

Appendix L Issues identified from the Diagnostic Phase

Slides presented for discussion at the validation workshops

1 Geography

- c. Needing to attend treatments in other towns/cities takes people away for an extended period of time - this has implications on the family and extended family
- d. Some chronic care services require people to come into the service for tests/to use resources, therefore they are not going out into the community
- e. Some patients, who have needed regular and ongoing treatment, have needed to move residence in order to be closer to services

“ I needed to come back home because I wanted to be closer to my brother and family. I know everyone here so it makes me feel better ”

When we are forced to leave our country and our homes we lose touch with our culture and identity. I haven't been back home to my country for 18 years because of my health condition

2 Prevention

- a. Aboriginal patients are not provided with education on and/or have limited understanding of the progression of their chronic conditions and to take care of their health in the early stages and not wait until they get sick (i.e. they are only accessing health care services in emergencies and crisis)
- b. AHS self management programs are not standardised/are scattered resulting in limited care planning/action planning

The first sign for me and acknowledging for myself that I had a serious chronic care condition was when I had to have my toe amputated

“ I didn't know much about cancer, heart disease and other health issues until I got sick. We need more young people to understand that they need to take care of their health from a very early age ”

2 Prevention

- c. Systems do not support the collection of standardised population health information to better understand the unmet health need
- d. Aboriginal patients have limited knowledge of the conditions/lifestyle choices that have major impacts and complications for their chronic disease e.g. smoking
- e. Resource limitations restrict the focus on Aboriginal people, with or at high risk of chronic disease, who can be optimally cared for in the community (general practice and other community based services)

“ I need a treatment plan to manage my emphysema as I was only told of the long term affects of smoking once I was diagnosed with this condition. I was told I needed to give up the smokes, exercise more and eat more healthy food because I wasn't doing this and had lots of health issues ”

3 Affordability

Cost to patient

- a. Cost of medication, transport, child care while receiving treatment, specialist appointments and limited bulk billing, patient and family member costs for extended stays (e.g. accommodation, meals, personal items) or for relocation to larger centres for services, cost of regular treatments and in-home care and equipment
- b. Aboriginal patient/community not understanding the care packages available to them (e.g. CAPAC, COMPAK, CACP), that is, if they are available at all

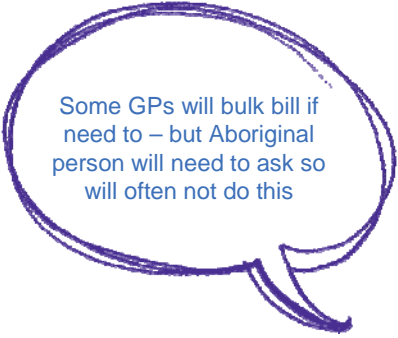
If we can't afford it we don't go to the appointments and we don't buy healthy food or the tablets we need

“ Unless you have someone working in Home Care and other places that provide these packages then our community just doesn't know about it and don't know where to go to ask ”

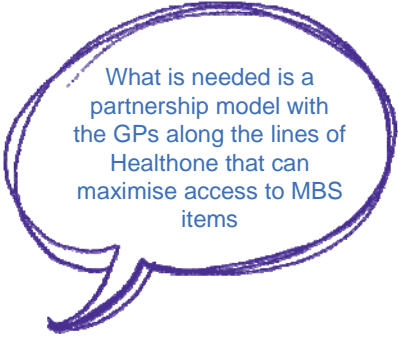
3 Affordability

Medicare and Pharmaceutical Benefits Scheme

- c. Lack of uptake of MBS/PBS/EPC reimbursement by GPs and specialists in the provision of care to Aboriginal patients



Some GPs will bulk bill if need to – but Aboriginal person will need to ask so will often not do this



What is needed is a partnership model with the GPs along the lines of Healthone that can maximise access to MBS items

“ HACC not aware of elderly Aboriginal problems therefore not accessing HACC, COMPAKs etc ”

4 Workforce

“ If we had Aboriginal male health workers employed they could make visits to the Aboriginal men in prison and be a liaison point between the mainstream doctors at the prison ”

Obtaining and retaining staff

- a. Lack of Aboriginal health workers (particularly male), Aboriginal nurses, Aboriginal health promotion workers, GPs etc
- b. Limited doctors in the prison system (particularly male doctors)
- c. Significant difficulty in attracting staff to rural communities
- d. AHS don't recruit positions for long periods and the difficulty recruiting, results in workforce vacancies and loss of corporate knowledge
- e. Lack of flexibility of staffing to conduct home visits/outreach
- f. Not enough flexible Aboriginal employee programs in health

4 Workforce

Education and training

- g. Lack of training and up skilling of Aboriginal workforce, where it is in place it is not always consistent
- h. Limited skills transfer currently occurring between mainstream and Aboriginal health service staff (e.g. not facilitating ATSI staff in AMS's to work in mainstream and mainstream staff work at AMS etc)
- i. Lack of understanding of roles of the AHW, ALO and AHEO etc and role descriptions do not allow movement between acute and community settings

“ The AMS health staff don't know what the mainstream health staff do and they don't know what we do ”

We, as ALO's need training on how to better educate Aboriginal clients on how they can access mainstream specific services for their specific health needs

5 Cultural sensitivity

Aboriginal culture considerations

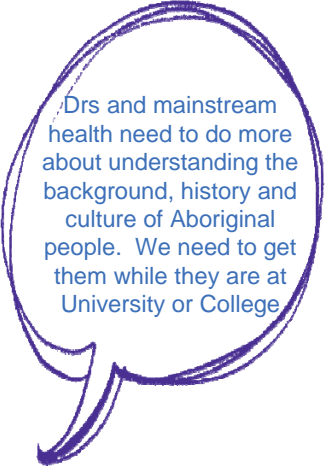
- a. Competing priorities of family and healthcare - family viewed as being of greater importance
- b. History and past experiences of family and friends (e.g. fear of death, child removal, past government practices and politics)
- c. Education/raising awareness of the community of mainstream service availability and how to access these services is limited
- d. Impact of men's business and women's business on way patients want their care delivered is not well understood by mainstream providers
- e. Transportation and finances are a major issue when considering healthcare, and sometimes if one of these isn't available, healthcare will wait

I prefer to go to the AMS to discuss 'personal women's health issues' because it is easier and I don't need to repeat myself and re-educate these doctors about Aboriginal women's business

5 Cultural sensitivity

Cultural awareness of mainstream providers

- f. Poor uptake of cultural training and limited availability of this training for mainstream providers, including GPs, therefore there is limited understanding of Aboriginal health and social issues, culture, values and priorities by these providers
- g. Racism/discrimination and not providing the same level of service as to non Aboriginal patients (whether real or perceived)
- h. Providers not taking the time to build trust with their Aboriginal patients and to make health messages tangible (e.g. ensuring they understand their medications and side effects) and to help them gain ownership of their disease

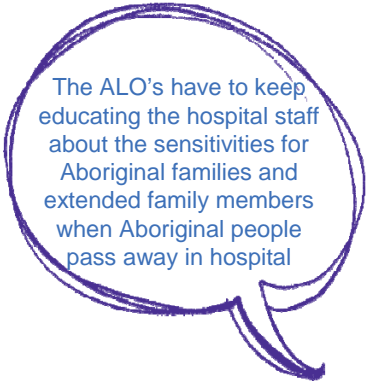


Drs and mainstream health need to do more about understanding the background, history and culture of Aboriginal people. We need to get them while they are at University or College

5 Cultural sensitivity

Cultural awareness of mainstream providers

- i. Aboriginal people not being provided with the choice of seeing a 'black face' when attending a mainstream service or any other identifier that Aboriginal people are welcome e.g. artwork, flag out front
- j. Mainstream providers may not be identifying who in the family has carer responsibilities/co-ordination for the patient and ensuring that they are engaged and supported
- k. The view is held by some mainstream providers that Aboriginal health is responsibility of Aboriginal Health Services
- l. Cultural awareness of safety and security: there are limited policies and procedures advertising Aboriginal issues/access



The ALO's have to keep educating the hospital staff about the sensitivities for Aboriginal families and extended family members when Aboriginal people pass away in hospital

“ I make the doctors feel comfortable when they look scared about me being Aboriginal ”

6 Infrastructure / accountability

Funding models

- a. Commonwealth/State funding split results in siloing of funding and does not promote continuity of care

Service infrastructure

- b. Staffing numbers are based on peak times and limited after hours services are provided
- c. Limited Aboriginal family rooms in hospitals
- d. Limited mainstream consultation with Aboriginal people about planning future health infrastructure (e.g. hospital clinics and units)

