



SA ABORIGINAL
CHRONIC DISEASE
CONSORTIUM

South Australian Aboriginal Heart and Stroke Plan

2022 – 2027

The South Australian Health and Medical Research Institute acknowledges, that the revised South Australian Aboriginal Heart and Stroke Plan 2022-2027 has been funded and supported by the Government of South Australia through the Department for Health and Wellbeing.

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South Australian Aboriginal Heart and Stroke Plan 2022-2027.

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Produced by the SA Aboriginal Chronic Disease Consortium



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ACKNOWLEDGMENT OF COUNTRY

The South Australian Aboriginal Chronic Disease Consortium acknowledges and celebrates that Aboriginal and Torres Strait Islander people are the Traditional Custodians of the land, known as Australia.

We recognise that Aboriginal and Torres Strait Islander people are the First Peoples of Australia and that within these two distinct cultural groups, there is great cultural diversity.

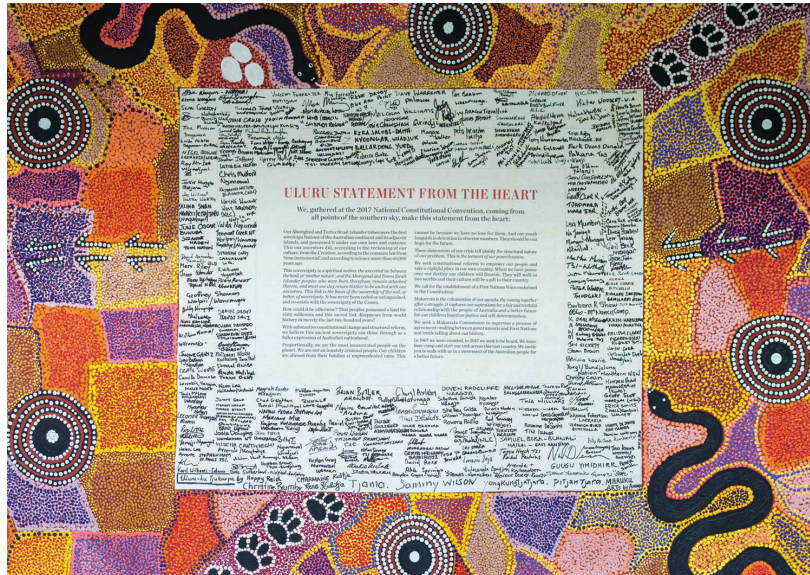
We acknowledge and pay our respects to the Aboriginal people across South Australia, Elders, past and present, their continuing connection to this land and thriving cultural practices and knowledge.

Preface

The First People of Australia, the Aboriginal and Torres Strait Islander people, were living strong and well within what is now called South Australia. In large part, this was a consequence of maintaining strong connections to lore, Country, culture, health, family, kinship, ceremony, and spirit prior to the dispossession and dispersal of the First People of Australia. The policies that led to the active disempowerment and disenfranchisement of Aboriginal people are directly linked to the types of differential outcomes that can be seen in Aboriginal health, housing, employment and education outcomes now. It is worth noting that poor health and wellbeing also leads to a reduced economic base for Aboriginal families and communities in South Australia, and that the strength of a community's economic base is itself a determinant of health. These dynamics are important considerations for a strategic, statewide approach to cardiovascular care in South Australia.

The Uluru Statement From the Heart

Over 250 Aboriginal and Torres Strait Islander delegates from across Australia, gathered at the First Nations National Constitutional Convention held in Mutitjulu, located at the base of Uluru, in May 2017. The Uluru Statement from the Heart (Uluru Statement) was released by delegates of this Convention. The Uluru Statement was an invitation for all Australian people to walk with Aboriginal and Torres Strait Islander people, to create a better future for all Australians. This future can only be achieved once the effects of colonisation are acknowledged and Aboriginal and Torres Strait Islander people can share their truths, their history.



The SA Aboriginal Chronic Disease Consortium recognises the generous invitation from Aboriginal and Torres Strait Islander people through the Uluru Statement and remains supportive of the call for greater self-determination and truth telling. The path towards rightful recognition of Aboriginal and Torres Strait Islander people in Australia's history needs to be re-forged now that the referendum on constitutional recognition was unsuccessful. Regardless of this, and now more than ever, the Consortium remains committed to listening to the voices of Aboriginal and Torres Strait Islander people, and we are pleased to see the South Australian Voice to Parliament progress. The Consortium also recognises the importance of Aboriginal and Torres Strait Islander people's self-determination, which is inevitably linked with health outcomes. An improvement is seen in health outcomes when Aboriginal and Torres Strait Islander people take control of their health.

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Acknowledgements

The Revised Plan

The SA Aboriginal Chronic Disease Consortium would like to acknowledge and pay respect to the traditional custodians of the area now called South Australia. We recognise the first peoples of Australia and the longest continuous living culture in the world. We recognise the injustices of the past and that Aboriginal people do not experience the same equality of rights and life expectancy as other Australians. We respect the resilience of Aboriginal people in the face of adversity.

We would like to acknowledge the South Australian Aboriginal Chronic Disease Consortium Heart and Stroke Leadership Group and other key stakeholders (see Appendix A) for their oversight and expert advice that has informed the revision of the SA Aboriginal Heart and Stroke Plan.

We acknowledge our funder SA Health.

Use of the Term 'Aboriginal'

The plan uses the term 'Aboriginal' to describe the people and communities, for whose benefit this plan is written, in recognition of the traditional owners of the lands now called South Australia.

The authors of the plan acknowledge the diversity of the people, families, and communities, who live in South Australia, which includes people from various Aboriginal and / or Torres Strait Islander backgrounds. The impacts of colonisation and past policies, still felt by many Aboriginal and Torres Strait Islander people today, have resulted in some complexities associated with traditional ownership, country and a sense of home and belonging. The authors would like to iterate that this plan is for the benefit of all, and the choice of terminology intends to respectfully acknowledge custodianship in accordance with Aboriginal traditions and customs.

The term Torres Strait Islander is specifically used where reference is made to Aboriginal and/or Torres Strait Islander people at a national level or where it is used in position titles and titles of publications and programs.

Background and Methodology

The SA Aboriginal Chronic Disease Consortium (the Consortium) was developed in 2017 to implement the original SA Aboriginal Heart and Stroke Plan 2017-2021 in conjunction with the SA Aboriginal Diabetes Strategy 2017-2021 and the SA Aboriginal Cancer Control Plan 2017-2021. The Consortium is a collaboration between Aboriginal communities, services, providers, organisations and system managers to reduce the impact of chronic disease experienced by Aboriginal people through delivery of coordinated, evidence-based, culturally responsive care.

The 2022-2027 Plan builds on the South Australian Aboriginal Heart and Stroke Plan 2017-2021.¹ The purpose of this Plan was to improve cardiovascular (CV) care and reduce CV morbidity of Aboriginal people in South Australia (SA).

In early 2015, the Wardliparingga Aboriginal Research Unit was commissioned by SA Health to develop a statewide plan to guide service development and the reorientation of services to improve CV care and outcomes for Aboriginal people over a five-year period. The Plan was built on the work undertaken in 'The Better Cardiac Care for Aboriginal and Torres Strait Islander People' (BCC). The BCC was a national project that focused on improving Aboriginal CV health. It was developed by the Australian Health Ministers' Advisory Council (AHMAC) with all states asked to implement this project in their state². The SA Aboriginal Heart and Stroke Plan 2017-2021 was SA Health's response to this agenda. In addition to developing this Plan, the strategies and enablers contained within this document were mapped against the BCC actions and measures.

The original Plan was guided by an expert Steering Committee, a Community Reference Group and consultations conducted with external agencies and communities through Roundtables and meetings. These stakeholders had a shared vision of improving

CV care and reducing CV morbidity and mortality for Aboriginal Peoples in SA. As the SA Aboriginal Heart and Stroke 2017-2022 Plan was designed to be a living document, it would be updated to reflect the latest evidence, policy, and practice changes at the end of its implementation date.

For the revision of this plan, the Consortium Coordinating Centre (CCC) identified and invited a broad range of stakeholders into the review process. These included the Aboriginal Community Controlled Health Sector, the SA Aboriginal Consortium's Heart and Stroke

Leadership Group and Consortium Executive Group, the Department for Health and Wellbeing Senior Officers Group on Aboriginal Health (SOGAH) and other stakeholders, including Aboriginal health professionals with expertise in cardiovascular disease (CVD) care, stakeholders who were either program leads or involved in CVD programs or initiatives and representatives from metropolitan, rural and remote SA. Stakeholders were invited to provide feedback to the CCC through written response or verbally via a face-to-face or online meeting.

