Access & Training Working Group

Purpose:
The purpose of the Clinical Access and Training working group was to:

- Map out an overview of what service coordination is currently happening in the Brisbane South (i.e. the area MDA covers in their IHSS contract) in the provision of refugee health including: any standards or principles underpinning service coordination and flow chart of the refugee/consumer pathway through service coordination.
- Identify roles and responsibilities and any areas of duplication or gaps
- Develop the resources and tools to support service coordination eg referral pathways, standardised referral templates and protocols, service directories, web based resources, desk top guide
- Develop training and provide support to implement service coordination processes
- Make recommendations for the ongoing sustainability of refugee service coordination protocols for health service providers.

Table 9 Clinical access working group membership	
Brisbane South Division of General Practice	QH (Service Integration Coordinator PAH Mental Health)
ECCQ (Chronic Disease Program Officer)	QH (Multicultural MH Coordinator PAH Mental Health)
GP – Brisbane North	QPASTT
GP Partners	RHQ
MUQCPHCI	Refugee Primary Health Care Centre, Discipline of General Practice, UQ
MDA	QTCMH
QH (Community & Primary Health Services Metro South HSD Inala CHC)	

Meeting frequency
It was not envisaged that this working group would meet often but would be available for input around specific activities such as workshop planning.

28/5/2009 (Group)

Individual meetings occurred:
18/5/2009 Acacia Ridge Medical Centre
16/6/2009 Discipline of General Practice
23/7/2009 Camp Hill; Medical Practice
10/9/2009 Transcultural Interest Group CYMHS
25/3/10 South Brisbane Division of GP, Logan Division of GP, SEA-GP, RHQ
25/3/10 QPASTT

Community Engagement Working Group

Purpose:
- Engage and consult with community groups
- Strategic advice and support for the project
- Collaboration on joint activities for example the Bi-Cultural Researchers

Table 10: Community engagement working group membership	
ECCQ	QPASTT
GPQ	RHQ
GP Partners	SEA-GP
MDA	

Meeting frequency:
It was not envisaged that this working group would meet together but would provide input to the Project Managers as required.

The Project Managers met with key stakeholders regularly, participated in various network meetings, investigated opportunities in Victoria and met with key leaders within the community. The list of meetings below indicates the commitment of the RaPH project to engage extensively with its community.

Meetings with key stakeholders:
RHQ 27/3/209, 22/4/2009, 4/6/2009, 16/6/2009, 30/7/2009, 27/8/2009, 8/10/2009, 2/3/2010, 4,3,2010, 11/3/2010,25/3/2010, 8/4/2010
MDA 24/4/2009, 13/5/2009
QPASTT 1/5/2009, 7/5/2009, 10/6/2009, 15/10/2009
SEA-GP 8/5/2009, 11/6/2009
ECCQ 29/5/2009, 17/6/2009
GPQ 2/6/2009, /3/2010
GP Partners 27/8/2009

Meetings with key community leaders:
QH Metro South Multicultural Health 23/4/2009
Griffith Uni – Multilink 30/4/2009
QPASTT 7/5/2009
QPASTT/ECCQ 14/5/2009
CEO Mater Health Services 14/4/2010
Head of Mission Mater Health Services 6/5/2010

Additional meetings:
Forum planning meeting 3/9/2009 ECCQ & Griffith Uni
Multicultural Health Network 12/11/2009, 28/1/2010
Refugee Health Coordination Group 24/7/2009, 24/9/2009, 26/11/2009
RCOA 26/11/09, 2/3/2010,
QH Chronic Disease unit 18/2/2010
Victorian NGO's 11/5/2009, 11/5/2009

Research and Evaluation Working Group

Purpose:

- Provide strategic advice and direction to the research
- Provide cross sectorial collaboration
- Provide strategic advice and direction to the evaluation activities
- Identification of future research opportunities

Table 11: Research and evaluation working group membership	
ECCQ	MDA
GPQ	QH Multicultural Health Services
Griffith University	RHQ
Latrobe University	Refugee Primary Health Care Centre, Discipline of General Practice, UQ
MUQCPHCI	TCMHQ

Meeting frequency:
24/4/2009, 25/6/2009, 27/8/2009 & 24/11/2009
There were also meetings specifically related to each research project that derived from these working group meetings. Additionally and of significance was a meeting on the 30/10/10 where the research findings were presented back to the refugee communities.

Partnership Evaluation

Two partnership evaluation activities were carried by the project in collaboration with MUQCPHCI. These were the Partnership Survey conducted in November 2009 (Appendix 5) and the Partnership Self-Assessment Tool May 2010 (Appendix 6). The first activity sought to determine stakeholder's thoughts relating to the importance of partnership, its value for the project and the projects partnership approach. The second evaluation activity sought to provide a measure of the 'Synergy' of the partnership. Synergy being the key indicator of how well the partnership's collaborative processes were combining the partners' knowledge, skills, and resources in order to accomplish more together than they could on their own.

November 2009

The aim of this evaluation activity was to engage partners in a discussion on the purpose and goal of the partnership as a vehicle for achieving the stated goals and objectives of the RaPH project. The survey questions were adapted from the Vic Health Partnership Analysis Tool (2003) and were circulated to all members of the RaPH Project Management Group on the 23.9.2009 via email. Participants were asked to return the completed questionnaires via email to either of the RaPH project managers by 29.9.09. In total eight partners completed the questionnaire. (53%)

The importance of partnering
The most frequently proposed reason that partnering was thought to be necessary for the RaPH project was to help improve effective service delivery for refugee communities. This included better coordination and wiser use of resources. The second most notable area was that of relationships, with partnering being seen as a way to build relationships and trust both between service providers but also between providers and refugee communities. Another important point to note is that refugee health was felt to be too broad an issue for one agency and thus a partnership approach would provide the opportunity for a shared response.

Partnering adds value
Notable points raised in response to how partnering is seen to add value to the RaPH project included an increased sense of empowerment and advocacy. This seems tied not only to the strength found in

being part of a group but also the increased knowledge and understanding of issues and the sense of sharing responsibilities and solutions.

Shared purpose

Each of the eight partners had a considerably different response to the question of whether they thought other agencies shared the same partnership purpose. The range of responses suggests that overall respondents felt other project partners did have or there was a desire to have a shared partnership purpose. However for some respondents it was felt that in reality other priorities or internal constraints impacted on the ideal to have a shared partnership purpose.

Partnership approach

All eight respondents felt that the partnership was operating at level iv seeing the partnership as 'an opportunity to exchange information, make a change in the environment, share resources and enhance the capacity of all members of the partnership in a manner that is mutually beneficial'. Although one respondent added the comment 'Hoping for iv'.

The eight respondents provided a very positive picture of the impact the RaPH project. The need for sustained impact after the end of the project was highlighted by respondents and continued to be a key focus for the project.

May 2010

The Partnership Self Assessment Tool devised by the Centre for the Advancement of Collaborative Strategies in Health, New York (http://partnershiptool.net/) was utilised by RaPH project to provide an opportunity for reflection, discussion and future planning in order to maximise the potential for partnership synergy.

Between February and May 2010 the Partnership Self-Assessment Tool was forwarded to 27 RaPH project partners representing 13 organisations felt to be *'active members'* as determined by the tools administration guidelines. An initial low response rate required a second round of circulation.

The Partnership Self-Assessment Tool requires a 65% response rate for validity. Unfortunately the second round of survey returns brought the response rate to 63% (n=17) of individual partners. Although the individual return rate is slightly below the validity percentage in consideration of the overall percentage of organisations represented 69% (9) it is felt that the findings are valid.

The findings indicated that the overall 'Synergy Score' for the partnership was 3.5 on a 0-5 scale. Similar scores 3.5 to 3.7 were observed in the Strengths and Weaknesses section of the survey when respondents were asked questions relating to Leadership, Efficiency, Administration & Management, Financial and Non-Financial Resources. Results in these areas indicate that the RaPH Partnership is currently operating in the *'Work Zone'*. This translated into *'more effort is needed to maximize the partnership's collaborative potential'.* In order for the partnership to progress through the 'Headway Zone' to the *'Target Zone'* the partnership was required to reflect on those areas of *'strength'* and *'weakness'* and determine appropriate actions to take.

Partners were then asked to reflect on their level of satisfaction in relation to their involvement in the partnership and were asked specifically about decision making processes, benefits and drawbacks and participation. When partners were asked to consider how the partnership faired in its decision making processes the responses to the three questions were varied. Although a majority of partners responded in the more positive range there were responses in the mid or lower end of the satisfaction scale. In particular 12% (n=2) of respondents felt that 'some of the time' they were left out of the decision making process with an additional 6% (n=1) reporting that this occurred 'most of the time'.