“ Many Indigenous people need access to after hour's acute care. The ALO's are going out at night a lot responding to calls from Aboriginal clients because they feel more comfortable calling us because they know us ”

6 Infrastructure / accountability

Accountability

- e. Treatment plans not being provided to Aboriginal patient so they can take ownership of their own health
- f. Services not understanding what one another provide and how to appropriately refer, therefore there is a siloing of services, or they are not getting referrals when the services are in place

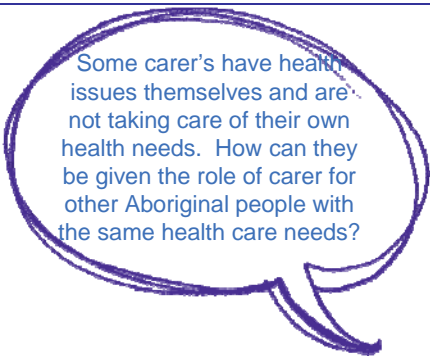
The mainstream plan provided was not clear and I needed to go through the health system before I knew and understood the details and the process I should take

“ I have all sorts of health issues and have never been provided with a written copy of my treatment plan ”

7 Communication

Communication with patients/community

- a. Aboriginal patients and carers receiving limited education on ATSI chronic care awareness
- b. Aboriginal patients/community don't know what services are being provided, the roles/responsibilities of staff, waiting times etc
- c. Carers not being made aware of support available to them
- d. Limited consultation with Aboriginal people about their specific health needs by mainstream services when planning for future changes to system
- e. Lack of training on appropriate communication between health workers and Aboriginal patients – i.e. ensuring language is appropriate and clear




Some carer's have health issues themselves and are not taking care of their own health needs. How can they be given the role of carer for other Aboriginal people with the same health care needs?

“ I don't understand what the doctors and nurses are saying to me when they explain the operation and tests I need to have and what I need to do. They don't write it down for me so I can ask other doctors at the AMS and my family members what it is all about ”

7 Communication

Communication with providers

- f. Poor communication within the AHS between services providers, hospitals, community health and with external providers (e.g. AMS)
- g. Stand alone systems lead to limited sharing of data and information
- h. Service entry criteria, health provider roles etc are not well known amongst service providers
- i. Relevant reports not getting to the people who have influence
- j. Communication regarding services doesn't promote the integration of mainstream and Aboriginal health services i.e. they are either 'black' or 'white' focused



Going from the Community to Area Health Service is a maze. It's problematic for primary health care staff let alone patients

“ We need to know what other providers are doing ”

Care provision

Recording of Aboriginality

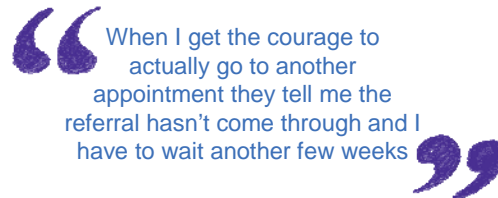
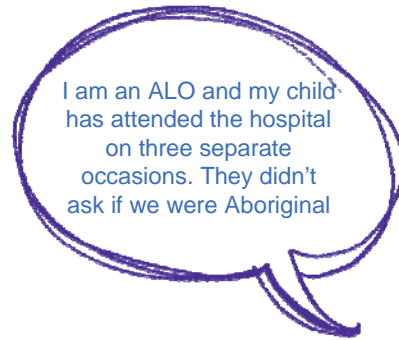
- a. Health care providers (including GPs) not asking the question of Aboriginality

Referral systems

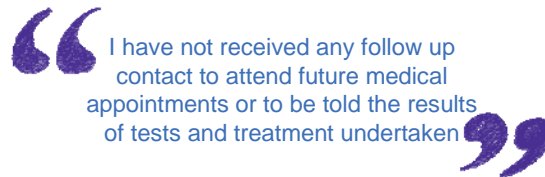
- b. Services not understanding how to appropriately refer patients to appropriate services

Screening/assessment

- c. No standardised tools for the screening and assessment of Aboriginal patients when they first present



Care provision



Provision of care

- d. Mainstream providers don't know the best model of care for their Aboriginal patients

Discharge process

- e. Discharge process does not facilitate links between services to share information about a patients discharge, care planning and follow-up care
- f. Lack of patient understanding post discharge about next steps but they may say they understand

Recall and follow-up

- g. Poor patient recall and follow-up

Appendix M Food for thought document

Chronic Care for Aboriginal People Project

Ideas for overcoming barriers to accessing health care by Aboriginal people

The aim of this document is to provide some ideas to AHSs to assist in thinking about solutions that will increase access to health services for Aboriginal people with or at risk of chronic disease. The ideas have been derived from a range of sources including feedback from Area Health Services (AHSs), patients and carers and experts. We hope that this document can be used to provide some inspiration or “food for thought” when considering ways to improve access; it should be noted that the solution ideas are not mutually exclusive and many address a number of barriers.

| Theme | Food for thought-Ideas for potential solutions |
|------------------|--|
| Geography | <p><i>Service Level Agreements (SLAs) for transports and accommodation</i></p> <ul style="list-style-type: none"> • Development of Service Level Agreements between AHSs and transport providers to provide transport for both short and long distance travel for Aboriginal people. <p><i>“Going to hospital” travel assistance fact sheet</i></p> <ul style="list-style-type: none"> • Identify financial assistance available for transport purposes from NSW Health eg petrol vouchers, cab charges. • Develop a culturally appropriate “Going to hospital” fact sheet specifically for Aboriginal people regarding available transport options, financial assistance and suitable and affordable accommodation for family members, including relevant contact details and guidance as to how to organise. Disseminate this information to Aboriginal community organisation, AMSs, primary care and community care centres. <p><i>Outreach services</i></p> <ul style="list-style-type: none"> • Develop outreach services targeting Aboriginal communities. Evidence² suggests that development of outreach services has the capacity to: <ul style="list-style-type: none"> - improve remote Aboriginal communities’ access to primary health care, specialist consultations, self-management programs, rehabilitation and prevention; - reduce patient travel costs, both monetary and non-monetary costs; and - improve communication and trust between health care staff and the Aboriginal patients. |

² NSW Health. (2003). Evaluation of the NSW Aboriginal Vascular Health Program. North Sydney: NSW Health. (2007). Adult Health Checks (AHC): Comprehensive early detection for chronic conditions in Aboriginal people. North Sydney: NSW Health; Gruen, R., & Bailie, R. (2000). Evaluation of the Specialist Outreach Service in the Top End of the Northern Territory. Menzies School of Health Research: NT.