Updates and amendments have been made to actions under most priority areas and new evidence has been included where available. A dedicated section with key enablers has been developed and structured to align with the revised SA Aboriginal Diabetes Plan 2022-2027 and the SA Aboriginal Cancer Plan 2022-2027, to enable implementation of priorities, that span across the 3 plans, through collaborative partnerships, and to facilitate across-plan monitoring and evaluation. The purpose, vision and goal remained unchanged from the original plan.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACS	Acute Coronary Syndromes
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHCSA	Aboriginal Health Council of SA
AHW/P	Aboriginal Health Worker/Practitioner
ALO	Aboriginal Liaison Officer
APY Lands	Anangu Pitjantjatjara Yankunytjatjara
BCC	Better Cardiac Care
BPG	Benzathine Penicillin G
CCC	Consortium Coordinating Centre
CQI	Continuous Quality Improvement
CT	Computerised Tomography
CTG	Closing the Gap
CV	Cardiovascular
CVD	Cardiovascular Disease
DVA	Department of Veteran Affairs
ECG	Electrocardiogram
EDs	Emergency Departments
GP	General Practitioners
Health Check	Aboriginal and Torres Strait Islander Peoples Health Check (MBS 715 or similar)
iCCnet RSS	Integrated Cardiovascular Clinical Network, Rural Support Service
LHNs	Local Health Networks
MBS	Medicare Benefit Schedule
MRI	Magnetic Resonance Imaging
NDIS	National Disability Insurance Scheme
NSQHS Standards	National Safety and Quality Health Service Standards
PATS	Patient Assistance Transport Scheme
PHC	Primary Health Care
POCT	Point of Care Testing
RAAHS	Remote Area Aboriginal Health Service
RFDS	Royal Flying Doctors Service
RHD	Rheumatic Heart Disease
SAAS	SA Ambulance Service
SDH	Social Determinants of Health
TCP	Transition Care Program
TIA	Transient Ischaemic Attack

Executive Summary

The South Australian Aboriginal Heart and Stroke Plan 2022-2027 (hereafter referred to as the Plan) has 5 priority areas with 21 actions and 8 enablers that are essential for effective delivery of this Plan.

The actions in this plan prioritise a statewide response to heart and stroke. The Plan focuses on 'evidence-based, culturally appropriate cardiovascular services' that should be provided across the life course and continuum of care.

To ensure that the implementation of this plan is successful, it will require a responsible governance structure and stakeholders who are committed to and demonstrate the will to make a positive difference in the lives of Aboriginal peoples in South Australia. Although it is a Plan that responds to the needs of Aboriginal communities, partnerships need to be established not only with Aboriginal organisations but with mainstream services and other non-Aboriginal organisations. This is to ensure that the health system is responsive and accountable to meet the diverse and everchanging needs of community. To do this will require a coordinated approach across all services and care level types. This means that the system will need to work together and communicate effectively with each other if real change is to be achieved.

Priority Areas and Actions

Cross-Sector Services

1. Review and reorient current mechanisms to improve delivery of culturally appropriate comprehensive primary health care services.
2. Develop a statewide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks based on greatest demand or need.
3. Maintain and expand the existing SA Rheumatic Heart Disease Control Program.
4. Enhance care for the identification, acute and ongoing care of children and adolescents with heart disease and stroke by paediatric cardiology services, with effective transition pathways into adult cardiology services.

Primary Preventive Care

5. Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s across SA.
6. Increase the use of cardiovascular risk assessment and management in all primary care settings.

Clinical Suspicion of Disease

7. Develop and implement a model of care and referral pathways to provide timely access to non-acute diagnostic services for identification and management of disease.
8. Establish a coordinated statewide specialist outreach service plan.

Acute Episode Care

9. Increase awareness of the warning signs and symptoms of heart attack and stroke among the Aboriginal community and service providers.
10. Improve access to emergency care by reducing the out-of-pocket costs of ambulance services.
11. Establish a system to identify Aboriginal or Torres Strait Islander status at the first point of medical contact.
12. Develop and implement a transfer and retrieval services protocol that responds to the clinical and cultural needs of Aboriginal people.
13. a) Maintain and expand iCCnet, Rural Support Service to provide coordinated services from first medical contact to definitive care for regional and remote Aboriginal clients with acute heart disease.
b) Implement a regional system of care from first medical contact to definitive care for regional and remote Aboriginal clients with stroke or Transient Ischaemic Attack (TIA).

-
14. a) Provide best practice clinical and cultural care for Aboriginal clients with heart disease at all South Australian hospitals, with targeted efforts at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Port Augusta Hospital and Ceduna Hospital.
b) Provide best practice clinical and cultural care for Aboriginal stroke clients at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Riverland General Hospital, Mount Gambier, Districts Health Service, Whyalla Hospital, Port Lincoln Hospital, Port Pirie Hospital, Wallaroo Hospital and Naracoorte Hospital.
 15. Establish and maintain where existing, an Aboriginal heart and stroke Aboriginal Health Practitioner/Nurse Coordinator position at Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Port Augusta Hospital and Ceduna Hospital to support Aboriginal clients and their families throughout their journey of care.
 16. Develop a statewide approach to a rheumatic valvular surgery centre of excellence.

Ongoing Care

17. Develop a model of care and protocols to provide patient centred and safe discharge from hospitals.
18. Develop a central referral service that ensures continuity of care from hospital to primary care, specialist follow-up and cardiac/stroke rehabilitation.
19. Establish a model of culturally appropriate, evidence-based cardiac and stroke rehabilitation services.
20. Build capacity in primary health care to provide coordinated management, secondary prevention and ongoing care for clients with established disease.
21. Establish culturally appropriate models of care and protocols for palliative and end of life care specifically for Aboriginal clients.

Enablers

1. Governance: Aboriginal Leadership and Partnerships

Establish and maintain robust governance structures, led by Aboriginal professionals and organisations, equipped to foster partnerships and collaboration between the wide range of organisations and stakeholders responsible for implementing this Plan.

2. Sustainable Funding

Establish and maintain robust governance structures, led by Aboriginal professionals and organisations, equipped to foster partnerships and collaboration between the wide range of organisations and stakeholders responsible for implementing this Plan.

3. A Strong Heart and Stroke Workforce

Increase the capacity and capability of the Aboriginal and non-Aboriginal workforce to provide high quality, culturally responsive, collaborative CVD care.

4. Transport and Accommodation Support

Improve access to health care through transportation (ensuring Aboriginal people have safe and appropriate home-to-care-to-home journeys) and culturally appropriate accommodation options for Aboriginal people.

5. Information and Communications Technology (ICT) Solutions

Invest in resources, coordination and systems for telehealth and virtual care. Also improve the utilisation and communication of information across patient information management systems.

6. Community Engagement

Meaningful engagement of Aboriginal people, families and communities must underpin the design and implementation of projects and services associated with this Plan.

7. Integrated and Coordinated Services

Achieve continuity of care for Aboriginal people with CVD through culturally responsive, integrated and coordinated services.

8. Monitoring and Evaluation

Monitor and evaluate the implementation of the Plan and health system changes that result in better health care of Aboriginal people.

Introduction

Cardiovascular disease is a chronic disease that is the biggest contributor to preventable mortality in Aboriginal communities.³ Although there has been a 40% reduction in CVD mortality in the past few decades, it still contributes to a quarter of deaths and 21% of premature years of life lost for Aboriginal and Torres Strait Islander people.³ Furthermore, CVD-related mortality and CVD events are observed in the Aboriginal population 10-20 years earlier than the rest of the population.³

To continue to improve upon CV outcomes for Aboriginal peoples in South Australia, the Heart and Stroke Plan 2017-2021¹ was refreshed to reflect changes in evidence, policy, and practice.

To ensure that culturally appropriate cardiovascular care is provided, it is described throughout the Plan. Extensive input was provided from the Community Reference Group and other key stakeholders to develop this definition.

Purpose

To guide the delivery of evidence-based services for the prevention and management of those at risk of, and with, CV disease in South Australia.

Vision

To improve CV care and reduce CV morbidity and mortality for Aboriginal Peoples in South Australia.

Audience

The Plan has been developed for policy makers, government and non-government organisations, health care professionals and researchers who are involved in the prevention, treatment, management, and monitoring of CV.

Time Frame

The time frame for the Heart and Stroke Plan is five-years (2022-2027). At the time of writing this plan, it reflected the current health system and its structure. The authors acknowledge that during the five-years of implementation, there are likely to be changes to the health system and its structure. Therefore, the Heart and Stroke Plan will need to adapt to these changes as they occur. It is expected that at the end of each year (commencing from 2023), an annual review will be conducted to map what activities have been completed against each of the actions and priority areas and whether any adaptations to the Heart and Stroke Plan are required. This work will be conducted by the member organisations of the SA Aboriginal Chronic Disease Consortium in partnership with the CCC.

Measuring Progress

The Heart and Stroke Plan contains a monitoring progress table that is located on pages 51-53. At the end of each implementation year, the progress made against each action will be mapped using a traffic light system approach. This work will be conducted by the CCC in partnership with member organisations of the SA Aboriginal Chronic Disease Consortium.