In relation to the benefits outweighing the drawbacks of being involved in the partnership, 76% of respondents stated that the benefits exceeded the drawbacks (47% stated they *'greatly exceeded'*). No respondents considered the drawbacks to exceed the benefits of participation.

Finally in the area of satisfaction with participation in the partnership in all five areas questioned (working together, influence, role, planning and implementation) the results indicated that at least two thirds of respondents felt *'mostly'* or *'completely satisfied'* with how the partnership was performing. The remaining percentage of respondents stated they were *'somewhat satisfied'* with the exception of 12% (n=2) reporting to be *'a little satisfied'* with the way people worked together in the partnership.

Considering the findings of the Partnership Self-Assessment Tool there were many areas that indicated the partnership was making significant headway. Equally there were a number of areas where actions were required if the partnership was to realise the full potential of its members and processes. The results of the evaluation were forwarded to the management group and were discussed.

Process Objective 3.2:
3.2 Link with existing initiatives to maximise project outcomes (project objective 4.2)

Indicator 3.2.1:
Key stakeholders are able to link project with existing initiatives

The RaPH project supported linkages with existing initiatives, ensuring that opportunities to work with or learn from other projects and services occurred. Initiatives RaPH worked with included:
- Refugee Health Queensland
- Ethnic Communities Council Chronic Disease Program
- Natural Leaders Project at Griffith University/Multilink/ACESS
- University of Queensland Division of General Practice
- Latrobe Refugee Research Centre
- RHeaNA (Refugee Health Network of Australia)

Other activities that support linkages to initiatives:
- A project mapping exercise at the outset of project indicated a number of existing initiatives.
- Visited the Victorian Refugee Health Network who were able to offer strategic advice and support to the Project Managers throughout the project.
- Supported the development of RHeaNA (Refugee Health Network Australia) by collaborating with a national group of refugee health providers supported the development of TOR for RHeaNA, participated in teleconferences.
- Contributed to three submissions:
  - Towards a National Primary Health Care Strategy (Feb 2009)
  - IHSS Review (July 2009)
  - Chronic Disease Inquiry Social Development Committee (Aug 2009)
- Successfully applied to the Sidney Foundation for funds to support the engagement of a consultant which assisted in consolidating the network and providing options for a sustainable governance framework.
- Successfully applied to The Royal Australian College of General Practitioners, Family Medical Care, Eduction and Research Grant (2009)
- Presentations made at:
  - Diversity in Health Conference
  - Chronic Disease Conference

Table 12 Objective 3 Summary		
	Indicator	**Completed**
3.1 Key stakeholders are engaged effectively in partnership	All key stakeholders (NGO's, Allied Health and Practice Staff) are satisfied with the partnership approach	√
3.2 Link with existing initiatives to maximise project outcomes	3.2.1 Key stakeholders are able to link project with existing initiatives	√

4. Context evaluation

Process Objective 4.1:
4.1 Describe a sustainable transferable model of care (Project Objective 5.1)

Indicator 4.1.1:
Sustainable transferable model described drawing on best practice principles

Through the shared learning's of the RaPH project a model of care was developed drawing on the Expanded Chronic Care Model (Barr et al, 2003) an extension of the Wagner Chronic Care Model (Wagner et al, 2001) with emphasis on building strong links and partnerships across early intervention, prevention and population health. This was presented as a poster to Queensland Health Chronic Disease Conference in May 2010.

A significant event in the development of the proposed model of care was the hosting of the Chronic Care model for people from refugee backgrounds: An Interactive Forum in October 2009. The Forum was delivered with key project partners - Community and Primary Health Services – Metro South (Queensland Health), the Ethnic Communities Council of Queensland Chronic Disease Program and the Logan Natural Helper Partnership (Griffith University, Multilink Community Services Inc, ACCES Service Inc and the Logan Beaudesert Coalition). The forum was facilitated in partnership with The State-wide Refugee Health Nurse Facilitator for Victoria and the Executive Officer of Health West Partnerships Victoria.

The Forum aimed to develop and document a model of care for people from refugee backgrounds living in Brisbane South who are at risk of developing chronic disease. It focussed on coordination, sustainability, transferability and on making positive changes in the health and well being of all people with chronic diseases or at risk of developing a chronic disease. A professional scribe was engaged for the duration of the forum and a written account produced for public circulation.

The project partners in the latter stages of the project have been consolidating the knowledge gained from the RaPH projects activities and have composed a discussion paper entitled '*Towards a sustainable transferable framework of care for the health and well being of people from refugee background settling in Queensland: A discussion paper'.* This additional work not originally envisaged as part of the deliverables of the RaPH project was made possible due to a time extension being granted by CHIC allowing unspent funds to be utilised for the writing of the paper. The publication of the discussion paper in relevant journals will be sought.

Table 13 Objective 4 Summary		
	Indicator	**Completed**
4.1Describe a sustainable transferable model of care	Sustainable transferable model described drawing on best practice principles	√

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5. Develop Evidence Base

Process Objective 5.1:
Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and development

Indicator 5.1.1:
Presentations of project research interests to appropriate tertiary institutions

The RaPH project collaborated with The University of Queensland, Griffith University and Latrobe University in addition to numerous stakeholders including RHQ, MDA and refugee communities, to identify opportunities to collaborate on research and development.

Process Objective 5.2:
Collect base line prevalence data which will contribute to evidence based best practice and inform policy

Indicator 5.2.1:
Research protocol articulated and ethics approval sought and granted

A research protocol was developed by the project to conduct research into the prevalence of chronic disease in newly arrived refugees to Brisbane. An ethics submission was made on the 16/4/2009 for the research which was accepted on 29/5/2009 (see section 2.3)

Indicator 5.2.2:
Data collection completed and approved

Data collection was completed in February 2011.

Indicator 5.2.3:
Qualitative research study:
With identified general practices
With refugee families

Research protocols were developed by the project to conduct two qualitative studies utilising a case study approach. Application for ethics approval was made on 11/8/2009 and accepted on 1/19/09. The first of the two studies gathered qualitative data from general practice staff using focus groups that included administration staff, practice nurses and general practitioners. The focus was on their experience of providing services to newly arrived refugees. The second study collected qualitative data from refugee families using peer-interviewer technique to understand the barriers to health access. (see section 2.3).

Strong links have been made with Griffith University Natural Helpers Partnership, UQ Division of General Practice and Refugee Health Research Centre, La Trobe University through the planning and completion of these research activities.

The project was also able to attract some additional funding in 2009 from RACGP to contribute to the qualitative research study.

Through the successful completion of these three research studies information has been gathered that will contribute to evidence based practice and inform policy. Presentation on the findings from these

studies have been made at the Diversity in Health Conference Melbourne June 2010 and RACGP conference.

Through the research conducted into prevalence of chronic disease in newly arrived refugees and collaborations through RHeaNA the project contributed to the ethics submission for a new multi-site national study in the area of Vitamin B12 research in refugee communities.

Presentation of research findings linked to this project are as follows:

Oral Presentations
2011 The prevalence of Vitamin B12 deficiency in newly arrived refugees in Australia
Dr. Jill Benson, Dr. Margaret Kay, A/Prof. Christine Phillips
Canadian Refugee Health Conference, in 2/6/11Toronto, Canada

2010
 Caring for refugees in primary health care – a qualitative study of general practices and newly-arrived refugees.
Dr. Margaret Kay, Dr. Rebecca Farley, Dr. Deborah Askew, Paula Peterson, Donata Sackey, Dr. Ignacio Correa-Velez
GP '10. Annual Scientific Convention, RACGP on 9th October, 2010.
6-9th October, 2010. Cairns.

 Prevalence of infectious diseases and nutritional deficiencies in Queensland's newly- arrived refugee community.
Dr. Margaret Kay, Peter McNaughton, Jacqui Murdoch, Anne Hibberd, Dr. Deborah Askew
2010 PHC Research Conference on 1st July, 2010. 30th June-2nd July, 2010, Darwin.

Working with diversity to optimise refugee primary health care
Dr. Rebecca Farley, Dr. Deborah Askew and Dr. Margaret Kay
Diversity in Health Conference 2010. on 9th June, 2010 . 7-9th June, 2010, Melbourne.