| Theme | Food for thought-Ideas for potential solutions |
|--------------------------------|--|
| <p>Geography (cont)</p> | <p>Case Study-Specialist Outreach Service, Northern Territory</p> <p><i>The Specialist Outreach Service (SOS) was established in 1997 by Darwin-based specialist staff in Surgery and Obstetrics & Gynaecology and is supported by the Royal Australasian College of Surgeons and Royal Australian College of Obstetricians and Gynaecologists. The program is funded by the Commonwealth and Northern Territory Governments.</i></p> <p><i>This program was developed in response to the perceived problems of access to surgical, obstetric and Gynaecological specialists, for remote community people and Aboriginal people in particular. The emphasis of this program is on consultation with small Aboriginal communities.</i></p> <p><i>The objectives of the SOS project are:</i></p> <ul style="list-style-type: none"> • <i>developing a culturally appropriate service;</i> • <i>providing readily accessible consultations with specialists for people living in remote communities;</i> • <i>improving continuity of care, follow-up and recall; and</i> • <i>improving cross-cultural communications and trust between Aboriginal people and health staff.</i> <p><i>In order to improve access to health care for the Aboriginal people, effective links between the local health services and specialists from SOS have been established. For example, the remote community clinics provide a list of patients prior to visit, transport, a consulting room and a driver to collect patients, practical support, nurse, and AHWs.</i></p> <p><i>Achievements of the SOS include:</i></p> <ul style="list-style-type: none"> • <i>an increase in Aboriginal people from remote areas accessing medical specialists, with around 3647 consultations and procedures occurring in remote clinics between 1997 and 1999;</i> • <i>five times as many Aboriginal people being able to see a specialist in a local setting;</i> • <i>staff and patients reported higher doctor-patient communication;</i> • <i>increased development of trust</i> • <i>reduced travel; and</i> • <i>reduced anxiety, fear and loneliness.</i> • <i>The SOS program has proved beneficial in improving Aboriginal access in remote communities to health care and specialist services. Outreach provides a more efficient, effective and equitable service than traditional hospital outpatient for the people of remote communities in the top end of the Northern Territory.</i> <p><i>Community based one-stop shops</i></p> <ul style="list-style-type: none"> • <i>Establish multi-disciplinary clinics at AMSs or other Aboriginal community locations, whereby all relevant health professionals are at the same place on the same day to encourage greater access and prevent the need for multiple visits. For example the Primary Health Care Network in NT.</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| <p>Geography (cont)</p> | <p>Case Study-Primary Health Care Network (PHCN), NT</p> <p><i>Aboriginal people have the highest prevalence of diabetes in the nation, often associated with avoidable complications and hospitals admissions. Many of these complications can be managed with community based primary health care, and an integrated coordinated approach is key to providing effective comprehensive service to Aboriginal communities.</i></p> <p><i>The PHCN Project was implemented in 2003, focusing on best practice management of diabetes. According to the NRAHS Diabetes Health Outcomes database, only 7 Aboriginal people were seen by a Diabetes Educator at Casino Aboriginal Medical Service (AMS) between June and December 2003 for diabetes.</i></p> <p><i>To improve access to and provision of health services, consultation process with community elders, members and health professional took place to identify gaps in the services. Trust was also developed between the key partners and Aboriginal communities. In addition, Diabetes Complication and Assessment Clinics (DCAC) were established and are held monthly, providing a range of services, including screening for diabetes, eye testing etc.</i></p> <p><i>Importantly, the program took a holistic approach and clients, assessing each client for a range of health issues and risk factors. Health promotion activities, which were also implemented included media campaigns, Goorie Diabetes Manual and Goorie Good Food Coloring Books using Aboriginal Artwork.</i></p> |
| | <p><i>A follow-up study demonstrated significant improvements to Aboriginal people's access to chronic health care. First, the services developed by this program replaced multiple visits to a variety of specialists with a single comprehensive visit, improving the likelihood of Aboriginal people accessing health care service. The impact of such outcomes is demonstrated by the fact that prior to the implementation of the DCAC, 7 new clients with diabetes seen between Jan and June 2003. New clients seen by the by the PHCN increased to 65 (Jan-Dec 2004) an increase of above 460%, and 47 new clients in Jan-June 2005.</i></p> |
| <p>Prevention</p> | <p><i>Health assessment, risk screening and care planning</i></p> <ul style="list-style-type: none"> • <i>Develop screening and assessment tools to identify at risk patients, followed by implementation of appropriate care plans to promote chronic disease management, eg the Partnership for Aboriginal Care used a tailored health assessment or screening tool and then developed a care plan process and template which facilitated complex care planning, claiming of MBS items and supported self management.</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| Prevention (cont) | <p>Case Study-the Partnership for Aboriginal Care (PAC)</p> <p><i>PAC was established as a part of the second round of Coordinated Care Trials in 2002, The trial was located on the Mid North Coast of NSW, and operated as a whole-of-population trial. Today, PAC continues to be a formal partnership between the North Coast Area Health Service (NCAHS), Hunter New England Area Health Service (HNEAHS), Biripi AMS and Durri AMS and works in partnership with number of providers. PAC aims to improve the long term health outcomes of Aboriginal people through implementation of a flexible, sustainable whole of community approach to coordinated care, building on partnerships between community controlled health organisations, mainstream health organisations, other non-government organisations and private providers, and focusing on communities, people with complex needs and responding to identified health and related needs.</i></p> <p><i>Care coordination activities include:</i></p> <ul style="list-style-type: none"> • <i>assessment of participants using a standardised and comprehensive tool (the Ongoing Needs Identification Assessment (ONI)) and the collection of standardised health needs data across a large, rural population.</i> • <i>This tool was developed by the Centre for Health Service Development, University of Wollongong in conjunction with the Care unit Sponsors (The local AMS) and other Mid North Coast stakeholders;</i> • <i>standardised care planning activities to support a large population across different geographical areas to identify service needs and gaps across a regional setting;</i> • <i>Early Health Assessment of non-complex participants (population health) to prevent chronic disease, provide care planning for increased personal responsibility for health and detect illness ie self management; and</i> • <i>Health assessment and care planning delivered by a team of Care Officers and Registered Nurses.</i> <p><i>The assessment tool consisted of Initial Contact Information and seven health profiles: Living arrangements; Carer; Health conditions; Psychosocial; Functional; Health behaviours; and Environmental. Care Officers conduct ONI assessments (Care Officers are generally members of the local Aboriginal community who typically do not have a clinical background). Assessments are undertaken in the participant's home or at the care unit. Following health assessment Aboriginal people participate in a process of care planning tailored to the complexity of their needs.</i></p> <p><i>The Complex needs care planning tool was developed in consultation with the Division of GP's with specific reference to Enhanced Primary Care (EPC) planning practices.</i></p> <p><i>Self-management strategies were promoted by care officers and Registered Nurses (RNs) via the care planning processes. The population health care plans were centrally focused on self management, which aimed to provide participants with the opportunity to learn about their health and health behaviours. Personal responsibility for health and accessing services was encouraged by the care officers and the RNs. A similar approach was undertaken for complex care plans depending on the participant's health status.</i></p> <p><i>In addition the ONI facilitated electronic standardised data collection for all participating community members. Through collecting and inputting the assessment data, a database describing health status at the individual, community and regional levels was being compiled by the trial.</i></p> |
| | <p><i>Use of clinical pathways and guidelines</i></p> <ul style="list-style-type: none"> • <i>Promote use of clinical pathways and guidelines eg in the NT CARPA guidelines have been developed and endorsed by specialist physicians and have led to increased ability of primary health care workers to manage chronic disease in the primary care setting.</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| <p>Prevention (cont)</p> | <p>Case Study-CARPA-Standard Treatment Manual</p> <p><i>The Central Australian Rural Practitioners Association (CARPA) is an educational forum and support network for rural practitioners that began in 1984. Its sphere of influence has grown over the years to include the Central Australian regions of the Northern Territory, Western Australia, South Australia, the Top End of the Northern Territory and parts of Northern Queensland and Northern Western Australia. One of the main activities of CARPA is the production of the Standard Treatment Manual (STM) which has an established role as:</i></p> <ul style="list-style-type: none"> • <i>a population health approach to primary care in remote and Aboriginal Central Australia;</i> • <i>a resource for most appropriate clinical practice;</i> • <i>a guide for practitioner training programs;</i> • <i>a tool for standardising practice across the range of service providers;</i> • <i>a tool for updating 'best practice'; and</i> • <i>reassurance and checklist for experienced remote practitioners.</i> <p><i>The CARPA-STM has become the Territory Health Service endorsed manual for use in remote health centres throughout the Territory. It is also the main clinic handbook used in all Aboriginal health Services in the Territory and surrounding Central Australian region. The STM is intended for use by trained health professionals including Aboriginal Health Workers, nurses and doctors. It is not intended as a layperson's manual. It is primarily intended to be used in remote Aboriginal communities, rural and urban Aboriginal health services and for non-Aboriginal people living in these communities.</i></p> <p><i>Formal evaluations have been undertaken which have confirmed the local anecdotal reports of the manual being widely and regularly used and having established an important role in standardizing clinical practice and greatly helping remote staff face the challenges of remote (mostly Aboriginal Health) work.</i></p> <p><i>The 4th edition now has more than 100 topics, with expanded sections on mental health, chronic diseases and some additional general practice topics. The focus is on what to do, with previous detail on how to do it being replaced with references to the CRANA Clinical Procedures Manual for Remote and Rural Practice.</i></p> <p><i>Tailored self-management programs</i></p> <ul style="list-style-type: none"> • <i>Tailor self-management programs to meet the needs of Aboriginal people, eg Aunty Jean's Good Health Team, Illawarra; Pika Wiya AMS, Port Augusta.</i> |
| | <p>Case Study-Aunty Jean's Good Health Team</p> <p><i>Aunty Jean's Good Health Team Program, was established to meet the needs of Aboriginal people, including:</i></p> <ul style="list-style-type: none"> • <i>limited availability and access to culturally appropriate self-management programs;</i> • <i>lack of culturally appropriate support systems for individuals with chronic and complex care needs;</i> • <i>lack of ongoing culturally appropriate education programs for people with chronic illness;</i> • <i>the finding that many Aboriginal people with chronic illness are also caring for family members, and</i> • <i>the need to address the many issues identified around stress, financial concerns, illness, social isolation and family problems.</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| <p>Prevention (cont)</p> | <p>The aim of the program therefore, was to develop 'a combined model of health promotion, education and self-management that could be supportive of and sustain the development of good health behaviours and strategies for Aboriginal people with chronic and complex care needs'.</p> <p><i>The program was designed around 12 modules of one day per week in the supportive environment of the Aboriginal Community Centre, combined with a self managed and self-directed home program of activity over the same timeframe. To improve access to appropriate health care for chronic conditions and disease, the self-management program was implemented. The success of this developed program was attributed to the establishment of relationships within the community, between the community and allied health and health professionals. These partnerships were built on a firm base of experience, local leadership, capabilities and skills, and mutual respect and trust, through participation in previous people focused Aboriginal Health Promotion programs.</i></p> <p><i>Other factors influencing the success of the program, were:</i></p> <ul style="list-style-type: none"> • <i>leadership and involvement of Elders to better understand health outcomes for Aboriginal people;</i> • <i>developing more culturally appropriate health behaviours;</i> • <i>the motivational power of community aspirations for better health in the Aboriginal Community; and</i> • <i>location of the program within a safe community space.</i> |
| | <p>Case Study-the Better Living Diabetes Project, Dalby, St. George & Toowoomba, QLD³⁸</p> <p><i>The Better Living Diabetes project focuses on Aboriginal people who suffer from diabetes, with particular emphasis on non-insulin dependant people from all age groups. The project works with people with diabetes and their families within the Goondir service region. The Better Living Diabetes Project was established in response to a small study undertaken in 2001 exploring Aboriginal peoples experiences with diabetes and looked at what they believed would help them most to manage their illness.</i></p> <p><i>According to the authors of the article, the success of the Better Living Diabetes Project is because it incorporates the identified health care needs and uses an approach that is culturally appropriate.</i></p> <p><i>The goal of the project is to reduce the health impact of diabetes by educating people with diabetes and their families about diabetes and lifestyle changes. The strategies implemented in the project can be categorised into two areas, (1) Education and (2) Clinical support.</i></p> <p><i>Education occurs on two levels:</i></p> <ul style="list-style-type: none"> • <i>Education and Training of participants (patients)-for example, a newsletter entitled Sweet Gossip contained recipes suitable for people with diabetes, messages regarding the project, words of encouragement and other relevant diabetes information. This newsletter helped provide education and training on a regular basis. An additional successful activity was the introduction of regular cooking demonstrations, showing people how to cook healthy. By eating the cooked food together, there was an enhancement of a sense of community. A final important training component is the Healthy Weight Program, which covers a variety of topics including low fat cooking and physical activity.</i> • <i>Education and Training of health workers and staff-the training and education of health workers in relation to managing illness was conducted through the Flinders Chronic Disease Self-Management Program, which encourages self-management of chronic disease through individualised plans evoking change. This training provided health care staff with a holistic perspective of chronic disease management.</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| <p>Prevention (cont)</p> | <p><i>The clinical component of the Better Living Diabetes Project contains several important strategies, including:</i></p> <ul style="list-style-type: none"> • <i>regular health screenings; and</i> • <i>regular testing of Hba1c which provides information on how effectively the individual's diabetes is being controlled</i> <p><i>Approximately 50 men and women with diabetes from Toowoomba, Dalby, and St George have taken part in the project and are showing improvement not only in relation to their diabetes, but also their general wellbeing.</i></p> <p><i>Identification of Aboriginality</i></p> <ul style="list-style-type: none"> • <i>Establish comprehensive recording of Aboriginality by hospital and mainstream health organisation staff, through provision of training on the identification and recording of Aboriginal status at intake and during all levels of health service provided. It is important to ensure that all hospital staff ask clients that access its service if they are Aboriginal, to explain the benefits of identifying Aboriginality (particularly in relation to having access to an Aboriginal cultural service response and tailored clinical pathway) and that all information will be treated in a confidential manner.</i> • <i>Provide education sessions for Aboriginal people to raise awareness about the benefits of identifying their Aboriginal status to the health services system.</i> <p><i>Mentoring group</i></p> <ul style="list-style-type: none"> • <i>Development of Aboriginal mentoring groups to facilitate health promotion and prevention.</i> |
| | <p>Case Study-Men's Talking and Learning Circles</p> <p><i>The monthly men's group called Men's Talking and Learning Circles was established by SWAHS to engage men who did not usually access health services. Elders identified a need to develop strategies to support and mentor young boys as they lacked male role models. Many of the men in the boy's lives had died early or were in jail.</i></p> <p><i>Suggestions from this monthly group led to a camp for men and boys being organised, and funding successfully applied for. The camp then expanded to finish with a Men's Conference that could cater for larger numbers of attendees.</i></p> |
| | <p><i>Community health promotion activities</i></p> <ul style="list-style-type: none"> • <i>Develop health promotion programs with community organisations to undertake, for example, healthy cooking classes.</i> |
| | <p>Case Study-the Riverstone Aboriginal Diabetes Outreach Cooking Group</p> <p><i>The aim of the group is to provide the Aboriginal community of Riverstone with the knowledge and skills to lead a healthy lifestyle; to cook and consume healthy foods, to understand the contents on the packaging of foods, and to cook in a hygienic environment. The program also monitors the blood sugar and blood pressure readings of the participants within the cooking group on a weekly basis.</i></p> |