The monitoring and evaluation framework developed for the three chronic disease plans (2016-2021), will be reviewed by the CCC in partnership with the Aboriginal Community Reference Group, Executive Group and the Heart and Stroke Leadership Group. The aim of this review is to identify key indicators that can be used by stakeholders to measure progress against the SA Aboriginal Heart and Stroke Plan 2022-2027.

Targets

1. Increase identification and management of those at high cardiovascular risk.
2. Reduce the rate of 30 day and 12-month unplanned re-hospitalisations following an acute heart or stroke event.
3. Reduce the age-standardised mortality rate for CV conditions (recognises differences in population age structures).

A snapshot of heart disease and stroke in the Aboriginal population

Nationally

- Chronic diseases are responsible for 70% of the disease burden gap between Aboriginal and Torres Strait Islander Australians and other Australians.⁴
- CVD accounts for 23% of the difference in premature mortality (years of life lost) and 14% of difference in premature morbidity (disability adjusted life years).⁵
- Aboriginal and Torres Strait Islander adults are 1.3 times as likely to have high blood pressure compared to non-Aboriginal adults.⁶
- Aboriginal and Torres Strait Islander women are nearly twice as likely to have CVD compared to non-Aboriginal women.⁷
- The overall diagnosis rate of RHD for Aboriginal and Torres Strait Islander people are more than 15 times the rate of non-Aboriginal people.⁸
- In 2016-2020, 476 deaths were reported among people with RHD in Queensland, Western Australian, South Australia and the Northern Territory. Of these, 322 people (68%) were Aboriginal and Torres Strait Islander people.⁹

South Australia

- Cardiovascular disease represents the largest cause of death for Aboriginal South Australians (26%).¹
- Coronary heart disease accounts for over half of all Aboriginal CV deaths (56%).¹
- Coronary heart disease accounted for nearly half of CVD hospitalisations of Aboriginal people.¹

Foundations for a healthy life

The *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*¹⁰, identifies four foundations that are key for a healthy life. These include;

1. Holistic health and wellbeing

‘Supporting Aboriginal and Torres Strait Islander people’s close connections and interactions with the mental, physical, cultural, environmental and spiritual health of their communities, and with society more broadly’.¹⁰

2. Cultural determinants of health

Protective factors that support good health and wellbeing, strengthen identity and enhance resilience (see protective factors page 12). It has also referred to as ‘the ways of knowing, being and doing that encompass a holistic Aboriginal and Torres Strait Islander understanding of health and wellbeing’.¹⁰

3. Social determinants of health

To achieve health equity of Aboriginal and Torres Strait Islander people, the social determinants of health (SDH) need to be addressed. The SDH ‘are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.’¹¹ It contributes to the health gap (34%) between Aboriginal and Torres Strait Islander people and non-Aboriginal people.¹⁰

4. A life course approach

‘Aboriginal and Torres Strait Islander people view health and wellbeing as involving the whole community throughout the entire life course.’ This perspective places the emphasis on wellbeing and health factors that occur at particular transition points at different stages of life.¹⁰

Risk and protective factors

It is known that the risk factors for developing CV diseases are multiple and complex. However, there are known **protective factors** that can support good health of Aboriginal people. The Mayi Kuwayu National Study of Aboriginal and Torres Strait Islander Wellbeing¹⁰ and other work¹² have identified a series of cultural determinants that act as protective factors. In addition to supporting good health, these factors support social and emotional wellbeing, strengthen identity, and enhance resilience.

Below is a brief list of protective, modifiable, and non-modifiable risk factors.

Protective factors

- Connection to Country
- Language
- Family, kinship and community
- Leadership
- Beliefs and knowledge
- Self-determination
- Cultural expression and continuity.

Modifiable risk factors

Factors that can usually be controlled by lifestyle modification and/or medication. Examples are:

- Poor nutrition
- Physical inactivity
- Smoking
- Consumption of alcohol and drugs
- Stress and worry (psychological distress).

Non-modifiable risk factors

Factors that cannot be controlled. Examples are:

- Age
- Gender
- Family history

Conditions covered in the Plan

The SA Aboriginal Heart and Stroke Plan covers the following conditions:

Cardiac disease, including:

- Coronary Heart Disease (also known as ischaemic heart disease): Including Acute Coronary Syndromes (ACS) [ACS includes angina and myocardial infarction]
- Acute Rheumatic Fever and Rheumatic Heart Disease (RHD)
- Heart Failure
- Atrial Fibrillation
- Hypertension

Cerebrovascular disease, including:

- Ischaemic and Haemorrhagic Stroke

Vascular disease, including:

- Atherosclerosis
- Peripheral vascular disease

The SA Aboriginal Heart and Stroke Plan 2022-2027

The Plan is driven by the following three elements:

1. Clients, family and community:

The individual, their family and community must be positioned at the centre of all stages of care. A holistic approach should acknowledge the physical, social, emotional, cultural, and spiritual aspects which make up the individual and collective wellbeing and ensure that all aspects of wellbeing are considered during diagnosis, treatment, management, and ongoing care

2. Evidence-based, culturally appropriate cardiovascular services:

Should be accessible to all Aboriginal people in SA and provided across the life course and continuum of care.

3. Essential enablers for effective strategy implementation:

These enablers are critical to facilitate the effective delivery of evidence-based, culturally appropriate CV services.

As in the previous plan, there are **5 priority areas** with **21 actions** (previously referred to as service strategies) and **8 enablers**, that need to be implemented. These actions provide a roadmap for service providers across SA on how to improve CV outcomes for Aboriginal people living and receiving CV care in this state.

Guiding Principles for the SA Aboriginal Heart and Stroke Plan

The following 13 principles should guide the implementation of the South Australian Aboriginal Heart and Stroke Plan.

- 1. Ensure equity in access to services**

Access to and the provision of health care services should be based on need.
- 2. Use a holistic approach in the provision of services**

Always consider each individual's physical, spiritual, cultural, emotional and social well-being and recognise the impact of the social determinants on health when determining the type and method of care.
- 3. Build local capacity to deliver patient-centred services**

Invest in local services and build local expertise to ensure there is capacity to deliver quality services where there is need.
- 4. A patient family-centred approach to service provision**

Wherever possible and agreed, family members and carers should be involved in the provision of care including care planning, decision making and education.
- 5. Invest in building relationships with Aboriginal people**

The development of trusting relationships with Aboriginal people should be prioritised by staff and services during the planning, delivery and evaluation of health care.
- 6. Provide culturally safe health care services**

Services must be culturally appropriate and safe for clients and their families. This includes zero tolerance of racism.
- 7. Services should be underpinned by cultural knowledge and scientific evidence**

Health practitioners should seek to learn from and respect Aboriginal and Torres Strait Islander peoples' cultural knowledge as well use the best available scientific evidence to inform practice.
- 8. Invest in Aboriginal leadership and Aboriginal staff in services provision**

Aboriginal people must be given opportunities to lead and deliver services with the support of non-Aboriginal colleagues.
- 9. Prioritise prevention activities whenever possible**

Wellness and prevention activities should be prioritised at all stages of the care continuum with clients and their families.
- 10. Involve all key stakeholders, including community voice in governance**

All key stakeholders, which includes community voice, should be included in the governance structure that addresses both the clinical and cultural needs of the plan.
- 11. Promote a system that encourages innovation and adaptation**

Develop a system that promotes and enables innovation and adaptation as knowledge, skills and experience evolve.
- 12. Zero tolerance of racism**

Individuals and health service staff must actively work to reduce racism within health services. Leaders in health care must actively work to reduce institutional racism.
- 13. Ensure system wide and service accountability**

Ensure accountability through prioritising monitoring and evaluation against the plan.

Priority issues identified by the Aboriginal community, health service providers, clinicians, and policy makers

During the development of the SA Aboriginal Heart and Stroke Plan 2016-2021, there were a range of issues and priorities identified from widespread consultations with Aboriginal people and communities, health service providers, clinicians, and policy makers.

In this revised version of the Plan, many of the priorities identified remain the same. Summarised below are the issues of concern (not listed in a particular order) and suggestions of what needs to be done.

Access to culturally appropriate services

Services need to be sensitive to the needs of Aboriginal people. This should include access to traditional healers including Ngangkari services.

Access to accommodation

Address accommodation concerns for clients coming from regional and remote locations and their escorts to Adelaide.

Build on existing effective services

Services that were already operating effectively were recognised by community members and services providers. It was suggested that these should be built on with secure, ongoing funding and support.

Comprehensive primary health care services

Access to general practice services that bulk bill, can provide Closing the Gap (CTG) services (including scripts for CTG medications), and are linked to interdisciplinary services.

Cost of ambulance services

Increase access to SA Ambulance Services in an emergency by increasing use of ambulance insurance and using systems that are already in place to reduce the burden of out-of-pocket costs.

Identification of Aboriginal or Torres Strait Islander status

Identifying Aboriginal clients at the first point of medical contact and sharing this information with specialist services as they help triage clients was supported by clinicians across the system.