2009
Addressing primary health care needs in the newly arrived refugee community
Dr. Margaret Kay and Dr. Megan Evans
1st Australasian Refugee Health Conference on 2nd September, 2009. 1-2 September, 2009. Perth.
Abstract published in the Conference Proceedings pp 45-46

Primary Health Care Research – Focusing of Refugee Health
Dr. Margaret Kay
1st Australasian Refugee Health Conference on 2nd September, 2009. 1-2 September, 2009. Perth.
Abstract published in the Conference Proceedings p33

Posters
2011 The prevalence of Vitamin B12 deficiency in newly arrived refugees in Australia
Dr. Margaret Kay, Dr. Jill Benson, A/Prof. Christine Phillips
2011 PHC Research Conference, 13th-15th July, 2011, Brisbane, Australia.

2010
 Improving the primary health care sector's capacity to care for refugees
Dr. Rebecca Farley, Dr. Deborah Askew and Dr. Margaret Kay
2010 PHC Research Conference on 1st July, 2010. 30th June-2nd July, 2010, Darwin.

Encouraging Research in Refugee Health
Dr. Jill Benson, Dr. Margaret Kay, A/Prof. Christine Phillips
Presented at Diversity in Health Conference 2010. 7-9th June, 2010, Melbourne.

2009

Refugee Health – A new model of care.

Dr. Margaret Kay, Prof. Claire Jackson, Ms. Caroline Nicholson.

2009 General Practice and Primary Health Care Research Conference,
 "Driving Change", 15th -17th July, 2009. Melbourne.
Abstract published in the Conference Proceedings p158

Publication
Kay, Margaret, Jackson, Claire, Nicholson, Caroline. "Refugee health: a new model for delivering primary health care" *Australian Journal of Primary Health*, 2010; 16:98-103.

Table 14 Objective 5 Summary		
	Indicator	**Completed**
5.1 Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and development.	5.1.1 Presentations of project research interests to appropriate tertiary institutions	√
5.2 Collect base line prevalence data which will contribute to evidence based best practice and inform policy	5.2.1 Research protocol articulated and ethics approval sought and granted	√
	5.2.2 Data download, merge completed and approved	√
	5.2.3 Case study approach used	√

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Summary of Outcomes

The following provides a summary of the most significant outcomes of the RaPH project followed by a brief discussion.

Process Objective 1 Clinical Care & Information Sharing

1. The broad consultation process used to perform a local mapping activity provided valuable information relating to current service gaps.
2. The project facilitated and contributed to many forums whereby strategies were identified to improve access for refugees to health services.
3. The project facilitated the collaboration of project partner's in relation to the development of clinical guidelines and referral protocols.
4. Input to and facilitated circulation of the 'Desk Top Guide' to local general practices provided access to quality information to assist clinicians in their decision making.
5. The projects assistance in developing and launching the Materonline Refugee Health website also assisted clinicians and other health providers to have access to relevant information relating to refugee health and services.
6. Contribution to newsletters / fax flyers enabled information to be circulated through existing health provider networks.
7. Successful application for funding to the Sidney Myer Foundation and and matched funding from the Mater Foundation (funds raised by QIRCH conference 2008) enabled RHeaNA (Refugee Health Network Australia) to develop a strategy to strengthen its capacity to facilitate national information sharing with respect to refugee health issues.

Process Objective 2 Education& Professional Development

1. The RaPH project devised training materials and hosted two information events for general practice and allied health staff.
2. The September 2009 information event gained high levels of satisfaction from participants relating to increased knowledge, meeting of learning needs and relevance to practice.
3. The April 2010 information event gained moderate levels of satisfaction relating to increased information and high levels of satisfaction relating to meeting of learning needs and relevance to practice.
4. A DVD and booklet was developed from the recording of the April 2010 information event and is available to download from Materonline and hard copies from RHQ.
5. The inclusive approach of the RaPH project in relation to involving a wide range of individuals and organisations in the planning, facilitation and participation of its educational events and forums increased inter-professional linkages.
6. Through three research activities the project facilitated opportunities for stakeholders to collaborate.
7. The project utilised many opportunities to inform general practice and allied health services about the role of RHQ.

Process Objective 3 Community Engagement / Partnership Approach Objectives

1. Key stakeholders were invited and encouraged to be involved in a number of critical project activities these included membership in the management group, three working parties and research activities that included training of bi-cultural researchers.
2. Through surveying the members of the projects management group the project was able gain important insight that facilitated a shared understanding of the significance of partnership to the RaPH project and refugee health service delivery. Results from the survey also highlighted partner's willingness to commit time and energy for the future benefit of refugee population's health.
3. The project engaged successfully with many existing initiatives and projects to increase understanding and improve service delivery to refugee populations.

Process Objective 4 Context Evaluation
1. The project successfully hosted a broadly attended interactive forum which examined the need to extend existing frameworks for working with refugee populations.
2. The project has built on existing knowledge to develop an enhanced model of health care for refugee populations. This has been communicated through presentation and will be further explored in the future publication of a discussion paper.

Process Objective 5 Develop Evidence Base
4. The project developed linkages with three tertiary institutions which enabled the completion of three research studies and contribution to a fourth.
5. The research studies have provided new insight into the prevalence of chronic disease in refugee populations in addition to the experiences of providers of health care to refugee populations and the experiences of refugee populations in accessing health care.
6. Broad circulation of the research findings has occurred through oral presentation, poster presentation and publication.

Conclusion

Based on the data available the findings indicate that the RaPH project has successfully delivered on all of its objectives and has been able to go beyond the original expectations in a number of significant areas. It has developed a model of primary care as described in the project's original statement of intent. With regard to implementation of the model, the project has acknowledged that current policy gaps contribute to fragmentation in the refugee health sector thus making it difficult for services to undertake coordinated and sustainable work. For the implementation of the expanded chronic care model within a primary care context more work needs to be undertaken with key service providers and supported by a refugee health and wellbeing policy framework. The legacy of the project will be the contribution to the evidence base through the research outcomes and the ensuing dialogue from the discussion paper.

The experienced Project Managers have been instrumental in engaging with a wide variety of passionate and knowledgeable individuals and organisations who strive to make a positive difference in the health care experience of refugee populations. By focusing much attention on the importance of partnership agencies and organisations have become used to working together to create benefits for all. The project has also been mindful to ensure it does not create a vacuum when it ends and has instigated various activities to ensure that momentum is sustained.

References

Barr et al (2003) The Expanded Chronic Care Model: An integration of concepts and strategies from population health promotion and the chronic care model, Hospital Quarterly Vol 7 No 1

Wagner et al (2001) Quality Improvement in Chronic Illness Care: A Collaborative Approach. Journal on Quality Improvement 27 (2): 63-80

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Appendices

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Refugees and Primary Health Project
Evaluation Plan
Final June 2009

Outcome	Process Objectives	Indicator	Tool	Who collects/collates data	Ethics
Develop and implement a sustainable primary care model which will support the clinical management of chronic disease, including health promotion and prevention in refugee populations.	**1. Clinical care** Support development of clinical skills by **1.1** In collaboration with key stakeholders develop and implement clinical tools and guidelines in relation to providing quality care to refugee populations *(Project Objective 1.1)*	Clinical tools/guidelines developed Gen Practice and Allied Health practitioners aware of available guidelines	Document review HPQ	Project managers and RHQ	No
	1.2 In collaboration with key stakeholders facilitate **access** for general practice staff and allied health to specialist services and evidence based knowledge, skills and cultural competencies required to undertake refugee health work in a community primary health care setting. *(Project Objective1.2)*	Map current processes and identify gaps Identification of strategies to improve access Access to information is made available (e.g. web site, newsletter) Health providers have access to information	Audit of visits to General Practice/allied health Document review HPQ	Project managers	No
	Clinical Information Sharing **1.3** In collaboration with key stakeholders develop referral protocols to facilitate access and transfer of quality information necessary for decision making by clinicians. *(Project Objective 2.1)*	Protocols developed	Document review	Project managers	No
	1.4 In collaboration with key stakeholders develop of referral templates for RHQ *(Project Objective 2.2)*	Standardised referral templates developed	Document review	Project managers RHQ	No

	1.5 Support and develop appropriate mechanisms to facilitate access to culturally relevant information, referral options and processes eg RHQ website, project newsletter *(Project Objective 2.3)*	Project newsletter disseminated Newsletter items distributed through existing stakeholder networks Website developed	Document review Audit	Project managers	No
	2. Education and professional development objectives **2.**1 Make education regarding protocols and tools available to general practice staff and allied health *(Project Objective3.1)*	Training material developed GP/AH perceptions of quality of training	Number of GP's receiving training Audit HPQ	Project Managers/RHQ	No
	2.2 Improve knowledge and skills of general practice staff and allied health through education regarding protocols and tools for *(Project Objective 3.2)*	GP/AH perceived knowledge skills and attitude improved Inter professional linkages are enhanced	Evaluation forms HPQ	Project managers/evaluator	No
	2.3 Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and training development *(links with Project Objective/Outcome 3.3)*	Key stakeholders identify opportunities to collaborate	Document audit Partners evaluation tool	Project managers /evaluator	No Yes
	2.4 Promote RHQ as supporting primary care within and external to general practices *(Project Objective 3.4)*	GP report awareness of role of RHQ	HPQ	Project managers/evaluator	
	3 Community engagement/partnership approach objectives				