| Theme | Food for thought-Ideas for potential solutions |
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| Prevention (cont) | <p><i>Family targeted education</i></p> <ul style="list-style-type: none"> • Education to include family members when an illness is diagnosed in one member, to increase awareness of early warning signs of disease process and risk factors. • Flip charts to be produced to allow easy presentation of facts regarding the illness. |
| Affordability | <p><i>Promotion of bulk billing services</i></p> <ul style="list-style-type: none"> • AHS to identify bulk billing services in areas that have large populations of Aboriginal people and to promote these to Aboriginal and mainstream services. • Highlight that some specialists or GPs provide bulk billing if a request is made by an Aboriginal person, through use of a simple logo eg “This is a GP partner in care practice” and the poster could be prominently displayed that would cue the Aboriginal person to identify as Aboriginal, and ask for their entitlements or preferably be automatically offered there entitlements eg bulk billing, adult health check. <p><i>Personal care package</i></p> <ul style="list-style-type: none"> • Develop hospital personal care packages for Aboriginal patients (particularly Elders); identify funding sources to produce these packages and approach corporate sponsors to assist in providing the items for the packages. These packages to include for example: soap, shampoo and conditioner, incontinence pads, health service contact details, affordable short term accommodation for individuals on discharge and family members, bulk billing services available, cab charges, petrol vouchers, healthy food items. <p><i>Promotion of adult health check</i></p> <ul style="list-style-type: none"> • Develop performance related targets to promote uptake of adult health check and corresponding action, thereby promoting accountability. • Develop capacity for other health professionals to undertake and receive Medicare rebates for undertaking adult health checks-look at expanding Medicare item 710-Adult Health Check, in order to make it more flexible and incorporate health worker delivered services. |
| | <p>As in the Partnership for Aboriginal Care model (see Case Study in Section on Prevention)-health assessment and care planning documentation can be tailored to match the requirements for claiming Medicare items such as adult health checks or care planning. This could then potentially generate income to fund additional health staff including AHWs to undertake care planning activities and bring in further Medicare rebates, thereby making additional AHW-led services self funding.</p> |
| Workforce | <p><i>Training and Development of Aboriginal Health Workers (AHWs)</i></p> <ul style="list-style-type: none"> • Provide disease specific training to Aboriginal Health Workers via linkages with educators eg Diabetes Educator or via tailored education programs as per cardiovascular training to AHWs through partnerships with National Heart Foundation of Australia, the Sydney West Area Health Service, the Department of Technical and Further Education (New South Wales), New South Wales Health, the University of Western Sydney and the Western Sydney Aboriginal Community Controlled Medical Service. |