Identification needs to become a standard procedure that is built into systems for all to use. It must become “the norm” for staff to ask, collect and record Aboriginal or Torres Strait Islander status. All clients should be supported to feel comfortable in providing information on how they identify.

Issues with workforce

Investment is needed across the sector, including primary healthcare, hospitals, and rehabilitation services, to increase cultural awareness and cultural capability. Developing the cardiovascular workforce is widely identified by all stakeholders as a priority.

Lack of transport is a major barrier to access

Lack of transport is an issue at all stages of the client journey. There is a need for a scheme that supports the needs for clients, regardless of where they live.

Gain insights from experiences and evidence from other regions and jurisdictions

Learnings from across SA and nationally can be shared, and experiences from one sector or phase of care can be considered across others.

Linking ACCHOs to acute service providers

Connecting Aboriginal Community Controlled Health Organisations (ACCHOs) to acute service providers in terms of emergency protocols, pre-admission and discharge referral pathways, specialist services and ongoing training and development was highlighted.

Links to Rural Support Service; iCCnet and SA Telestroke Service, disease identification and management and video conferencing services should be prioritised.

Clients are often lost in the system, especially post-discharge

Better coordination from hospitals to primary health service providers and specialists can ensure follow-up and rehabilitation services are available.

Prevention a community priority

Prevention-based education and culturally appropriate health promotion activities targeted from early age are important. Also, raising awareness of risk factors related to heart attack and stroke and the impact and extent these conditions have on the Aboriginal community. Activities should also include the sharing of personal stories.

Racism

Provision of culturally respectful health services free of racism and which address the needs of Aboriginal people is required.

Cultural context

Culture is a foundation of health and wellbeing for Aboriginal and Torres Strait Islander people.

It is understood that there is no single Australian Aboriginal or Torres Strait Islander culture or group and that there are many diverse communities, language groups and kinships throughout Australia. It is also recognised that Aboriginal and Torres Strait Islander people currently live in metropolitan, rural and remote settings, practice westernised, traditional, or other lifestyles, and may frequently move between these ways of living. The strong connection to culture is important to Aboriginal and Torres Strait Islander people and should be both acknowledged and respected for each individual and their CV story/pathway, especially the link between culture, land, and CV health.

What is Aboriginal health?

In the National Aboriginal and Torres Strait Islander Health Plan, Aboriginal Health is defined in the following way;

'Aboriginal health means not just the physical wellbeing of an individual but refers to the social, emotional, and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.'¹⁰

What is culturally appropriate care?

All care provided by services for Aboriginal and Torres Strait Islander people should be conducted in a manner which is tailored to an individual in connection with their family, community, culture, spirituality, and Country. It is important to recognise and understand the diversity of Aboriginal people across SA. There are many differing cultural profiles, norms and practices operating within this state and for Aboriginal clients who travel from interstate. Care must be respectful and culturally sensitive to take account of their particular circumstances.

Diagram 1 shows the relationship between services that are: available, accessible, acceptable, and affordable (outermost circle) and also highlights four main features that are vital to delivering culturally appropriate care: culturally safe services; holistic care; clinically and culturally capable workforce; and best practice care (adapted from Davy et al 2016; see diagram 1)¹³. The needs of individuals and communities should be considered in relation to each feature.

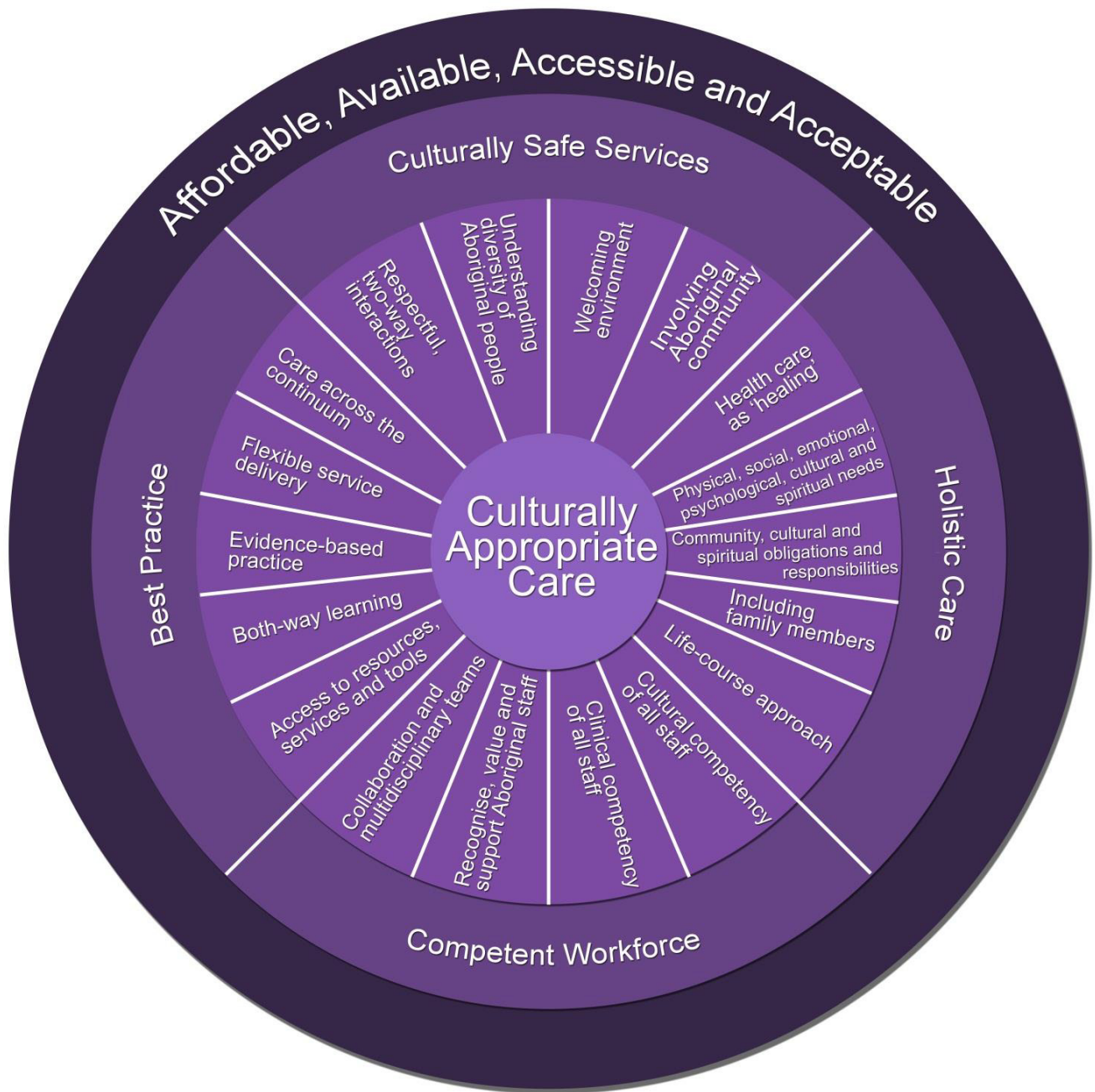


Diagram 1: Adapted from "A Wellbeing Framework for Aboriginal and Torres Strait Islander Peoples Living with Chronic Disease"¹³

Defining the features of culturally appropriate services

Four features are described below.

1. Culturally safe services

Culturally safe services refer to services that expect and perform zero tolerance for racism at any level. Cultural safety is determined by the person or family receiving care. Culturally safe care should be embedded within the health system, including private general practice.

Cultural safety is supported by services that:

- Develop and maintain respectful, both-way interactions between staff and clients (and their families and broader communities);
- Recognise and appropriately respond to the diversity of Aboriginal individuals and communities;
- Provide a welcoming environment, both physically and relationally; and
- Actively involve Aboriginal community members or representative groups in priority setting, governance and accountability.

2. Holistic care

Holistic care is supported by services that:

- Approach health care as 'healing', and support engagement with Traditional Healers and healing practices;
- Respond to holistic and personal needs of clients, including their physical, social, emotional, psychological, cultural and spiritual needs;
- Accommodate the complex family, community, cultural and spiritual obligations and responsibilities that clients or their family members may be experiencing;
- Include family members in planning, decision-making or education, where appropriate; and

- Recognise that for many Aboriginal people, a life-course approach is cyclical, and extends from pre-conception (e.g., adolescent nutritional or sexual health; health promotion) through to post-mortality (e.g. palliative care, end-of-life care, support around grief and loss).

3. What is best practice care?

Best practice care is supported by services that:

- Provide coordinated care across the continuum (i.e., prevention, primary care, acute services, tertiary care, ongoing follow-up or rehabilitation, etc.);
- Approach service delivery in flexible ways that can accommodate diverse needs;
- Support both-way learning regarding Aboriginal cultural knowledges and practices, as well as the best available scientific evidence to inform practice;
- Apply evidence-based practice; and
- Ensure access to all relevant resources, services and tools to support effective delivery of care.