	3.1 Key stakeholders are engaged effectively in partnership (Project objective 4.1)	All key stakeholders (NGOs, allied health, practice staff) are satisfied with the partnership approach	Partnership evaluation tool HPQ	MUQCPHC	No
	3.2 Link with existing initiatives to maximise project outcomes (project objective 4.2)	Key stakeholders are able to link project with existing initiatives		Project managers	No
	4. Context evaluation *4.1* Describe a sustainable transferable model of care *(Project Objective 5.1)*	Sustainable transferable model is described drawing on best practice principles	Project report Document review	Project managers	No

Underpinning the project is a strong commitment to developing a research evidence base for an appropriate model for the care of refugees with chronic disease in the primary care setting.

	5. Develop evidence base				
	5.1 Build links and partnerships with tertiary institutions and service providers to identify opportunities to collaborate on research and development –	Presentations of project research interests to appropriate tertiary institutions	Record of presentations and meetings held		
	5.2 Collect base line prevalence data which will contribute to evidence based best practice and inform policy.	Research protocol articulated and ethics approval sought and granted.	Ethics proposal	Project Research Coordinator	Yes
		Prevalence data download, merge and analysis.	data audit	Project Research Coordinator	
		Focus group & semi structured interviews with identified general practices	audit	Project Research Coordinator	
		Semi structured interviews with refugee communities	audit	Project Manager	

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Appendix 2

Refugees and Primary Health Care Information Evening
Evaluation Report September 2009

Total number of participants:
Total number of evaluations completed: 34

To what extent were your learning objectives met?

Learning Objective	Not met	Partially met	Entirely met
Increase knowledge about the clinical issues for newly arrived refugees from diverse cultural backgrounds (n=34)		10	24
Increase knowledge about the psycho-somatic issues for newly arrived refugees and how these are manifested in physical presentations (n=34)	1	13	20
Increase awareness of the cultural and social issues for newly arrived refugees especially new and emerging groups such as Rohingya Community (n=34)		7	27
Increased knowledge of care pathways and clinical tools and resources available (n=34)		9	25
To what extent were your learning needs met? (n=34)		12	22

To what extent was this education activity relevant to your individual practice? (n=34)

Not relevant	Partially relevant	Entirely relevant
	7	27

What else would you like to know in relation to this subject which we could try to include in future education events:

- Detection and management of other specific diseases common to refugee groups. (4)
- Mental health issues/PTSD / psycho-somatic presentations & counselling techniques.(4)
- Pathway prior to arriving at General Practice (2)
- More on cultural issues & etiquette. (2)
- Support services / medical services (2)
- Selection and prioritisation criteria for refugees (1)
- Logical problems from birth trauma (1)
- Immunisation catch up (1)
- All information is relevant and helpful (1)

What subsequent topics would you be interested in eg chronic disease management, mental health, antenatal care, infectious diseases?

- Mental health issues / somatic presentations & counselling techniques (10)
- Infectious diseases (8)
- Chronic disease implications for refugee patients/communities (3)
- Nutrition (2)
- Disease management of most common medical problems (1)\
- Relevant issues concerning the problems of present group of refugees as they arrive(1)
- Cultural attitudes to medicine & examination (1)
- Assimilation issues (1)
- Co-morbidities : management of in general practice (1)
- Youth specific issues (1)
- More specific medical information probably in the form of case studies (1)
- Self care for professionals caring for refugees whose stories are always harrowing (1)
- Specialists with special interest (1)

Any other comments or feedback:

- Good presentations, relevant to working with refugee population. Good insights into Rohingya community.
- Very informative evening
- Great event, thanks for organising this I can't wait for future sessions.
- Very Good
- Beaut meeting but food cold and ran out. (Not typical of previous Mater CE meetings) Great line up, clear, useful info, good props.
- Great meal, interesting guest speakers, very informative evening.
- Refugee Maternity Service - fantastic to hear about this service.
- A fantastic meeting - what a wonderful group of dedicated people making a real difference. I have learnt more in this one evening which may have taken a long time to source. Thank you.
- Thanks for organising valuable night.
- Well done, V. Good information evening.
- Great to get more familiar with 'the network' and put faces to names.
- thanks, keep 'em coming
- Thank you so much for a very informative and interesting evening. Thanks for all the catering-great food! Excellent speakers - many thanks to all of them. Great preparation - thank you.
- Well done, the session has been very informative.
- Would almost work as a series of lectures.
- Very interesting and informative.
- Great networking.
- Sadly, it is my GP's who need this education but none of them are here. Maybe there needs to be more CME points attached to encourage them. I really don't have an answer. I will certainly take all I have learned tonight back to my GP's.

Appendix 3
**"Working with refugees in primary health care- how to make it work for you and
your practice"**
Evaluation Report 22 April 2010

Participants:
8 Nurses
9 GPs
16 Health workers (NGO, Government and Private Organisations)

Total number of participants: 33
Total number of evaluations completed: 15

To what extent were your learning objectives met?

Learning Objective	Not met	Partially met	Entirely met
Increase knowledge about the management of refugee patients in general practice	(0)	67% (10)	33%(5)
Increase knowledge of care pathways and resources available.	(0)	67% (10)	33% (5)
Increase awareness and knowledge of the networks and support services available to general practice in undertaking management of refugee patients.	(0)	47% (7)	53% (8)
Increase information on the changes to the refugee program and primary care.	(0)	67% (10)	33% (5)
Increased knowledge and awareness of the issues being face by primary care providers and refugee community in providing and accessing primary health care.	(0)	47% (7)	53% (8)
To what extent did the presenters clearly meet your learning needs? *One no response*	(0)	40% (6)	53% (8)

To what extent was this education activity relevant to your individual practice?
One no response

Not relevant	Partially relevant	Entirely relevant
☐	20% (3)	73% (11)

*What else would you like to know in relation to this subject which we could try to include in future
education events:*
- Summary of resources available in Brisbane/handout with services discussed what they do and contact numbers
- Medical issues facing refugees that are not normally seen in other patients
- A sheet explaining acronyms eg QPASTT, MDA and what they do
- More about refugee experiences
- More about recognizing mental health issues in refugee patients
- How and who can be "utilised" to be able to successfully use EPC for refugee patients who have chronic conditions just like everybody else? How can radiology/allied health access TIS?

o   Personal health records for patients

What subsequent topics would you be interested in eg chronic disease management, mental health, antenatal care, infectious diseases and what format would you like to receive this information eg face to face meetings, emails, formal training?

o   Chronic disease
o   Antenatal care
o   Diseases affecting refugees that we should be aware of
o   Email updates on topical refugee health issues eg chronic and acute infections disease – diagnosis and   management
o   Mental health – similar structure to this event about accessing services
o   Mental health – face to face
o   Chronic disease management

Would you be interested in participating in any of the following?

☐ GP refugee health special interest group (3)
☐ bi-monthly refugee health clinical learning group for GPs, nurses and allied health (7)
☐ Nurses network on refugee health – including electronic updates and quarterly teleconferences (4)
☐ practice managers network on refugee health – including electronic updates and quarterly meetings (3)
☐ Formal training or workshops on refugee health (9)

Any other comments eg suitability of venue, resources provided?

o   Excellent format of the evening – very interactive
o   Fantastic evening
o   Good dinner
o   At Mater it's convenient and good food and comfortable – thank you for parking
o   Nice food
o   Room is too warm
o   Good venue

.

Appendix 4

Chronic Care model for people from refugee backgrounds: An Interactive Forum
Monday 19th October 2009

Post Forum Feedback Summary

Number of attendees: 44
Number of feedback forms retuned: 10

Section A: General satisfaction	strongly disagree	disagree	neutral	agree	strongly agree
1. The forum provided me with relevant information on the expanded chronic care model which will be useful to my organisation **(N=9)**			1	5	3
2. The forum was a good networking opportunity with people and organisations which I would not usually network **(N=9)**				6	3
3. There was a good balance of formal presentations and opportunities for small group discussions. **(N=9)**			3	6	2

Section B: Expectations

4. What were your expectations of the Forum?

- 'Importance of health promotion and consideration of social and behavioural determinants of health in expanded chronic care model. I still think there would be much discussion on how we could focus on those factors and improve health outcomes of chronic disease in Refugee people and CALD communities. I have learnt a lot from other NGO and government organisation working for the same issue to improve health outcomes in Refugee health and CALD communities.'