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| <p>Workforce (cont)</p> | <p>Case Study-Sustaining better diabetes care</p> <p><i>The Torres Strait Islands are located in far north east Australia and has a population of 9600 Aboriginal people. This population also has the highest prevalence of diabetes in Australia and many preventable associated complications.</i></p> <p><i>In 1999, a one year randomised cluster trial showed improved diabetes²⁸ care processes and reduced admissions to hospital when local Aboriginal Health Workers used registrars, recall and reminder systems and diabetes care plans. At this time, a specialist outreach service was also implemented.</i></p> <p><i>A three year follow-up³ of the 21 primary health care centres involved reviewed the strategies for change which were implemented in the cluster trial in 1999. These strategies for change included:</i></p> <ul style="list-style-type: none"> • <i>audit and feedback to clinicians and managers;</i> • <i>provision of clinical guidelines;</i> • <i>clear management structure; and</i> • <i>workshops and training (this study demonstrated training and education should be available to support staff using the protocols).</i> |
| | <p><i>Outcomes of this study were:</i></p> <ul style="list-style-type: none"> • <i>increased number of Aboriginal people on the registers, from 555 in 1999 to 921 in 2002;</i> • <i>improved processes and clinical interventions; and</i> • <i>reduced hospital admissions of Aboriginal people with diabetes, from 25% in 1999 to 20% in 2002.</i> <p><i>Such outcomes demonstrate that in remote Aboriginal settings, appropriate management structures, clinical support and clinical protocols, for Aboriginal people with diabetes can lead to improvements in care processes, access to health care services, and reduced complications that result in admission to hospital.</i></p> |
| | <p><i>Development of Aboriginal health positions such as:</i></p> <ul style="list-style-type: none"> • <i>Develop condition-specific roles for Aboriginal people, including specialised training, for example Aboriginal Health Workers with specific training in chronic disease.</i> • <i>Develop Aboriginal health promotion positions in partnership with the Aboriginal community, AMSs and community health centres in locations with high populations of Aboriginal people with chronic conditions.</i> • <i>Develop role of Aboriginal GP liaison nurse.</i> |

³ McDermott, R., Tulip, F., Schmidt, B., & Sinha, A. (2003). Sustaining better diabetes care in remote Indigenous Australian communities. *British Medical Journal*, 327, 428-430.

| Theme | Food for thought-Ideas for potential solutions |
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| Workforce (cont) | <p>Case Study-Justice Health Aboriginal Mental Health Worker Trainee</p> <p><i>The Aboriginal Mental Health Worker Trainee Program employs Aboriginal people as full-time permanent employees of a mental health or drug and alcohol service. The positions are recruited as Trainees and supported in acquiring a recognised degree such as the Bachelor of Health Science (Mental Health) degree as a condition of employment. The Justice Health-Adolescent Health Trainee is placed with the Justice Health-Adolescent Court and Community Team (Justice Health-ACCT). The Trainees are supported through an integrated system of peer support, on the job training and supervision. Justice Health-ACCT works with young people in contact, or at risk of contact with the criminal justice system as well as working closely with other agencies to assist in the assessment and management of the mental health needs of these young people.</i></p> |
| | <p><i>Provide opportunities for training of Aboriginal people linked with employment</i></p> |
| | <p>Aboriginal Employment and Training</p> <p><i>SSWAHS is offering 16 Aboriginal & Torres Strait Islander Traineeships in the following Health positions and the opportunity to complete the related Certificate III course whilst employed on a full time basis for 2 years:</i></p> <p><i>Pharmacy Assistant</i></p> <p><i>Dental Assistant</i></p> <p><i>Administration Officer</i></p> <p><i>Allied Health Assistant</i></p> <p><i>Sterilising Technician</i></p> |
| | <p><i>Increase in male Aboriginal Health Workers</i></p> <p><i>Extension of the Aboriginal Employment Strategy to include Aboriginal male health worker positions within rural and regional areas to encourage greater participation of Aboriginal men in exercise programs, health living and eating information sessions and regular adult health checks.</i></p> |
| Cultural sensitivity | <p><i>Develop culturally appropriate health programs</i></p> <ul style="list-style-type: none"> • <i>Develop programs in areas of high need that are tailored specifically to the needs of Aboriginal people, eg NSW Aboriginal Maternal and Infant Health Strategy.</i> |
| | <p>Case study-NSW Aboriginal Maternal and Infant Health Strategy</p> <p><i>The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) was funded by NSW Health in December 2000 and commenced implementation in 2001. The goal was to improve the health of Aboriginal women during pregnancy and decrease perinatal morbidity and mortality.</i></p> <p><i>The AMIHS was established to address the following barriers to Aboriginal women accessing mainstream services:</i></p> <ul style="list-style-type: none"> • <i>many rural areas do not have public antenatal services available for women through their local hospital although women give birth in these centres;</i> • <i>most hospital-based services provide fragmented care. Research has clearly shown that childbearing women prefer continuity of care and carer;</i> |

| Theme | Food for thought-Ideas for potential solutions |
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| <p>Cultural sensitivity (cont)</p> | <ul style="list-style-type: none"> • <i>the bureaucratic nature of most mainstream public services means that women choose not to attend. For example, inflexible clinic appointments, long waits for appointments and expecting women to make their own way to the hospital, which is often on the outskirts of town with limited public transport; and</i> • <i>antenatal care with a GP was expensive and often entailed long waits in the waiting room, particularly if the GP had to go to the hospital to attend a birth.</i> <p><i>The Strategy included:</i></p> <ul style="list-style-type: none"> • <i>seven targeted antenatal/postnatal programs for Aboriginal women and infants across six of the former Area Health Services, representing 20 Local Government Areas (LGAs);</i> • <i>a state-wide Training and Support Program for midwives and Aboriginal Health Workers who provide these services; and</i> • <i>a formal evaluation.</i> <p><i>In five of the former Area Health Services (AHS), a community midwife and Aboriginal Health Worker (AHW) or Aboriginal Health Education Officer (AHEO) team were established to provide community-based services for Aboriginal women in conjunction with existing medical, midwifery, paediatric and child and family health staff. A sixth AHS chose to initially provide a community development program across the AHS. In 2003, this AHS commenced clinic services at specific sites due to an identified need. Community development programs have been designed by all the AMIHS programs in varying degrees. The aim of these community development programs is to address structural factors and achieve social change by encouraging and enabling communities to take control of factors that contribute to ill health.</i></p> <p><i>The success of the program was attributed to</i></p> <ul style="list-style-type: none"> • <i>the inclusion of an Aboriginal person on the team enabling the teams to provide culturally appropriate care (with the midwives receiving unique cultural awareness training). Aboriginal women were particularly positive about the level of continuity provided by a culturally appropriate caregiver that the AMIHS provided;</i> • <i>being based in the community was a considerable advantage for women, especially those AMIHS programs based within an AMS. This meant that women could receive care, often close to home and in familiar surroundings. Attending a hospital or GP rooms was unfamiliar and often inaccessible;</i> • <i>the strong partnerships that have developed as a result of AMIHS being located in Aboriginal community controlled health services; and</i> • <i>the team approach, where an AHW/AHEO and a midwife work together in a primary health care model to provide continuity of care.</i> <p><i>The aim of the AMIHS is to provide an enabling primary health care model. Services that are provided in community-based settings, especially those in community controlled organisations, have a higher capacity for an enabling model of care. Access to holistic, culturally appropriate services are essential elements of a primary health care approach.</i></p> <p><i>The recent evaluation has concluded that the AMIHS is achieving its goals in relation to the provision of antenatal and postnatal care and has demonstrated improvements in perinatal morbidity and mortality rates.</i></p> |

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| <p>Cultural sensitivity (cont)</p> | <p><i>Environmental changes</i></p> <ul style="list-style-type: none"> • Make health services more welcoming and familiar to Aboriginal people by making changes to health service environment to include: <ul style="list-style-type: none"> - Aboriginal health posters, artwork and artifacts; - Aboriginal symbols and flags so that the building can be identified; and - Appropriate signage in the form of a recognition plaque of the traditional owners/custodians to the land. <p><i>Develop cultural competence in all health service staff</i></p> <ul style="list-style-type: none"> • Introduce mandatory Aboriginal cultural awareness sessions for all health service staff. AHSs to work with NSW Health and AMSs to develop and deliver specifically tailored programs, including awareness of Aboriginal family obligations and priorities which will supersede appointments and meetings. Priority for delivery to be to staff who have regular and particularly face to face interactions with Aboriginal people eg receptionists, case workers, clinicians, nurses, outreach workers and emergency services staff at hospitals. • Research has suggested that misconceptions held by health professionals about patient engagement impacted upon patient management of their chronic disease and proved detrimental to relationships and communication between health professionals and patients. In NT they have set up a training program to facilitate changing health professionals' attitudes and beliefs in this area, which has led to improvements in chronic disease management amongst Aboriginal patients. |
| | <p>Case Study-Culturally Appropriate Health Services, Inala, QLD</p> <p><i>Inala is an urban area in Queensland, with an Aboriginal population of approximately 8% of the total population. A review conducted by the Inala Health Centre General Practice identified problems concerning poor access to health care services by the Aboriginal and Torres Strait Islander people.</i></p> <p><i>In response, an intervention was implemented in July 1995, covering five important strategies, which were aimed at increasing Aboriginal people's access to Inala Health Centre General Practice. The strategies included employing an Aboriginal person in the Centre, purchasing culturally appropriate health posters and artifacts for the centre to make Aboriginal people feel more at home, providing cultural awareness talks to all staff within the centre, disseminating information into the Aboriginal community about what services are available at the centre and promoting intersectoral collaboration.</i></p> |