4. Culturally and clinically capable workforce

A culturally and clinically capable Aboriginal and non-Aboriginal workforce is supported by services that:

- Foster collaboration within and between multi-skilled or interdisciplinary teams;
- Recognise, value and support the unique contributions of Aboriginal staff members, as well as respect and provide support for the unique challenges they may encounter;
- Ensure clinical competency of all staff, including providing training and support, as required; and
- Ensure cultural competency of all staff, including providing training and support, as required.

Features of person-centred care for Aboriginal people

Four features are described below.

1. Aboriginal people have a holistic view of health and wellbeing

- Health and wellbeing encompasses all aspects of physical, emotional, social, spiritual and cultural wellbeing and a specific kinship with family; and
- There is a belief that wellbeing is determined socially, rather than biologically or pathologically.

2. Structured and busy specialist clinical services may not cater well for the cultural needs of Aboriginal people

- This can contribute to a broader sense of disillusionment, indifference, and apathy;
- Adherence to unfamiliar treatments that have unpleasant side effects may be poor, especially when there are competing pressures to meet community responsibilities; and
- Clients in unfamiliar environments where cultural and allied support is not provided and their needs are not met, can become lost.

3. Many Aboriginal people experience discomfort with health professionals of the opposite gender

- Traditionally, there are divisions in the roles of men's and women's business, including differences from western values in relation to reproduction and sexuality; and
- For example, it is often not appropriate for Aboriginal men to discuss any part of their body in the presence of a woman.

4. Family and community involvement in health decision making is of paramount importance in Aboriginal cultures

- Aboriginal cultures place a high importance on kin, with holistic, family-based care being valued over segregated care; and
- Aboriginal health is more of a collective consideration about family and community, therefore individualistic decision-making rarely occurs within Aboriginal society.

5. Support Aboriginal people in having a strong connection to Country (traditional homelands), and value being on Country or close by, particularly when ill

- Aboriginal people have strong links to Country and this connection can be strong regardless of whether they are living a culturally traditional lifestyle or live in metropolitan, regional or remote areas; and
- Some people may be reluctant to leave their community for treatment, even though this care may only be available in a metropolitan setting.

Priority Area 1: Cross Sector Services

GOAL: Enhancing services that have touch points across the continuum of care to help facilitate a connected network approach to service provision.

ACTION 1: Review and reorient current mechanisms to improve delivery of culturally appropriate comprehensive primary health care services.

Rationale

- About 50% of Aboriginal people access comprehensive primary care services that are provided by Aboriginal Community Controlled Health Services. Access to community-controlled services is not possible in some areas of metropolitan Adelaide and country SA;
- SA Health funded services, including Aboriginal Health Services, provide services in these gaps however their services are geographically restricted; and
- Private general practitioners (GPs) provide care to Aboriginal people, however there is limited understanding on use, due to problems with accuracy of Aboriginal identification in mainstream administrative health data.

Pathways to action

Review and, where necessary reorient, current mechanisms to improve access to and coordination of care in primary health care services for Aboriginal clients. Comprehensive primary health care services should provide clients with continuous, accessible, high-quality, and patient-centred care. The review and re-orientation should ensure that services:

- Co-ordinate and provide CV care across the continuum of disease, including prevention, risk assessment and management, ongoing management and secondary prevention of established disease, and palliative and end of life care;
- Prioritise antibiotic prophylaxis for RHD;
- Have access to interdisciplinary, specialist and support services for clients and clinicians;
- Support clients and their families to facilitate appointments, provide transport support, and minimise out-of-pocket costs;
- Improve utilisation of funding mechanisms to support improved access by Aboriginal clients;
- Effectively implement electronic quality improvement systems;
- Utilise telehealth and/or ICT solutions where appropriate; and
- Have a sufficient workforce which is clinically and culturally capable in providing culturally appropriate comprehensive primary health care services, including GPs, nurses and Aboriginal Health Worker/Practitioner (AHW/P).

This may involve increasing the availability of ACCHOs where there is an identified need by community.

Enablers for Action 1

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 2: Develop a statewide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks based on greatest demand or need.

Rationale

- Statewide SA Telestroke Service providing 24/7 access to Neurologist support for regional clinicians and stroke support clients;
- There is no statewide model or framework for cardiology that determines, on a state level, delivery of services based on level of need, across the continuum of care; and
- There is a Statewide Stroke Community of Practice and statewide protocols and procedures that aim to address the service delivery needs for the state and across the continuum of care. However, this is overdue for review and administrative and project support to continually update this to a 'Living Guidelines' model is currently lacking.

Pathways to action

The statewide model must facilitate delivery of the following services:

- Outreach diagnostic and management clinics;
- 24/7 acute specialist advice;
- Referral pathways and clinical guidelines for acute event assessment, transfers, specialist referrals and follow-up care;
- In-patient cardiac and stroke coordinator; formalised links between acute and primary health care providers and allied health practitioners;
- Structured rehabilitation programs;

- Data collection and reporting systems – consider increasing digital health strategies to improve data collection;
- Integrated use of telehealth, and ICT solutions;
- Coordination of transportation;
- Standard medication kits, protocols and stock management systems for acute clients at regional and remote centres;
- Improved feedback and reminder systems to support clinicians;
- Service planning and clinical leadership;
- Regular mandatory training and competencies for clinical staff;
- Reviews and evaluations of processes, costs and outcomes; and
- Support systems for GPs providing rehabilitation care.

Enablers for Action 2

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 3: Maintain and expand the existing SA Rheumatic Heart Disease Control Program.

Rationale

- As of July 31, 2022, there were 503 people enrolled on the SA RHD Register with a diagnosis of ARF and/or RHD, and 88% of these identify as Aboriginal¹⁴;
- As of December 2020, 68% of severe and moderate RHD clients in SA received regular echocardiography screening within guideline recommended timeframes¹⁴;
- In 2020, SA clients with acute rheumatic fever and RHD received, on average, 78% of their scheduled antibiotic prophylaxis¹⁴;
- As of 31 December 2020, there were 9,158 people on the RHD registers living with a diagnosis of ARF and/or RHD in New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory, Aboriginal and Torres Strait Islander people accounted for 7,492 (82%) of the diagnoses¹⁵; and
- In 2016–2020, 476 deaths were reported among people with RHD in Queensland, Western Australia, South Australia and the Northern Territory. Of these, 322 people (68%) were Aboriginal and Torres Strait Islander people¹⁵.

Pathways to action

The SA RHD Program must be expanded to become a full control program including the following elements:

- Continued commitment from national, regional and local services to ensure long-term funding and governance support;
- An effective advisory committee;
- Ongoing coordinating team;

- An electronic patient register that contains data elements that support quality patient management and reporting requirements;
- Advocacy for a stable supply of benzathine penicillin G (BPG);
- Support primary health care services to provide primary and secondary antibiotic prophylaxis;
- Active surveillance for cases of acute rheumatic fever RHD and assessment and monitoring of the burden of disease;
- Partnerships between clinicians and public health services to support the needs of people with ARF/RHD and the community;
- Provision of education for health practitioners and health workers, and supported health education for the community, those with disease and their families;
- Activities guided by locally relevant, evidence-based guidelines;
- Notification of ARF/RHD supported by public health surveillance activities;
- Coordination of a system which identifies and prioritises services for those at highest risk;
- A mechanism for monitoring delivery of secondary prophylaxis and ongoing care; and
- Evaluation of client management and program activities.

Enablers for Action 3

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 4: Enhance care for the identification, acute and ongoing care of children and adolescents with heart disease and stroke by paediatric cardiology services, with effective transition pathways into adult cardiology services.

- Support the early recognition and management of risk factors for CV disease;
- Develop safe and effective pathways for transition to adult care; and
- Recognise the special needs of Aboriginal clients transitioning from paediatric to adult cardiac services.

Rationale

- Nationally, Aboriginal children experience hospitalisation for congenital heart disease at similar rates as non-Aboriginal children¹⁵;
- Long-term survival for Aboriginal children with congenital heart disease is lower compared to non-Indigenous children;¹⁶ and
- There are the new Australian National Standards of Care for Childhood-onset Heart Disease (CoHD Standards) that are being developed by HeartKids Ltd with support of the Federal Government.¹⁷

Enablers for Action 4

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- Transport and accommodation support
- ICT solutions
- Integrated and coordinated services

Pathways to action

The existing models of care for the identification and management of paediatric cardiac issues be enhanced to:

- Consolidate the Women's and Children's Hospital as the statewide provider of specialist services and advice (within and outside hospital) for paediatric cardiology;
- Improve access to care as close to home as possible for specialist paediatric cardiology services in metropolitan, regional and remote areas;
- Support the coordination of care for hospitalisation, especially those travelling interstate for surgery, including pre-admission planning, transport support, inter-hospital communication, discharge planning, ongoing specialist services and linkages to primary health care services;

Priority Area 2: Primary Preventative Care

GOAL: Improved access and uptake of evidence based preventive health interventions to reduce future burden of disease.