- 'To gain a better understanding o the potential role of General Practice in health care for refugees and gain an understanding of the specialised refugee services that are already in existence. To be able to contribute by explaining our process of linking GP to the community services in our district.'

- 'My expectations were to listen to other voices around migrant health and wellbeing. However, I also had an expectation to use a common working language with other people in order to gain some consensus on how we can forge productive relationships and partnerships. This was not entirely the case, perhaps this is because more work is needed to forge productive partnerships.'

- 'To learn more about other organisations experiences, achievements, challenges and things that worked better. Knowledge on existing programs and activities they offer. Get knowledge on the major issues faced by the communities and service providers.'

- 'To share experiences on CDM & give input to how we operate in our workplace.'

- 'To create an opportunity where representatives from a range of organisations involved in health care outcomes to refugees could share ideas and current thoughts as to where they are at / where they want to head. I was hoping that together we could prioritise some important issues / tasks to work on in the future in a collaborative way.'

- 'I was hoping to meet GP's from the North side of Brisbane and other allied health professionals from the community who may come into contact with Refugee and CALD clients'

- 'Networking with others involved in Refugee Health. See what other organisations are doing in terms of Refugee Health and Chronic Disease Management.'

- 'An opportunity for meeting other partners in the project who have not attended regular meetings; learning about what others are doing in relation to refugee primary healthcare; have constructive discussion about proposed expanded chronic care model for refugee communities; identifying key priorities for developing the model further in the Brisbane context.'

- '..more about what's worked well (or not) ie Vic & elsewhere / Raise & priorities key issues were discussed.'

	Not met	Partiall y met	Entirely met
5. To what extent were your expectations met? **(N=9)**		6.5	2.5

Section C: Future events	Yes	No
6. Would you be interested in attending a similar event in the future? **(N=9)**	7	2

If yes to question 6, please tick which of the following you might be interested in:
- 4 Geographically specific planning on primary health care for refugees
- 6 A strategic working group to develop relevant options for a Qld wide refugee health plan
- 2 Other :
  - 'A strategic decision making and partnership approach in health outcomes in chronic disease in CALD communities.
  - One person indicated 'other' but did not indicate in which areas they were interested.

Any other comments or feedback?

- 'Thanks for inviting Brisbane South Division for this information interactive forum. I guess this kind of regular events will definitely make a difference and bring new ideas to progress towards refugee health.'

- 'Trying to get people to complete the PDSA methodology without having any instruction on the technique was a poor use of the limited time available. I am concerned that existing issues were re-identified but no real solutions found. Possibly specific case studies could have been discussed in small groups where the gaps in service provision may have been identified. I hope the organising committee gained some valuable information.'

- 'Well done and I have learnt a lot on refugee community health problems and the challenges faced by the service providers.'

- 'My only 'criticism' is that there is not enough time to get through the tasks in the small groups, and that it would have been useful to hear from other groups as to what they were doing in their sectors already (not just the gaps). How you could have created another few hours in that day I am not sure!'

- 'I was wondering if there would be a similar forum that would be either Brisbane North of Greater Brisbane (including Logan / Ipswich) will be held. I was a little disappointed that there were only a few direct community health workers, social workers and a few GP's in attendance as I believe that this was a very valuable session not only to discuss health issues but for some attendance it was very educational. While I realise participants were pushed for time to come, I thought this session would be better over two days as the extra time would promote more in-depth discussion around these topics.'

- 'I believe that the last item of the forum where the gaps of the chronic care model were identified in Brisbane context required more time and greater group discussion.'

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Refugees and Primary Health (RaPH) Project

Partnership Evaluation
Summary November 2009

Evaluation aim:
To engage partners in a discussion on the purpose and goal of the partnership as a vehicle for achieving the stated goals and objectives of the RaPH project.

Evaluation tool:
Questions were modified from the Vic Health Partnership Analysis Tool (2003)

Circulation:
The questionnaire was circulated to all members of the RaPH Project Management Group on the 23.9.2009 via email. Participants were asked to return the completed questionnaires via email to either of the RaPH project managers by 29.9.09.

Response:
In total eight partners completed the questionnaire.

Findings:

1. **Could you identify up to three reasons as to why partnering is necessary in the RaPH project? Please rank in order of importance with the most important listed first.**

First most important
- Enable more effective, appropriate and coordinated services (3)
- Refugee health is 'everyone's responsibility', it 'goes beyond *health* to include housing and employment' it therefore needs to involve everyone (2)
- To build and facilitate relationships and trust (2)
- Better use of resources and expertise
- Identifying needs and issues
- Reduce duplication and service gaps
- 'Partnership is imperative' for integrated service delivery to refugees
- Fragmented care' is a 'barrier to consumers and health providers'

Second most important
- Combining efforts / Needs cannot be met by a single agency (2)
- Creates opportunities for communication and collaboration (2)
- Wiser use of resources
- Ensures project findings are shared to all stakeholders
- To make certain the PHC Model is informed by both refugee communities and service providers
- Facilitates relationships between researchers and refugee communities

Third most important
- Sharing resources
- Builds trust (between service providers & providers and communities)
- CHIC funding requirement
- By partnering advocacy becomes easier
- Integration requires 'capacity to embrace change'…partnerships provides the means to support this.
- Ensure model is sustainable

- Avoid duplication and improve efficiency
- Encourages relationship building between providers.

Summary of Q1

The most frequently proposed reason that partnering was thought to be necessary for the RaPH project was to help improve effective service delivery for refugee communities. This included better coordination and wiser use of resources. The second most notable area was that of relationships, with partnering being seen as a way to build relationships and trust both between service providers but also between providers and refugee communities. Another important point to note is that refugee health was felt to be to broad an issue for one agency and thus a partnership approach would provide the opportunity for a shared response.

2. Could you identify up to three ways in which partnering adds value to the RaPH project? Please rank in order of importance with the most important listed first.

First most important
- Empowering (2) (brings people together, develops capacity)
- Sharing information helps in planning and service delivery
- Ensures 'longevity' and provides an incentive to continue after the project ends
- Provides access and understanding of tertiary services
- Provides a 'reality check' ('what is there, what has been done, what needs to be done and what can be done..')
- Develops relationships within and beyond the partnership.
- Increases communication (a central point, improves speed of access and understanding)

Second most important
- Information sharing (3) (Complexity & diversity of issues / people)
- Share resources
- Builds capacity (knowledge, skills and attitudes)
- Opportunities to share challenges and come up with 'mutually beneficial solutions to problems'
- Provide and further develop linkages
- Government involvement indicates commitment to refugee health as a state priority.

Third most important
- Strengthens advocacy (2) (for community and program / 'adds *face')*
- Identification of areas for collaborative work
- Maximises use of resources
- Provides a 'linking point'
- 'Enables multiple levels of interaction with diverse groups'

Summary of Question 2:

Notable points raised in response to how partnering is seen to add value to the RaPH project include an increased sense of empowerment and advocacy. This seems tied not only to the strength found in being part of a group but also the increased knowledge and understanding of issues and the sense of sharing responsibilities and solutions.

1. **Do you think other agencies would share the same partnership purpose?   Can you explain your answer briefly?**

- Yes... 'a partnership allows issues to be raised whilst not taking on the whole project.
- No 'they would not all have the same purpose BUT still there are mutual benefits for all in these partnerships.' (eg UQ & RHQ assist each other)
- 'Some would and some wouldn't' (1) 'in practice its impossible' (some networking – others fully involved in sharing goals, responsibilities and resources)
- Most do (shown by regular attendance at meetings and commitment to support project)
- Core purpose yes but priorities may be different for agencies
- All agencies involved 'value partnership models and objectives' but there is experience of constraints and limitations
- Requires a common vision by all agencies
- 'The service providers involved in the RaPH project are not in competition with each other, they are complementary and it can only be of a benefit to work together in this way.'

Summary of question 3:

Each of the eight partners had a considerably different response to the question of whether they thought other agencies shared the same partnership purpose. The range of responses suggests that overall respondents felt other project partners did have or there was a desire to have a shared partnership purpose. However for some respondents it was felt that in reality other priorities or internal constraints impacted on the ideal to have a shared partnership purpose.