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| Cultural sensitivity (cont) | <p><i>Before implementation the centre was not well used by local Aboriginal people, recording only 12 Aboriginal patient contacts in one year. After implementation there were 890 Aboriginal patient contacts in the first year of implementation, increasing to 3894 in 2000-01, demonstrating that these strategies have been highly successful in improving Aboriginal people's access to health services.</i></p> |
| | <p><i>Gender specific clinics</i></p> <ul style="list-style-type: none"> • Recognise the importance of distinguishing between women's and men's business and health issues and therefore holding gender-specific clinics. <p><i>Assessment of organisational cultural sensitivity</i></p> <ul style="list-style-type: none"> • Develop and implement an audit tool to assess the cultural appropriateness of programs, eg the Partnership for Aboriginal Care is applying a tool that has been sourced from Ngwala Willumbong Co-operative Ltd, an Aboriginal Drug and Alcohol organisation in Victoria. |
| | <p>Case Study-the Partnership for Aboriginal Care (PAC) assessment of Drug and Alcohol Services</p> <p><i>PAC has been leading a project to assist organisations, within a quality assurance framework, by examining the cultural appropriateness of programs addressing substance misuse within the local Aboriginal communities. A key outcome of the project will be the development of resources and training to ensure an integrated approach in the delivery of culturally appropriate Drug and Alcohol services on the Mid North Coast.</i></p> <p><i>Phase one of the project involves the review of current service delivery for Aboriginal people accessing participating organisations utilising a self reporting tool, completed by individual organisations. This tool has been sourced from Ngwala Willumbong Co-operative Ltd, Victoria.</i></p> <p>The key elements of this tool include a checklist of service features and the respondent needs to state how well the statement reflects their organisation's current situation.</p> |

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| <p>Cultural sensitivity (cont)</p> | <p><i>Examples include:</i></p> <p>Operational policies, procedures and practices</p> <ul style="list-style-type: none"> • <i>Our Vision Statement has a statement about diversity which also refers to the provision of services to Aboriginal people.</i> • <i>All staff are aware of the organisations policies and procedures which relate to the provision of services to Aboriginal people.</i> • <i>The employment of Aboriginal people is supported through our employment policy.</i> • <i>Our staff regularly consult with representatives and staff from Aboriginal agencies.</i> • <i>Our Organisation utilises current information about the Aboriginal population in our catchments area when planning and evaluating service programs and practices.</i> <p>Physical environment</p> <ul style="list-style-type: none"> • <i>The waiting area is suitable for large families and groups, with a suitable area for children.</i> • <i>If an Aboriginal client needs to fill out forms, these are user-friendly⁴ and assistance is available.</i> • <i>The appearance and design of the waiting room is friendly and welcoming, with appropriate images to help Aboriginal clients feel comfortable (eg Aboriginal artwork, posters).</i> • <i>Information materials about Aboriginal agencies, services and programs are on display in our waiting areas.</i> • <i>Information materials, advising of our services, are produced in consultation with representatives of local Aboriginal community groups and agencies.</i> <p>Staff Development</p> <ul style="list-style-type: none"> • <i>Adequate resources are allocated for staff to receive Aboriginal Cross Cultural Awareness Training activities.</i> • <i>Staff are provided with an orientation package that includes a component about Aboriginal culture, beliefs, values and history, including past and present experiences.</i> |
| | <ul style="list-style-type: none"> • <i>Ongoing, mandatory, professional development programs are available to staff to enable them to respond effectively to the needs of Aboriginal people.</i> • <i>Staff have a demonstrated knowledge and understanding of Aboriginal cultural values and history.</i> <p><i>Staff demonstrate interpersonal skills (eg empathy, a sensitive voice, appropriate body language) when working with Aboriginal clients.</i></p> |

⁴ 1. The 'friendliness' of our forms has been assessed through feedback from

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| <p>Infrastructure/ accountability</p> | <p><i>Community partnerships</i></p> <ul style="list-style-type: none"> • Establish an Area Health Service Aboriginal Services Partnership Group for Community Health Service organisations to provide a forum for key staff to participate in discussions with various Aboriginal Community stakeholder groups within their service delivery areas in order to strengthen service delivery to, and access by, Aboriginal people in their Region. <p>The forum could be run twice a year and incorporate all interested mainstream community and health services. Mainstream community and health services would need to identify if they are interested in providing a small amount of administrative support to the Partnership Group for organising and hosting meetings. Otherwise, the Area Health Service Manager could provide secretariat support for this forum.</p> <p>The forum would enable:</p> <ul style="list-style-type: none"> - information to be shared about initiatives to improve health and well-being outcomes for Aboriginal people in each of the Area Health Service Regions; and - opportunities to be identified to improve and strengthen service delivery and access issues through coordinated responses to issues, needs and priorities identified by local Aboriginal clients and organisations. <ul style="list-style-type: none"> • NSW Health and Area Health Services coordinate a meeting with interested Aboriginal community members and Aboriginal organisations in their areas to discuss the development of a Partnership Agreement that supports culturally appropriate engagement practices and the delivery of and access to culturally appropriate health services. The purpose of this Partnership would be to commit all parties to a long-term collaborative relationship, accepting shared responsibility for strengthening the foundations for the achievement of health and wellbeing in the community. The key objectives of this Agreement could include: <ul style="list-style-type: none"> - improving access by Aboriginal people to mainstream health services; - enhancing service quality through increasing cultural awareness and appropriateness; - facilitating better community engagement and participation; and - increasing Aboriginal specific services and employment opportunities. <p>Ensure appropriate representation of community members on planning groups, to ensure input by Aboriginal people into service planning and development.</p> |

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| <p>Infrastructure/ accountability (cont)</p> | <p>Case Study-Aboriginal Health Promotion and Chronic Care Partnership, Victoria</p> <p><i>In response to the significant inequalities in the health status and access to health care services of Aboriginal populations, the Victorian government allocated \$1.7 million in 2005-2006 (\$7.06 million over four years). The Aboriginal Health Promotion and Chronic Care (AHPACC) partnership was therefore established in order to prevent and better manage chronic disease in Aboriginal people, across nine geographical areas in Victoria.</i></p> <p><i>The aim of the AHPACC partnership is to improve access for Aboriginal people to culturally appropriate health care. The AHPACC partnership supports community health services and Aboriginal community controlled health organisations to work collaboratively to improve health outcomes for Aboriginal people with, or at risk of, chronic disease.</i></p> <p><i>The vision of the AHPACC partnership is: “Aboriginal Victorians can access primary health care that is culturally respectful and addresses aspects of health including prevention, promotion and treatment, underpinned by principles of self-determination and collaboration, and endeavors to achieve a quality of life for Aboriginal people, equal wit all other Victorians.”</i></p> <p><i>This vision will be achieved through:</i></p> <p><i>increased access to primary health care services by Aboriginal Victorians;</i></p> <ul style="list-style-type: none"> • <i>improved clinical service delivery, coordination and continuity of care, and support for chronic disease self-management approaches;</i> • <i>coordinated approaches to health promotion planning, implementation and evaluation by building upon other programs;</i> • <i>increased capacity of Community Health Services (CHS) in the provision of culturally sensitive services; and</i> • <i>workforce development and organisational support for both Aboriginal and mainstream workers.</i> <p><i>Expected long-term outcomes include:</i></p> <ul style="list-style-type: none"> • <i>improved access by Aboriginal Victorians to primary health care services;</i> • <i>improvement in process indicators related to health outcomes for Aboriginal Victorians with chronic disease or at risk of chronic disease;</i> • <i>enhanced delivery of comprehensive primary health care services by community health services to Aboriginal Victorians;</i> • <i>reduction in hospital admission for chronic disease complications;</i> • <i>strengthened collaborative relationships between Aboriginal Community Controlled Health Organisations and Community Health Services; and</i> • <i>increased capacity of the Aboriginal workforce in planning and delivering health promotion, chronic disease prevention and chronic disease management services for Aboriginal Victorians.</i> |