ACTION 5: Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s across SA.

Health Promotion and Disease Prevention

Rationale

- There are currently no Aboriginal-specific CV health promotion or disease prevention programs being run statewide, nor chronic disease prevention programs;
- There is some federal and state funding for tobacco control initiatives, however it is time limited;
- Limited and uncertain funding is available for nutrition and physical activity prevention activities, primarily led by Aboriginal Health Council of SA (AHCSA); and
- There is a strong message from community that there should be targeted community awareness campaigns about heart disease and stroke to encourage healthy lifestyles, risk management, primary prevention and ongoing management messages. This should have strong community leadership and use of culturally appropriate and strength-based approaches.

Pathways to action

Develop an awareness and prevention campaign for heart and stroke. This must:

- Focus across the life course, with specific approaches for different age groups (i.e. children and adolescents);
- Co-design programs with Aboriginal people that recognise the geographic and cultural diversity of Aboriginal people;
- Develop sex and gender specific programs and health promotion campaigns (all ages);
- Consider family and community programs and approaches;
- Recognise the social and economic disadvantage experienced by many Aboriginal people, and the role these factors play in risk behaviours and health status;
- Have a key focus on physical activity, mental health, nutrition, smoking, alcohol and other drugs;
- Have a key focus on streptococcal infections, ARF and RHD
- Have smoking campaign resources that are available for Aboriginal communities to utilise in quit smoking programs;
- Support smoke-free initiatives in public places, events and in homes;
- Be coordinated with other appropriate prevention programs, including schools-based programs, as part of a holistic, culturally appropriate approach to health and wellbeing;

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- Use a strength-based approach focusing on protective factors and the stories of survivors;
 - Consider the use of narratives to convey the key health messages;
 - Learn from and build upon existing effective awareness and prevention campaigns;
 - Promote early detection of disease through annual CV risk assessments as part of an adult health check; and
 - Be aligned with the SA Aboriginal Diabetes Plan (2022-2027)

Enablers for Action 5

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- Community engagement
- Monitoring and evaluation

ACTION 6: Increase the use of cardiovascular risk assessment and management in all primary care settings.

Risk Assessment and Management

Rationale

- There is strong evidence to support CV risk assessment and management with Aboriginal and Torres Strait Islander people;
- Cardiovascular Risk Assessment and subsequent management in ACCHOs can be improved upon. Although the rate of CV Risk Assessment and subsequent management in state funded Aboriginal Health Services and private General Practitioners (GP) is unknown, it is likely to be low;
- Mainstream staff are generally unaware of the extent and impact of heart disease and stroke on the Aboriginal community, especially with respect to the early age of disease onset;
- In 2021 in SA, 45% of Aboriginal and Torres Strait Islander clients aged 35–74 with no known history of CVD had information available to calculate their absolute CVD risk in the previous 24 months¹⁸ (services funded under the Indigenous Australians' Health Programme, Australian Government); and
- Most community members have little knowledge of the existence or benefits of CV risk assessments.

Pathways to action

Support uptake of CV risk assessment and management through the development of a model of care, including protocol, toolkit and implementation plan. This must:

- Facilitate assessment in people aged 15 years and over at least once every year, as part of an Adult Health Check;
- Identify opportunistic ways of assessment through family-focused care (i.e., education on risk and assessments);
- Support timely, appropriate management of risk and established disease, including lifestyle advice, support and long-term pharmacological and non-pharmacological treatment;
- Identify women who are of increased risk of CVD through the promotion of an annual Health Check (MBS 715 or similar);
- Identify communication methods that deliver a clear understanding of CV health messages to clients and family members;
- Integrate management into holistic approaches to care;
- Support referral to primary care, acute sector, specialist services and allied health care services including pharmacy;
- Outline integration into key elements of practice management such as patient information management systems, workforce requirements and continuous quality improvement;
- Support approaches to improve access, including bulk billing and transport support;
- Be developed through coordination between all primary health care providers, allied health, and pharmacies;
- Be included in sector-specific capability training, such as risk assessment and management in primary health care;

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- Be integrated with management of other disease, particularly diabetes mellitus and kidney disease;
 - Improve knowledge of the existence of CV risk assessments in the community;
 - Improve knowledge amongst mainstream providers on the impact of heart disease and stroke has on community; and
 - Consider opportunistic assessment and referral for management in Emergency Departments (EDs) and hospital.

Enablers for Action 6

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

Priority Area 3: Clinical Suspicion of Disease

GOAL: Improved access to services to identify disease, or markers of disease, as early as possible.

ACTION 7: Develop and implement a model of care and referral pathways to provide timely access to non-acute diagnostic services for identification and management of disease.

Diagnostic Investigation Services

Rationale

- There is very limited data on utilisation of diagnostic and specialist services to inform this section;
- Medicare Benefits Schedule (MBS) records of receipt of diagnostic investigation and technical services are the only records available and are not routinely aggregated by Aboriginal status;
- The far north and far west of the state have very limited access to diagnostic investigation and technical services, however a significant Aboriginal population who are likely to need heart and stroke services live in these regions;
- The northern and western suburbs of metropolitan Adelaide have limited access to the medical imaging services however a significant Aboriginal population who are likely to need heart and stroke services live in these regions;
- There has been limited integration of diagnostic services into ACCHOs servicing rural and remote communities; and
- There is limited access to diagnostic investigative services and follow-up care for transient ischaemic attack (TIA) clients in country SA. There are a few magnetic resonance imaging (MRI) facilities in country SA.

Pathways to action

Develop and implement a model of care and referral pathways for non-acute diagnostic services for suspected coronary heart disease, TIA, management of acute rheumatic fever/RHD and heart failure. This must:

- Be a culturally appropriate model of care;
- Include electrocardiography, echocardiography, coronary angiography, chest x-ray, magnetic resonance imaging (MRI) brain scan, haematology, stress test, ambulatory blood pressure and holter tests;
- Outline what should be provided across SA, based on geographic accessibility and burden of disease across the population;
- Provide care as close to home as possible;
- Consider appropriate definitions of 'accessible' within appropriate timeframes;
- Be developed through a central coordinating body;
- Be integrated with electronic patient information management systems;
- Develop and integrate ICT solutions to improve clinical information sharing, including POCT; and
- Consider how opportunistic screening can be undertaken to identify support for ongoing management during unrelated presentations to acute services.

Enablers for Action 7

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- ICT solutions
- Community engagement
- Integrated and coordinated services

ACTION 8: Establish a coordinated statewide specialist outreach service plan.

Specialist Services

Rationale

- Specialist physicians play a role in facilitating access to diagnostic services for cardiac conditions;
- There is poor coordination of specialist services across the state with multiple providers and significant overlap in some regions and very limited access to specialist services in other regions;
- The TIA clinics are metro based and therefore, access to specialised TIA units is required;
- There is a lack of specialist services in relation to need in:
 - » western and northern Adelaide suburbs;
 - » the far north and far west of SA
- There is a lack of coordination between the GP, specialist and investigative services and fragmented specialist care post discharge;
- Specialist services are not routinely linked to all ACCHOs and specialist services are not always culturally appropriate; and
- Clients are unable to routinely access transport to attend specialist outreach services not funded by SA Health.

Pathways to action

Develop a coordinated specialist outreach service plan for metropolitan, rural and remote SA. The plan must:

- Provide on-the-ground cardiac, stroke, allied health and nurse specialists across the state to deliver specialist care for stroke, acute rheumatic fever/RHD, heart failure, coronary heart disease, and atrial fibrillation;
- Provide ongoing specialist support and up skilling to primary health care providers, including GPs, nurses and nurse practitioners, and AHW/P;
- Integrate ICT solutions (i.e., telehealth) to supplement usual face-to-face consultations in rural and remote communities;
- Ensure that models of delivery of specialist services are defined by local service needs and current provision of primary care services;
- Integrate specialist services within ACCHO sector where preferred by that service;
- Incorporate specialist services into follow-up care;
- Be informed by existing mapping of services; and
- Incorporate monitoring, including services activity, community need and outcomes.

Enablers for Action 8

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- ICT solutions
- Integrated and coordinated services
- Monitoring and evaluation

Priority Area 4: Acute Episode Care

GOAL: Development of the acute system to ensure that retrieval and transfer services and the major tertiary hospitals (Royal Adelaide Hospital, Flinders Medical Centre and Lyell McEwin Hospital), as well as Port Augusta and Ceduna hospitals provide the best care to Aboriginal heart and stroke clients first time, every time.

ACTION 9: Increase awareness of the warning signs and symptoms of heart attack and stroke among the Aboriginal community and service providers.

Planned and Urgent Transfers, and Emergency Retrieval Services

Rationale

- Warning signs are variable and are not well understood among Aboriginal communities and service providers; and
- Lack of awareness of the warning signs contributes to delays in the diagnosis and treatment of heart attack and stroke leading to poor health outcomes.