2. **From your perspective, how would you describe the partnership approach of RaPH? Please circle one response which best describes your perspective.**

a.   IV (8)

All eight respondents felt that the partnership was operating at level iv seeing the partnership as 'an opportunity to exchange information, make a change in the environment, share resources and enhance the capacity of all members of the partnership in a manner that is mutually beneficial'. Although one respondent added the comment 'Hoping for iv'.

Conclusion

The eight respondents have provided a very positive picture of the impact the RaPH project has made to date in the promotion of an effective partnerships in the area of Primary Health Care for People from Refugee backgrounds. The need for sustained impact after the end of the project has been highlighted by respondents and continues to be a key focus for the project. This is even more significant taking into consideration the complex nature of refugee health, the observed shortfalls of service provision and the current enthusiasm of agencies to work together.

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Appendix 6

RaPH Project
Partnership Self-Assessment Tool*
Report Findings

Survey Coordination & Analysis:
Mater UQ Centre for Primary Health Care Innovation
Date: 26.5.10

* C. CENTER FOR THE ADVANCEMENT OF
COLLABORATIVE STRATEGIES IN HEALTH
(http://partnershiptool.net/)

Contents

1. EXECUTIVE SUMMARY

This report provides a summary of the findings from the Partnership Self Assessment Tool utilised by the Refugee and Primary Health Project (RAPH) Project. The tool devised by the Centre for the Advancement of Collaborative Strategies in Health, New York (http://partnershiptool.net/) has provided the RaPH Partnership with an opportunity for reflection, discussion and future planning in order to maximise the potential for partnership synergy. The findings provide a useful snapshot of how well the participants view the current functioning of the partnership in a broad cross section of subject areas.

On the 16th of February 2010 the Partnership Self-Assessment Tool was forwarded to 26 RaPH project partners. These members represented 13 organisations involved in the partnership and were felt to be *'active members'* as determined by the tools administration guidelines. The surveys were coded to ensure confidentiality.

On the 22nd March after an extension to the closing deadline, 10 participants (38%) had completed and returned their survey. This represented 6 (48%) of organisations involved in the partnership. The data was analysed as per tool guidelines and the findings were presented to the project partners in a draft report in April. Due to the low response rate it was agreed by the project partners that the survey was to be re-sent to those partners who had not previously responded with an email from the evaluator explaining the importance of the survey.

Fourteen survey requests were emailed out on the 22nd April, an additional person was invited to participate bringing the total number to 27. One month later on the 24th May submissions closed with a further seven surveys received. The evaluator received emails from four partners who had not felt they had been 'active' in the partnership, two decided not to complete the survey, one decided to use meeting minutes to assist in their responses and one further partner had not submitted by the 24th May. One partner stated they had returned their survey in the first instance but this was not received and due to time limitations they could not re-submit the survey. Additionally three project partners had left their organisations and therefore were no longer members of the partnership.

The Partnership Self-Assessment Tool requires a 65% response rate for validity. Unfortunately the second round of survey returns brought the response rate to 63% (17) of individual partners. Although the individual return rate is slightly below the validity percentage in consideration of the overall percentage of organisations represented 69% (9) it is felt that the findings are valid.

The findings indicated that the overall 'Synergy Score' for the partnership was 3.5 on a 0-5 scale. Similar scores 3.5 to 3.7 were observed in the Strengths and Weaknesses section of the survey when respondents were asked questions relating to Leadership, Efficiency, Administration & Management, Financial and Non-Financial Resources. Results in these areas indicate that the RaPH Partnership is currently operating in the *'Work Zone'*. This translates into *'more effort is needed to maximize the partnership's collaborative potential'.* In order for the partnership to progress through the 'Headway Zone' to the *'Target Zone'* the partnership will need to reflect on those areas of *'strength'* and *'weakness'* and determine its appropriate actions to take.

Partners were then asked to reflect on their level of satisfaction in relation to their involvement in the partnership and were asked specifically about decision making processes, benefits and drawbacks and participation. When partners were asked to consider how the partnership faired in its decision making processes the responses to the three questions were varied. Although a majority of partners responded in the more positive range there was a notable percentage of responses in the mid or lower end of the satisfaction scale. In particular 12% (2) of respondents felt that 'some of the time' they were left out of the decision making process with an additional 6% (1) reporting that this occurred 'most of the time'.

In relation to the benefits outweighing the drawbacks of being involved in the partnership, 76% of respondents stated that the benefits exceeded the drawbacks (47% stated they *'greatly exceeded'*). No respondents considered the drawbacks to exceed the benefits of participation.

Finally in the area of satisfaction with participation in the partnership in all five areas questioned (working together, influence, role, planning and implementation) the results indicated that at least two thirds of respondents felt *'mostly'* or '*completely satisfied'* with how the partnership was performing. The remaining percentage of respondents stated they were *'somewhat satisfied'* with the exception of 12% (2) reporting to be *'a little satisfied'* with the way people worked together in the partnership.

Considering the findings of the Partnership Self-Assessment Tool there are many areas that indicate the partnership is making significant headway. Equally there are a number of areas were actions are required if the partnership is to realise the full potential of its members and processes. Some areas will be easier than others to impact upon but most importantly ongoing commitment from partnership members with passion, vision and determination will greatly influence the outcome as will effective facilitation and organisation. It would be of importance for these findings to be discussed within the context of a partnership meeting and a plan of action drawn up to address the areas the members feel are of most significance. Additionally the repetition of this Partnership Self-Assessment survey after a given period of time will assist the partnership to measure the impact of interventions that have been implemented.

2. INTRODUCTION

This action-oriented report has five sections. It begins by discussing the respondents and the response rate for your partnership. These are important factors to consider in interpreting the information in this report.

The report then presents and interprets your partnership's synergy score. This score is a key indicator of how well your partnership's collaborative process is working. It tells you how well the process is combining your partners' knowledge, skills, and resources so they can accomplish more together than they can on their own.

The report continues by presenting your partnership's strengths and weaknesses in areas that are known to be related to synergy:
(1) the effectiveness of your partnership's leadership;
(2) the efficiency of your partnership;
(3) the effectiveness of your partnership's administration and management;
(4) the sufficiency of your partnership's resources.

This information can help your partnership identify what it is doing well and what it needs to focus on to improve the success of its collaborative process.

Next, the report presents your partners' views about their own participation in the partnership. It describes their views about the decision-making process in the partnership, the benefits and drawbacks they are experiencing as a result of participating in the partnership, and their overall satisfaction with the partnership. Acting on this information can help your partnership be more successful in recruiting and retaining a broad array of partners.

The report concludes by discussing how your partnership can use the information in this assessment report to take corrective action.

3. YOUR PARTNERSHIP RESPONDENTS AND RESPONSE RATE:

In your partnership:
27 people were asked to complete the questionnaire representing **13** organisations
17 people completed the questionnaire representing **9** organisations
63% is your <u>partnership's response rate</u> with 69**%** of organisations represented

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According to the Centre for the Advancement of Collaborative Strategies in Health, developers of the Partnership Self-Assessment Tool a response rate of fewer than 65% invalidates the findings. However it is proposed in this instance that a response rate of 63% representing 69% of organisations does indicate a sufficiently high response rate to deem the findings valid.

4. KEY TO INTERPRETING SCORES

The survey questions pertaining to the partnership's Synergy Score and the questions within the Strengths and Weaknesses section have been determined by calculating the mean score. The mean is then matched to a zone determined by the Centre for the Advancement of Collaborative Strategies in Health as can be seen below.

Mean score	Zone	Description
1.0–2.9	Danger Zone	This area needs a lot of improvement
3.0–3.9	Work Zone	More effort is needed in this area to maximize the partnership's collaborative potential
4.0–4.5	Headway Zone	Although the partnership is doing pretty well in this area, it has the potential to progress even further
4.6–5.0	Target Zone	The partnership currently excels in this area and needs to focus attention on maintaining its high score

The remaining four survey areas which relate to the views of partners own participation in the partnership have been calculated as percentages of respondents.

5. YOUR PARTNERSHIP'S SYNERGY SCORE:

In the Partnership Self-Assessment Tool, synergy is measured by a set of 9 questions. Your partnership's overall synergy score is the mean of all of your respondents' answers to all 9 of these questions. It reflects the extent to which the participants in your partnership are accomplishing more together than they can on their own.

Your partnership's overall synergy score is **3.5**. This score is in the **Work Zone**.

The following table shows how your partnership scored on each of the 9 questions that make up the overall synergy scale. The 9 questions each represent an attribute of synergy.