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| <p>Infrastructure/ accountability (cont)</p> | <p>Case Study-Partnership between Maari Ma Health Aboriginal Corporation and GWAHS</p> <p><i>Partnerships between ACCHs and AHSs are critical to achieving improved health outcomes for Aboriginal populations. In the Remote Cluster of GWAHS a unique partnership arrangement exists between GWAHS and Maari Ma Health Aboriginal Corporation.</i></p> <p><i>Communities within the Remote Cluster have a significant and sometimes predominant Aboriginal population and generally suffer poorer health status than their Eastern counterparts. Maari Ma Health Aboriginal Corporation has management responsibility for the health services within this Cluster, excluding Broken Hill.</i></p> <p><i>The unique management structure ensures that an Aboriginal perspective is imbedded into all management decisions and those are reflective of community need. There is an increased focus on primary health care and prevention. An example of this is the Maari Ma Chronic Disease Strategy which focuses on starting well and staying healthy. This Strategy is being systematically implemented across all services in Remote Cluster to address and control Chronic Disease amongst Aboriginal communities.</i></p> <p><i>A review of the partnership arrangement has recently been published (Griew R and Houston S, 2007, Review of the Lower Western Sector Agreement Greater Western Area Health Service and Maari Ma Health Aboriginal Corporation). The Review found, in relation to health outcomes, significant improvements had been achieved both in access to antenatal care in the first 20 weeks of pregnancy and for vaccine preventable hospitalisations for the Aboriginal population covered by the Agreement. The Review also noted encouraging trends for premature and low birth weights and falling rates of hospitalisations for ambulatory care preventable health conditions.</i></p> |
| | <p><i>Engage carers</i></p> <ul style="list-style-type: none"> • Hold community based forums to engage carers on the importance of following health care treatment plans and the type of assistance that can be provided by mainstream services. <p><i>Develop linkages between specialists and primary health care</i></p> <ul style="list-style-type: none"> • Break down silos and promote visibility and accessibility of specialists to primary care practitioners through the development of partnerships between AHSs and primary care organisations. |
| | <p><i>Performance indicators</i></p> <ul style="list-style-type: none"> • Develop performance indicators that are everyone’s responsibility, not just the CEs, eg increasing the number of Aboriginal people accessing rehabilitation services for their chronic disease, could be a performance indicator for all health professionals working in this field, including those responsible for referral, delivery and the managers responsible for these staff up to CE level. <p>Delivering culturally appropriate services to Aboriginal people and establishing partnerships and agreements with Aboriginal Medical Services could be some ideas for developing performance indicators for all health professionals working in chronic care.</p> |

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| <p>Infrastructure/ accountability (cont)</p> | <p><i>Culturally specific educational and health promotional materials</i></p> <ul style="list-style-type: none"> • Develop education and health promotion material that is clear and simple to read and understand, avoiding medical jargon and utilising culturally specific pictures and examples. Disseminate materials to Aboriginal services and community organisations as well as patients. <p><i>Communication training</i></p> <ul style="list-style-type: none"> • Provide staff with intercultural communication training, to enable Aboriginal people to make informed choices in the context of their culture and language. • Provide Aboriginal liaison people with training to prepare them for work within the healthcare setting. • Promote strategies to monitor the effectiveness of communication and to repair the negative consequences of miscommunication. • Develop educational resources to facilitate a shared understanding of (a) physiological processes and treatment options; and (b) cultural, social and economic realities confronting Aboriginal patients and their families. |
| | <p>Case Study-‘Sharing the True Stories (STTS)’ Longitudinal Participatory Action Research Project, NT</p> <p><i>The STTS project developed as a result of the Yolngu, and other Aboriginal people’s, dissatisfaction with the explanations provided by doctors, nurses and other health professionals in renal and hospital services. They believed they were not being told the ‘true story’.</i></p> <p><i>The project focuses on Yolngu language speakers from North-East Arnhem Land communities and Aboriginal patients with end-stage renal disease (ESRD), and was conducted from January 2001 to June 2005.</i></p> <p><i>The aim of the project was :</i></p> <p><i>“to improve health outcomes for Aboriginal client groups by addressing the three key areas for change management, namely to improve cultural communication, develop shared understandings and educational resource, thereby enabling Aboriginal patients and their families to exercise more control in their health care, specifically in interactions with predominately non-Aboriginal health staff.”</i></p> <p><i>Strategies implemented to improve staff-patient communication, and thus in turn access to appropriate health care services, included:</i></p> <ul style="list-style-type: none"> • <i>installation of a toll-free number for in-calls to the renal unit and distribution of an information card with key telephone numbers for medical, housing and income support. While it is a small initiative, it provides Aboriginal patients with more control over their health care, and facilitates more effective staff-patients communication about social and medical concerns;</i> • <i>restructured the renal unit to better accommodate the needs and preferences of the patients eg people with the same language attended meetings to talk and discuss matters;</i> • <i>institutionalise use of interpreters at the Nightcliff Renal Unit;</i> • <i>Aboriginal Cultural Awareness Program;</i> • <i>opening a training facility for self-care home haemodialysis for Aboriginal patients and supporting kin;</i> • <i>‘Bush Tucker’ trips in Darwin were arranged on a regular basis to build trust and shift the balance of power. In this context it was the Aboriginal patients who became the experts and the staff became the learners; and</i> |

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| Infrastructure/ accountability (cont) | <ul style="list-style-type: none"> development of educational media resources on the respiratory and circulatory systems, kidney function and haemodialysis, known as ‘machine stories’. <p>“Balance between different points of views is possible. That’s what our Yolngu life is all about. Balancing difference between Yirritja and Dhuwa, between men and women and so on.”</p> |
| Communication | <p><i>Culturally specific care card</i></p> <ul style="list-style-type: none"> Develop a patient-held care card including information about diagnosis, management, treatment, self-management guidance and appointments, as well as screening prompts and checks. The care card is an initiative being looked at by Justice Health and would involve a pocket size card, collating essential health care information in a format that’s easy to carry and would fit in a wallet or trouser pocket. <p><i>Use Aboriginal specific examples</i></p> <p>Providing information that people can understand eg comparing the type of diet to combat chronic disease with a bush tucker diet; this demonstrates a culturally specific example at the same time as showing that you value traditional knowledge.</p> |
| Provision of care | <p><i>Promote ongoing disease management</i></p> <p>Develop risk registers and support systems to promote ongoing management of chronic disease and coordinated care</p> |
| | <p>Case Study-Juvenile Justice Centre Release Treatment Scheme (JJCRTS) Pilot Project</p> <p><i>The JJCRTS pilot project is designed to improve the number of young people accessing healthcare in the community following release from custody. The project aims to demonstrate that supported healthcare follow-up following custodial release leads to increased healthcare engagement with family/carers and improved treatment engagement.</i></p> <p><i>It is hoped that recidivism rates are reduced, and return to employment/ education is improved as well. Participants have to have an identified drug and/or alcohol problem. Physical and mental health issues were also included with the Health Professional providing a link between custodial-based services and community based services.</i></p> |
| | <p><i>The population served by this project are primarily from disadvantaged backgrounds- characterised by family disruption, poor education, risk taking behaviour and poor health status. There is a very high prevalence of Drug and Alcohol and Mental Health issues. 80 percent of the Young People in the Orana Detention centre served by this project are Aboriginal.</i></p> <p><i>This project aims for improvements in primary health care, including oral health, drug and alcohol, mental and population health. Importance is placed on medication management. The JJCRTS Health Professional was recruited in November 2005 with the position being filled by a Clinical Nurse Consultant (CNC). The CNC acts as a link between custodial and community health services including medical, drug & alcohol and mental health services provided by the Area Health Service, GPs, NGOs and Aboriginal Medical Services. To assess the effectiveness of the first twelve months of the project a non-blinded randomised controlled trial methodology was implemented. This trial involved participants being placed in either the intervention group or to usual care (control) group. Outcome measures were collected for both groups.</i></p> |