Pathways to action

Advocate for funding to develop resources that discuss the warning signs of heart and attack and stroke. The campaigns should:

- Co-designed with Aboriginal communities;
- Have messages which are culturally appropriate and recognise the geographic and cultural diversity of Aboriginal people;
- Have sex-specific, gender messaging for the warning signs of a heart attack and stroke;
- Be integrated with the broader heart, stroke and diabetes awareness and prevention campaign; and
- Utilise and promote existing resources from the National Heart Foundation and Stroke Foundation (e.g., Our Stroke Journey' resources).

Enablers for Action 9

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- Community engagement
- Monitoring and evaluation

ACTION 10: Improve access to emergency care by reducing out-of-pocket costs of ambulance service.

Rationale

- In an emergency many Aboriginal people do not call 000 due to the real and the perceived cost of ambulance use.

Pathways to action

Explore and develop approaches to reduce the out-of-pocket cost of transport by ambulance for people with significant economic disadvantage. The final approaches must be:

- Integrated into a systems response;
- Supported by the Aboriginal community; and
- Promoted throughout the Aboriginal communities in SA.

Enablers for Action 10

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- Integrated and coordinated services

ACTION 11: Establish a system to identify Aboriginal and Torres Strait Islander status at the first point of medical contact.

Rationale

- Aboriginal identification of clients is not formally or systematically collected/registered during the emergency phase of their journey; and
- There is poor identification of Aboriginal clients across the system with many reasons given for not asking all clients about their Aboriginal and/or Torres Strait Islander status.

Pathways to action

Establish and maintain a system where identification of all Aboriginal clients occurs as early as possible. This will enable appropriate clinical decision making in recognition of specific risk, and consideration of cultural elements of care to be incorporated into management. The system must be:

- Integrated into electronic patient information management systems;
- Incorporated into workforce training;
- Written into care pathways; and
- Implemented across SA Ambulance Service (SAAS), Royal Flying Doctors Service (RFDS), emergency services and departments, and hospitals.

Enablers for Action 11

- Governance: Aboriginal leadership and partnerships
- ICT solutions
- Integrated and coordinated services

ACTION 12: Develop and implement a transfer and retrieval services protocol that responds to the clinical and cultural needs of Aboriginal people.

Rationale

- Transfer and retrieval processes are not systematically culturally appropriate.

Pathways to action

The protocol should:

- Be triggered by identification;
- Be implemented in all non-metropolitan services which have clients which are transferred and/or retrieved;
- Help facilitate the transfer of information from the hospital of origin to the referral hospital and hence be part of the formal communication system; and
- Have e-referral systems to ensure that no one is missed.

Enablers for Action 12

- Sustainable funding
- ICT solutions
- Integrated and coordinates services

ACTION 13a: Maintain and expand iCCnet, Rural Support Service to provide coordinated services from first medical contact to definitive care for regional and remote Aboriginal clients with acute heart disease.

- Incorporate results from POCT and electrocardiograms (ECGs) into a statewide electronic database to record, share and store results with specialists and across sites;
- Integrate the transfer and retrieval services protocol; and
- Be integrated into triaging and coordination processes with referring and receiving hospitals.

Rationale

- There is poor coordination between referring and referral hospital;
- There is high need for but low levels of service provision in Port Augusta and the northwest region; and
- When considering heart specific services, access to POCT for troponin and other relevant diagnosis testing is an issue in some locations if the iCCnet or SA Pathology are not involved.

Enablers for Action 13a

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Integrated and coordinated services

Pathways to action

Maintain and expand iCCnet for regional and remote Aboriginal clients with acute heart disease, from first point of medical contact to definitive care. The regional system must:

- Ensure statewide network access to timely specialist advice through the iCCnet is continued;
- Enable video-conferencing to support thrombolysis admission;
- Link ACCHOs into the statewide network for access to timely specialist advice through the iCCnet and extended to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands;
- Establish feasibility of providing thrombolysis in large remote clinics, with adequate resourcing for training and support for medical and nursing staff;
- Provide adequate resourcing to iCCnet to provide POCT equipment, training and support to all country hospitals and key points of medical contact including remote ACCHOs;

ACTION 13b: Implement a regional system of care from first medical contact to definitive care for regional and remote Aboriginal clients with stroke or Transient Ischaemic Attack (TIA).

Rationale

- Aboriginal clients with suspected acute stroke or TIA may have difficulties accessing acute assessment and treatment, despite recent advances facilitated by the SA Telestroke Service;
- Planned appointments for clients from country regions are often haphazard with limited funding for transport;
- There is high need for but low levels of service provision in Port Augusta and the northwest region; and
- With respect to less acute stroke (i.e. symptom duration >24 hours), it is difficult to access specialist support.

Pathways to action

Implement a regional system of care for regional and remote Aboriginal clients with acute stroke or TIA from first point of medical care to definitive care, building on current SA Health protocols. The regional system must:

- Ensure all clients identified with probable acute stroke are transported to a neuroimaging capable hospital, wherever logistically possible;
- Ensure statewide network access to timely acute stroke specialist advice through the 24/7 SA Telestroke service;
- Integrate the 24/7 Telestroke service into SAAS MedStar service;
- Enable video-conferencing to support thrombolysis provision at Computerised Tomography (CT)-capable country stroke services (currently eight regional SA hospitals

and Alice Springs Hospital), and acute stroke and transfer advice to centres without CT facilities;

- Utilise the Royal Adelaide Hospital as the primary tertiary hospital for all potential stroke episodes requiring potential endovascular thrombectomy;
- Connect ACCHOs into the statewide network, to enable timely specialist advice;
- Explore feasibility of providing CT services enabling thrombolysis with adequate resourcing for training and support for medical and nursing staff;
- Explore the feasibility of providing specialist Telestroke advice for less acute stroke (>24 hour symptom duration) in regional SA;
- Provide adequate training and support to all country hospitals and key points of medical contact including remote ACCHOs, including use of pre-hospital screening tool and triage and retrieval processes;
- Support implementation of models of care for stroke and TIA clients in rural and remote location, utilising telehealth where appropriate; and
- Encourage a national imaging repository to allow previous neuroimaging performed in disparate locations to be easily accessed for acute stroke and TIA decision making.

Enablers for Action 13b

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 14a: Provide best practice clinical and cultural care for Aboriginal clients with heart disease at all South Australian hospitals, with targeted efforts at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Port Augusta Hospital and Ceduna Hospital.

Acute Hospital Services

Rationale

- Aboriginal identification of clients is not formally or systematically collected/registered during the emergency phase of their journey;
- The coordination of Aboriginal clients into and out of hospital can be improved;
- There is a need to build a culturally capable workforce;
- There is a need to improve health, cultural and financial support, including nursing staff who are both culturally and clinically skilled, for clients and families during their hospital visit;
- Experiences of racism in hospitals are regularly reported by Aboriginal clients and their families; and
- The resources for Aboriginal Liaison Units need to be improved to operate efficiently and/or effectively.

Pathways to action

For those hospitals with the largest number of Aboriginal clients admitted with CVD, develop a service which is nationally recognised for providing best practice Aboriginal heart clinical and cultural care. Care should meet the defined six actions that specifically meet the needs of Aboriginal and Torres Strait Islander people in the National Safety and Quality Health Service Standards (NSQHS),

Australian Commission on Safety and Quality in Health Care (ACSQHC) and Acute Coronary Syndromes (ACS) Standards. Effective delivery of care should include:

- Identification of all Aboriginal clients;
- Care delivered in a culturally appropriate manner;
- Timely access to emergency care by a capable clinician;
- Timely access to reperfusion therapies appropriate to the resourcing at that site, with systems to facilitate transfer within a coordinated regional system, within the index admission;
- Specialist cardiac care units with dedicated staff and appropriate treatment capacity to that hospital;
- All CV clinical staff achieving cultural capability including Emergency Department, cardiac and outpatient services; and
- Adequate resourcing of Aboriginal Liaison Units to enable Aboriginal Liaison Officers (ALOs) to work with ward staff and support Aboriginal clients, escorts and family members.

Enablers for Action 14a

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 14b: Provide best practice clinical and cultural care for Aboriginal stroke clients at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Berri Hospital, Mount Gambier Hospital, Districts Health Service, Whyalla Hospital, Port Lincoln Hospital, Port Pirie Hospital, Wallaroo Hospital and Naracoorte Hospital.

Rationale

- Aboriginal identification of clients is not formally or systematically collected/registered during the emergency phase of their journey;
- The coordination of Aboriginal clients into and out of hospital can be improved;
- There is a need to build a culturally capable workforce;
- There is a need to improve health, cultural and financial support, including nursing staff who are both culturally and clinically skilled, for clients and families during their hospital visit;
- Experiences of racism in hospitals are regularly reported by Aboriginal clients and their families; and
- The resources for Aboriginal Liaison Units need to be improved to operate efficiently and/or effectively.