How well, by working together, the participants in your partnership are able to:	Partnership mean:
Identify new and creative ways to solve problems (n=16)	3.7
Include the views and priorities of the people affected by the partnership's work (n=16)	3.8
Develop goals that are widely understood and supported among partners (n=16)	3.6
Identify how different services and programs in the community relate to the problems the partnership is trying to address (n=16)	3.8
Respond to the needs and problems of the community (n=16)	3.4
Implement strategies that are most likely to work in the community (n=16)	3.2
Obtain support from individuals and organizations in the community that can either block the partnership's plans or help move them forward (n=16)	3.6
Carry out comprehensive activities that connect multiple services, programs, or systems (n=16)	3.1
Clearly communicate to people in the community how the partnership's actions will address problems that are important to them (n=16)	3.2

6. YOUR PARTNERSHIP'S STRENGTHS AND WEAKNESSES IN AREAS THAT ARE KNOWN TO BE RELATED TO SYNERGY

The Centre's National Study of Partnership Functioning identified four factors that are related to a partnership's ability to achieve high levels of synergy:

- the effectiveness of the partnership's leadership
- the efficiency of the partnership
- the effectiveness of the partnership's administration and management
- the sufficiency of the partnership's resources

The Partnership Self-Assessment Tool measured your partnership's strengths and weaknesses in these areas. With this information, your partnership can identify what it is doing well and what it needs to focus on to improve the success of its collaborative process.

6.1. THE EFFECTIVENESS OF YOUR PARTNERSHIP'S LEADERSHIP

In the Partnership Self-Assessment Tool, the effectiveness of a partnership's leadership is measured by a set of 11 questions. Your partnership's overall score for leadership effectiveness is the mean of all of your respondents' answers to all of these questions.

Your partnership's overall score for leadership effectiveness is **3.5**.
This score is in the **Work Zone**.

The following table shows how your partnership scored on each of the 11 questions that make up the leadership effectiveness scale. The 11 questions each represent an attribute of effective leadership.

Leadership attributes:	Partnership mean:
Taking responsibility for the partnership	3.6
Inspiring and motivating people in the partnership	3.4
Empowering the people in the partnership	3.2
Communicating the vision of the partnership	3.3
Working to develop a common language within the partnership	3.3
Fostering respect, trust, inclusiveness, and openness in the partnership	3.8
Creating an environment where differences of opinion can be voiced	3.6
Resolving conflict among partners (n=11)	3.4
Combining the perspectives, resources, and skills of partners (n=16)	3.7
Helping the partnership be creative and look at things differently	3.5
Recruiting diverse people and organizations into the partnership	3.5

6.2 THE EFFICIENCY OF YOUR PARTNERSHIP

The National Study of Partnership Functioning documented the importance of partnership efficiency in achieving high levels of synergy. Partnership efficiency is a measure of how well a partnership optimizes the involvement of its partners. An efficient partnership maximizes synergy and keeps its partners engaged by:

- matching the roles and responsibilities of its participants with their particular interests and skills
- making good use of its participants' financial and in-kind resources

- running a collaborative process—including meetings—that makes good use of its participants' time

In the Partnership Self-Assessment Tool, the efficiency of a partnership is measured by a set of 3 questions. Your partnership's overall efficiency score is the mean of all of your respondents' answers to all of these questions.

Your partnership's overall efficiency score is **3.7**.
This score is in the **Work Zone**.

The table below shows how your partnership scored on each of the questions that make up the efficiency scale. The 3 questions each represent a dimension of partnership efficiency.

Efficiency: How well your partnership is using its partners…	Partnership mean:
Financial resources (n 16)	3.7
In-kind resources	3.8
Time	3.6

6.3. THE EFFECTIVENESS OF YOUR PARTNERSHIP'S ADMINISTRATION AND MANAGEMENT

The administration and management of a partnership is the "glue" that makes it possible for multiple, independent people and organizations to combine their knowledge, skills, and resources. The findings of the National Study of Partnership Functioning suggested that partnerships need a certain kind of administration and management to achieve high levels of synergy— one that is very different from bureaucratic forms of management (which tend to be rigid and control what people do). Partnerships that maximize synergy, and are thus able to make the most of collaboration, effectively carry out the following kinds of administration and management activities:

- facilitating timely communication—not only among a broad array of partners, but also with people and organizations outside the partnership
- coordinating meetings, projects, and other partnership activities
- supporting partnership participants in applying for grants and managing funds
- providing the partnership with analytic support, for example, by preparing documents that inform participants and help them make timely decisions and by evaluating the progress and impact of the partnership
- providing orientation to new participants as they join the partnership
- minimizing barriers that can prevent certain participants from participating in the partnership's meetings and activities (for example, by providing transportation, child care, and translation services and by holding meetings at convenient places and times)

In the Partnership Self-Assessment Tool, the effectiveness of a partnership's administration and management is measured by a set of 9 questions. Your partnership's overall score for the effectiveness of its administration and management is the mean of all of your respondents' answers to all of these questions.

Your partnership's overall score for the effectiveness of its administration and management
is **3.5.**
This score is in the **Work Zone**.

The following table shows how your partnership scored on each of the 9 questions that make up the administration and management effectiveness scale. The 11 questions each represent an attribute of effective administration and management.

Administration and Management Activities:	Partnership mean:
Coordinating communication among partners	3.6
Coordinating communication with people and organizations outside the partnership (n=16)	3.1
Organizing partnership activities, including meetings and projects	3.6
Applying for and managing grants and funds (n=14)	3.8
Preparing materials that inform partners and help them make timely decisions (n=16)	3.7
Performing secretarial duties (n=15)	3.8
Providing orientation to new partners as they join the Partnership (n=11)	3.4
Evaluating the progress and impact of the partnership (n=15)	3.1
Minimizing barriers for participation in partnership meetings and activities (n=16)	3.3

6.4. THE SUFFICIENCY OF YOUR PARTNERSHIP'S RESOURCES

The knowledge, skills, and other resources that participants contribute to a partnership are the basic building blocks of synergy. It is by combining these resources in various ways that participants create something new and valuable that transcends what they can accomplish on their own. Below are the findings in relation to the partnerships ability to obtain needed non-financial resources and needed financial and other capital resources.

6.4.1 YOUR PARTNERSHIP'S NON-FINANCIAL RESOURCES

The findings of the National Study of Partnership Functioning suggested that the ability of a partnership to achieve high levels of synergy depends on the contribution of sufficient non-financial resources from its partners.

Important non-financial resources include:
- the broad array of skills and expertise that partnerships need to recruit partners, support the collaboration process, carry out comprehensive interventions, document and evaluate the work of the partnership, and get their message out;
- the various kinds of data and information that partnerships need to support joint problem-solving, such as statistical data;
- the perspectives, values, and ideas of different stakeholders and community groups;
- information about the community's assets, politics, and history;
- connections to particular people, organizations, and groups, such as community residents directly affected by the problem the partnership is trying to address, political decision makers, government agencies, private sector funders, academic institutions, businesses, and other partnerships in the community;
- endorsements that give the partnership legitimacy and credibility with various stakeholders;
- convening power—the influence and ability to bring people together for partnership meetings and other activities.

In the Partnership Self-Assessment Tool, the sufficiency of a partnership's non-financial resources is measured by a set of 6 questions. Your partnership's overall score for sufficiency of non-financial resources is the mean of all of your respondents' answers to all of these questions.

Your partnership's overall score for sufficiency of non-financial resources is **3.6.**
This score is in the **Work Zone.**

The following table shows your partnership's scores for each kind of the non-financial resources.

Kinds of Non-Financial Resources:	Partnership mean:
Skills and expertise	3.4
Data and information	3.5
Connections to target populations	3.7
Connections to political decision-makers, government agencies and others	3.3
Legitimacy and credibility (n=15)	3.7
Influence and ability to bring people together for meetings/ activities	3.8

6.4.2 YOUR PARTNERSHIP'S FINANCIAL AND OTHER CAPITAL RESOURCES

Financial and other capital resources, including space, equipment, and goods, are clearly important assets to a partnership since they are essential for hiring staff and carrying out certain kinds of programs. Yet the relationship of financial resources to synergy is probably indirect; partnerships need financial and other capital resources to support their administration and management activities, which, in turn, promote synergy.

In the Partnership Self-Assessment Tool, the sufficiency of a partnership's financial and capital resources is measured by a set of 3 questions. Your partnership's overall score for sufficiency of financial and capital resources is the mean of all of your respondents' answers to all of these questions.

Your partnership's overall score for sufficiency of financial and other capital resources is **3.5.**
This score is in the **Work Zone**.