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| <p>Provision of care (cont)</p> | <p><i>Data from the project at the twelve-month point indicates that young people allocated to the JJCRTS group at three-month had:</i></p> <ul style="list-style-type: none"> • <i>Greater improvements in their level of access to health care (84% for JJCRTS group against 53% for usual care group)</i> • <i>Improved levels of engagement with their family/carer(s) with respect to health care (82% for JJCRTS group)</i> • <i>Improved their adherence to treatment plans (35% for JJCRTS group)</i> • <i>The mean number of weeks since previous admission to a DJJ centre improved more for the JJCRTS group (4.3 weeks longer) than for the usual care group (1.0 week shorter)</i> <p><i>In addition to this young people on the JJCRTS program indicated a strong preference to continue contact with the JJCRTS Health Professional. There was also wide acceptance of the program amongst Justice Health and DJJ staff involved with the project.</i></p> <p><i>Risk register, recall and reminder systems</i></p> <ul style="list-style-type: none"> • <i>Development of a risk register, complemented by an electronic recall and reminder system for patients identified to be with or at risk of chronic disease.</i> |
| | <p>Case Study-Torres Strait Islander Diabetes Service</p> <p><i>The Torres Strait Island people have an extremely high prevalence of type 2 diabetes (a total of 26% of the adult population). In addition, Torres Strait Islanders experience high rates of preventable complications, high rates of hospitalisations due to these complications, and poor access to specialist diabetes services.</i></p> <p><i>A recent study by McDermott et.al. (2001) was carried out, in response to increasing evidence supporting that improved care and access to care of people with diabetes in a community setting leads to reduced diabetes complications. The aim of this study was to find the best way to translate this into practice in the remote clinics of the Torres Strait and Northern Peninsula Area Health Service District.</i></p> <p><i>First, the program established a diabetes outreach service to provide direct assistance to the communities involved. In addition, 8 (out of the 21) clinics were randomly selected for the establishment of a paper-based recall and reminder system, which was used for routine diabetes care and managed by local health workers. Health workers were also given basic diabetes care training, as well as receiving bi-monthly newsletters and attending mid-project workshops.</i></p> <p><i>McDermott et. Al. (2001) found that most measures of good diabetes care had improved in all centers, demonstrating significant improvements of access to good health care for the Aboriginal community. In clinics where the recall and reminder system was in place they had performed 21% better than those without a system. In addition, people with diabetes who were treated at clinics with the recall system were 40% less likely than those treated at other centres to have been hospitalised for a diabetes related condition.</i></p> <p><i>Two years later, McDermott et. Al. (2003) completed a follow-up study, finding that significant improvements were sustained two years after the end of the trial. The improvements in diabetes care and outcomes where recall systems were managed by local health workers, as described above, suggests that greater health access and gains can be made by supporting local Aboriginal community based chronic disease care systems. Priorities of this project now also include increasing the availability and affordability of good food, achieving weight loss and increasing appropriate used of hypoglycaemic agents.</i></p> |

Food for thought document

| Theme | Food for thought-Ideas for potential solutions |
|---------------------------------|---|
| Provision of care (cont) | <i>Improved patient medication management through use of support systems</i> <ul style="list-style-type: none">• Use of dosette boxes or Webster packs.• Provision of culturally appropriate verbal and written information on medications, including affects of medications, frequency of use, cheaper alternatives and implications of not taking medications. |

Abbreviations

| | |
|----------------|--|
| AHS | Area Health Service |
| AHW | Aboriginal Health Worker |
| AHEO | Aboriginal Health Education Officer |
| AHMRC | Aboriginal Health and Medical Research Council |
| ALO | Aboriginal Liaison Officer |
| AMIHS | Aboriginal Maternal and Infant Health Strategy |
| AMS | Aboriginal Medical Service |
| ACCHS | Aboriginal Community Controlled Health Setting |
| CARPA | Central Australian Rural Practitioners Association |
| CE | Chief Executive |
| DCAC | Diabetes Complication and Assessment Clinics |
| EPC | Enhanced Primary Care |
| FWAHS | Far West Area Health Service |
| GWAHS | Greater Western Area Health Service |
| GP | General Practitioner |
| GWAHS | Greater Southern Area Health Service |
| HNEH | Hunter New England Area Health Service |
| Justice Health | Justice Health |
| LGA | Local government area |

Food for thought document

| | |
|---------|---|
| NCAHS | North Coast Area Health Service |
| NSCCAHS | North Sydney Central Coast Area Health service |
| NGO | Non Government Organisation |
| ONI | Ongoing Needs Identification |
| PAC | Partnership for Aboriginal Care |
| PHCN | Primary Health Care Network |
| RN | Registered Nurse |
| SESI | Sydney East Sydney Illawara Area Health Service |
| SLA | Service Level Agreement |
| SOS | Specialist Outreach Service |
| SSWAHS | Sydney South West Area Health Service |
| STM | Standard Treatment Manual |
| SWAHS | Sydney West Area Health Service |

Appendix N State-wide workshop attendees

| Name | AHS / Position |
|---------------------|--|
| Gail Daylight | Area Manager Aboriginal Health, SESIAHS |
| Julie Dixon | A/PPP, SESIAHS |
| Charmaine Maron | Chronic Care, SESIAHS |
| Wendy Sue Forder | Clinical Coordinator La Perouse Aboriginal Community Health Centre |
| Kay Stewart | SESIAS AHEO |
| Jean Turner | SESIAS Aboriginal Vascular Health Coordinator |
| David Follent | SESIAS OM Coordinator |
| Beverly Crowther | SESIAS OM Coordinator |
| Eunice Simons | SESIAS Project Manager CRU |
| Bronia Kandl | SESIAS Cardiac Rehabilitation Clinic |
| Matthew Daly | CEO NSCCAHS |
| LaVerne Bellear | Area Director Aboriginal Health, NSCCAHS |
| Coralie Lifu | NSCCAHS Aboriginal CC Coordinator |
| Annette Marley | NSCCAHS Acting Chronic Care Manager |
| Vicki Wade | SSWAHS Director for Aboriginal Health |
| George Long | SSWAHS A/Director AH |
| Louise Conry | SSWAHS EO to the DON and MS |
| Stephen Johnson | SSWAHS Director CRU |
| Maureen Hanly | Justice Health |
| Ian Sinnett | Justice Health |
| Jenny Graham | Justice Health |
| Mary Fitzsimon | Justice Health |
| Aghia Gunawan | Justice Health |
| Elizabeth McEntyre | Manager Aboriginal Health, Justice Health |
| Libby Johns | AVHP Coordinator Justice Health |
| Paul Van Den Dolder | A/Director Adolescent Health, Justice Health |
| Heather Baker | Justice Health Service Director Women's Health |
| Kerry Wilcox | Cardiac Services Coordinator, NCAHS |
| Vahid Saberi | DPPP, NCAHS |
| Anthony Franks | NCAHS Manager Aboriginal Health |
| Jeff Richardson | CEO DHARAH AMS Casino |
| Wendy Moore | Snr Manager "Partnership" GWAHS AHMT |
| David Peebles | GWAHS Chronic Care Coordinator |

State-wide workshop attendees

| Name | AHS / Position |
|---------------------|--|
| Craig Shields | GWAHS Manager CSR |
| Angela Hudson | Practice Development HNE |
| Tina Pidcock | Aboriginal Practice Development Office, HNE |
| Lee Simpson | GSAGS-Program Developer/ Coordinator Aboriginal Health |
| Marjo Roshier-Taks | GSAHS Manager Medical, chronic and palliative care |
| Trish Heal | SWAHS AHU A/Manager Programs |
| Elaine Buggy | SWAHS Mgr. Chronic care and strategic initiatives |
| Michelle Honey | Project coordinator GSAHS Redesign |
| Alex Swain | The Alliance of NSW Divisions: Aboriginal Health Coordinator |
| Kerrie Goldston | Heart Foundation Senior Manager Clinical Issues |
| Glenn Power | Area Stream Manager Aged Chronic & Community |
| Margaret Teuma | Assistant Director OATSIH (DOHA) |
| Tony O' Connel | NSW Health |
| Raj Verma | NSW Health |
| Ashley Young | NSW Health |
| Raylene Gordon | NSW Health |
| Lynette Mieni | NSW Health |
| Lisa Donnelly | NSW Health |
| Erica Gray | NSW Health |
| Robyn Speerin | NSW Chronic Care Program HSPIB |
| Kim Stewart | A/Director Aboriginal, Health |
| Anne-Marie Feyer | PricewaterhouseCoopers |
| John Walsh | PricewaterhouseCoopers |
| Christine Callaghan | PricewaterhouseCoopers |
| Ray Quigley | PricewaterhouseCoopers |
| Rebecca Jessop | PricewaterhouseCoopers |
| Deanna Pyper | PricewaterhouseCoopers |
| Elizabeth Sweeney | PricewaterhouseCoopers |

Note: not everyone signed the attendance form.