The following table shows your partnership's scores for each kind of the financial and capital resources.

Kinds of Financial and other Capital Resources:	Partnership mean:
Money (n=15)	3.2
Space (n=16)	3.6
Equipment & goods (n=15)	3.7

7. YOUR PARTNERS' VIEWS ABOUT THEIR OWN PARTICIPATION IN THE PARTNERSHIP

Partners are the source of most partnership resources. They provide partnerships with many resources directly. In addition, they use their resources— such as their skills, connections, and credibility—to obtain external funding and in-kind support. To achieve high levels of synergy, partnerships need to be able to recruit and retain partners who can provide needed resources. To make the most of collaboration, partnerships need to identify and actively engage participants with a sufficient range of knowledge, skills, and other resources to give the group a full picture of the problem it is trying to solve, to stimulate new, locally responsive ways of thinking about solutions to this problem, and to implement comprehensive interventions.

A number of factors influence the willingness of people and organizations to participate actively in partnerships:
- their views about the decision-making process of the partnership
- the benefits and drawbacks they experience as a result of participation in the partnership
- their overall satisfaction with participation in the partnership

7.1 HOW YOUR RESPONDENTS VIEW THE PARTNERSHIP'S DECISION-MAKING PROCESS

A partnership's decision-making process determines who is involved in partnership decision making and how partnership decisions are made. In the Partnership Self-Assessment Tool, respondents' views about a partnership's decision-making process are measured by 3 questions.

When respondents were asked how *comfortable* they are with the way decisions are made in your partnership:
6% reported they are extremely comfortable
59% reported they are very comfortable
35% reported they are somewhat comfortable
0% reported they are a little comfortable
0% reported they are not at all comfortable

When respondents were asked how often they *support* the decisions made by the partnership:
23% reported all of the time
53% reported most of the time
18% reported some of the time
6% reported almost none of the time
0% reported none of the time

When respondents were asked how often they feel they have been *left out* of the decision-making process:
0% reported all of the time
6% reported most of the time
12% reported some of the time
41% reported almost none of the time
41% reported none of the time

7.2 HOW YOUR RESPONDENTS VIEW THE BENEFITS AND DRAWBACKS OF PARTICIPATION

One of the most important factors that influence the decision by people and organizations to participate in a partnership is their perception of the relative benefits and drawbacks involved. Partners who receive substantial benefits from participating in partnerships tend to be more active in the partnership than partners who do not. Minimizing the drawbacks that are associated with participation may be just as important to partners as providing them with additional benefits.

In the Partnership Self-Assessment Tool, your respondents were asked to compare the benefits and drawbacks they are experiencing as a result of participating in your partnership and to identify the particular kinds of benefits and drawbacks they have experienced thus far.

When respondents were asked how the benefits of participating in your partnership compare to the drawbacks:

47% reported that the benefits greatly exceed the drawbacks

29% reported that the benefits exceed the drawbacks

23.5% reported that the benefits and drawbacks are about equal

0% reported that the drawbacks exceed the benefits

0% reported that the drawbacks greatly exceed the benefits

The table below shows the percentage of respondents in your partnership who have received each of 11 kinds of *benefits*.

Kinds of Benefits:	% Receiving
Enhanced ability to address important issues	82%
Development of new skills	76%
Heightened public profile (n=16)	94%
Increased utilization of my expertise or services	70%
Acquisition of useful knowledge about services, programs, or people in the community	88%
Enhanced ability to affect public policy (n=16)	62.5%
Development of valuable relationships (n=16)	100%
Enhanced ability to meet the needs of my constituency or clients(n=16)	87.5%
Ability to have a greater impact than I could have on my own (n=16)	94%
Ability to make a contribution to the community	82%
Acquisition of additional financial support	29%

The table below shows the percentage of respondents in your partnership who have experienced each of 6 kinds of *drawbacks*.

Kinds of Drawbacks:	% Experiencing
Diversion of time and resources away from other priorities or obligations	53%
Insufficient influence in partnership activities	6%
Frustration or aggravation (n=16)	0%
Viewed negatively due to association with other partners or the partnership (n=16)	18%
Insufficient credit given to me for contributing to the accomplishments of the partnership	0%
Conflict between my job and the partnership's work	12%

7.3 HOW SATISFIED YOUR RESPONDENTS ARE WITH THEIR PARTICIPATION IN THE PARTNERSHIP

Participants who are satisfied with their involvement in a partnership are more likely to maintain and increase their level of commitment than participants who are not satisfied. In the Partnership Self-Assessment Tool, your respondents' satisfaction with participation in your partnership was measured by 5 questions.

When respondents were asked how satisfied they are with the way the people and organizations in your partnership *work together*:

29% reported they are completely satisfied

53% reported they are mostly satisfied

6%reported they are somewhat satisfied

12% reported they are a little satisfied

0% reported they are not at all satisfied

When respondents were asked how satisfied they are with their *influence* in your partnership:
12% reported they are completely satisfied
53% reported they are mostly satisfied
35% reported they are somewhat satisfied
0% reported they are a little satisfied
0% reported they are not at all satisfied

When respondents were asked how satisfied they are with their *role* in your partnership:
12% reported they are completely satisfied
65% reported they are mostly satisfied
23% reported they are somewhat satisfied
0% reported they are a little satisfied
0% reported they are not at all satisfied

When respondents were asked how satisfied they are with your partnership's *plans* for achieving its goals:
12% reported they are completely satisfied
65% reported they are mostly satisfied
23% reported they are somewhat satisfied
0% reported they are a little satisfied
0% reported they are not at all satisfied

When respondents were asked how satisfied they are with the way your partnership has *implemented* its plans:
18% reported they are completely satisfied
65% reported they are mostly satisfied
18% reported they are somewhat satisfied
0% reported they are a little satisfied
0% reported they are not at all satisfied

8. SUMMARY OF FINDINGS

The Partnership Self-Assessment Tool requires a 65% response rate for validity. Unfortunately the second round of survey returns brought the response rate to 63% (17) of individual partners. Although the individual return rate is slightly below the validity percentage in consideration of the overall percentage of organisations represented 69% (9) it is felt that the findings are valid.

The overall 'Synergy Score' for the partnership which is the measure of the impact of collaborative processes that enable the full potential of its members to think and act beyond it's individuals was 3.5 on a 0-5 scale. Similar scores 3.5 to 3.7 were observed in the Strengths and Weaknesses section of the survey when respondents were asked questions relating to Leadership, Efficiency, Administration & Management, Financial and Non-Financial Resources. Results in these areas indicate that the RaPH Partnership is currently operating in the *'Work Zone'*. This translates into *'more effort is needed to maximize the partnership's collaborative potential'.* In order for the partnership to progress through the 'Headway Zone' to the *'Target Zone'* the partnership will need to reflect on those areas of *'strength'* and *'weakness'* and determine its appropriate actions to take.

Partners were then asked to reflect on their level of satisfaction in relation to their involvement in the partnership and were asked specifically about decision making processes, benefits and drawbacks and participation. When partners were asked to consider how the partnership faired in its decision making processes the responses to the three questions were varied. Although a majority of partners responded in the more positive range there was a notable percentage of responses in the mid or lower end of the satisfaction scale. In particular 12% (2) of respondents felt that 'some of the time' they were left out of the decision making process with an additional 6% (1) reporting that this occurred 'most of the time'.

In relation to the benefits outweighing the drawbacks of being involved in the partnership, 76% of respondents stated that the benefits exceeded the drawbacks (47% stated they *'greatly exceeded'*). No respondents considered the drawbacks to exceed the benefits of participation.

Finally in the area of satisfaction with participation in the partnership in all five areas questioned (working together, influence, role, planning and implementation) the results indicated that at least two thirds of respondents felt *'mostly'* or *'completely satisfied'* with how the partnership was performing. The remaining percentage of respondents stated they were *'somewhat satisfied'* with the exception of 12% (2) reporting to be *'a little satisfied'* with the way people worked together in the partnership.

Considering the findings of the Partnership Self-Assessment Tool there are many areas that indicate the partnership is making significant headway. Equally there are a number of areas were actions are required if the partnership is to realise the full potential of its members and processes. Some areas will be easier than others to impact upon but most importantly ongoing commitment from partnership members with passion, vision and determination will greatly influence the outcome as will effective facilitation and organisation. It would be of importance for these findings to be discussed within the context of a partnership meeting and a plan of action drawn up to address the areas the members feel are of most significance. Additionally the repetition of this Partnership Self-Assessment survey after a given period of time will assist the partnership to measure the impact of interventions that have been implemented.

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