Pathways to action

For those hospitals with the largest number of Aboriginal clients admitted with stroke or are SA Health Stroke Centres develop a service which is nationally recognised for best practice Aboriginal stroke clinical and cultural care. Care should meet the defined six actions that specifically meet the needs of Aboriginal and Torres Strait Islander people in the NSQHS, SA Health Stroke Management Procedures & Protocols and the ACSQHC Stroke Standards. Effective delivery of care should include:

- Identification of all Aboriginal clients;
- Care delivered in a culturally appropriate manner;
- Timely access to emergency care (including imaging) by a culturally and clinically capable clinician;
- Timely access to thrombolysis for ischaemic stroke;
- Systems to facilitate timely transfer within a coordinated regional system, within the index admission to a metropolitan hospital capable of providing stroke unit care or a regional hospital providing stroke unit-like care (e.g., Whyalla, Berri and Mount Gambier), respectively reflecting client preference and informed consent;
- Specialist stroke units/services with dedicated staff and appropriate treatment capacity to that hospital;
- All CV clinical staff achieving cultural capability including ED, neurology, rehabilitation and outpatient services;
- Adequate resourcing of Aboriginal Liaison Units to enable ALOs to work with ward staff and support Aboriginal clients, escorts and family members;

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- In-hospital communication to ensure that all clients, and their family and community are informed and have control of their care;
 - In-hospital education to ensure that all clients receive education using culturally relevant resources, with involvement of family; and
 - Established referral systems to rehabilitation services and ongoing care.

Enablers for Action 14b

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

ACTION 15: Establish and maintain where existing, an Aboriginal heart and stroke Aboriginal Health Practitioner/Nurse Coordinator position at Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Port Augusta Hospital and Ceduna Hospital to support Aboriginal clients and their families throughout their journey of care.

- Implement models of care in-hospital to improve culturally capable care; and
- Establish local CV planning committees.

Enablers for Action 15

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Community engagement
- Integrated and coordinated services

Rationale

- There is a need to build a culturally capable workforce;
- There is a need to improve health, cultural and financial support, including nursing staff who are both culturally and clinically skilled, for clients and families during their hospital visit; and
- Self-discharged rates are observed higher in Aboriginal people than non-Aboriginal people.

Pathways to action

These roles should be adapted to meet the needs of that hospital and the region. The positions should be a regional coordination role. The role of the coordinator must:

- Have clinical skills in heart and stroke care;
- Be focused on case management and coordination of services;
- Ensure adequate pre-operative planning and support;
- Ensure in-hospital support for clients and their families, and facilitate communication and education;
- Support pre-discharge planning, development of a discharge plan and communication of that plan to primary health care services;
- Support specialist outreach and ongoing care;

ACTION 16: Develop a statewide approach to a rheumatic valvular surgery centre of excellence.

Rationale

- Given the burden of RHD in South Australia and the pathway from the NT for RHD clients, a single, statewide rheumatic valvular surgery centre of excellence should be developed.

Pathways to action

This surgical centre of excellence must:

- Have necessary volume of cases to develop and maintain technical expertise;
- Have established systems to provide clinically and culturally appropriate pre- and post-operative care;
- Enable decision making for treatment options to involve the client, their family, the primary healthcare team and the referring specialist;
- Utilise planned transfer protocols;
- Be integrated and share client information with the SA RHD Control Program;
- Establish post-surgical follow-up and specialist support to primary health care for long term management;
- Have systems to initiate and support ongoing primary health, diagnostic and specialist care; and
- Have the capacity to provide treatment as early as possible.

Enablers for Action 16

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Community engagement
- Integrated and coordinated services
- Monitoring and evaluation

Priority Area 5: Ongoing Care

GOAL: A system that connects clients leaving the acute sector with high quality ongoing, accessible care including rehabilitation and management in primary care.

ACTION 17: Develop a model of care and protocols to provide patient centred and safe discharge from hospitals.

Hospital Discharge Planning and Follow-Up

Rationale

- Follow up with primary care services is limited and clients often fall through gaps during this transition phase and are lost to follow up post hospital discharge;
 - SA Pharmacy helps Aboriginal people with the cost of medicines when being discharged from hospital or attending an outpatient clinic at SA public hospitals¹⁹;
 - At SA public hospitals, eligible Aboriginal people can access all medicines¹⁹:
 - » Free if they have a Centrelink or Department of Veteran Affairs (DVA) concession card or access medicines through a Remote Area Aboriginal Health Service (RAAHS) or¹⁹;
 - » Cheaper at the concessional rate (\$6.60) if they do not have a Centrelink or DVA concession card.¹⁹
 - If a client is transferred or retrieved from a country hospital as an inpatient and discharged from the tertiary hospital, the Patient Assistance Transport Scheme (PATS) may be able to fund transport home, as per eligibility criteria.
- There are programs available to provide patients access to support, services and care such as the National Disability Insurance Scheme (NDIS) and Transition Care Program (TCP).

Pathways to action

A statewide model of care should be developed to guide patient centred, safe discharge processes from hospital. Each hospital should develop a site-specific protocol based on the model of care. The model of care must incorporate:

- Engagement with client and family members in planning;
- Involvement of Aboriginal Liaison Unit/ Aboriginal support services;
- The predicted need for follow-up specialist care;
- Access to funded transport to home;
- Access to support and care through funded programs such as NDIS and TCP
- Central referral to primary care and rehabilitation; and
- Communication of discharge summary be provided to the individual's primary care provider and any other providers involved in that individual's hospitalisation.

Enablers for Action 17

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Transport and accommodation support
- ICT solutions
- Integrated and coordinated services

ACTION 18: Develop a central referral service that ensures continuity of care from hospital to primary care, specialist follow-up and cardiac/stroke rehabilitation.

Enablers for Action 18

- Sustainable funding
- A strong heart and stroke workforce
- ICT solutions
- Integrated and coordinated services

Rationale

- Pre-discharge education and discharge planning is often not undertaken;
- When pre-discharge education and discharge planning is undertaken, it rarely involves family members;
- There is low adherence to specialist follow-up for cardiac and stroke clients at tertiary centres; and
- There are difficulties accessing culturally specific cardiac and stroke rehabilitation specialists in country areas.

Pathways to action

Establish a web-based central e-referral service through the iCCnet (RSS) to enable effective and timely clinical communication and handover occurs following discharge of all eligible clients. The e-referral service using predominantly telephone and telehealth follow-up must facilitate

- A discharge summary reaching primary care provider within 48 hours post discharge;
- A client follow-up visit at the preferred primary health care service 7-10 days post discharge;
- Referral to an appropriate rehabilitation program and mode of delivery as chosen by client (inpatient, outpatient, community-based or rehabilitation in the home);
- GP referral to interdisciplinary specialist and support services and use of a GP Management Plan and Team Care Arrangements; and
- The referral service should have test-and-learn cycles integrated into implementation.

ACTION 19: Establish a model of culturally appropriate, evidence based cardiac and stroke rehabilitation services.

Hospital Discharge Planning and Follow-Up

Rationale

- Once Aboriginal clients commence a cardiac rehabilitation program, their completion rates are higher than that of non-Aboriginal people. However, they remain low compared to best-practice;
- Cardiac rehabilitation referral rates during in-hospital stay are low; and
- Cardiac and stroke rehabilitation services are not culturally or age specific for many Aboriginal people.
- Stroke rehabilitation is multi-disciplinary and needs to cover ongoing disability in the domains of mobility, language and communication, swallowing, in/dependence in activities of daily living, cognition and mood-related issues.

Pathways to action

Review existing models of cardiac and stroke rehabilitation and develop culturally appropriate services for Aboriginal clients. The model must:

- Ensure coverage across metropolitan, regional and remote SA;
- Ensure all clients have timely access to services (within 8 weeks post-discharge);
- Support client choice in mode of rehabilitation through multiple models, including one-to-one, group, and virtual programs;
- Ensure cardiac rehabilitation cover the key components in delivering appropriate care;

- Ensure a multidisciplinary, team approach to stroke rehabilitation. Include the supports of allied professionals such as physiotherapists, speech pathologists, occupational therapists, rehabilitation nurses and mental health professionals;
- Involve the client, family, specialist, primary health care practitioner and consider the recovery aspect;
- Have sex and gender specific models of care to ensure that services are culturally responsive to people's needs;
- Have a rehabilitation component of the model that is specific to children and adolescents with stroke;
- Have Medicare item numbers to conduct GP based cardiac rehabilitation;
- Access to support and care through funded programs such as NDIS and TCP; and
- Include culturally appropriate secondary prevention education materials.

Enablers for Action 19

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- ICT solutions
- Integrated and coordinated services

ACTION 20: Build capacity in primary health care to provide coordinated management, secondary prevention and ongoing care for clients with established disease.

- Coordination with diagnostic and specialist services, facilitated through a regional network; and
- Development of a clinically and culturally capable workforce.

Rationale

- There are limited community based culturally appropriate prevention activities for clients to access post discharge. There are models of effective programs interstate which should inform any services in SA;
- There are some overlaps and gaps in primary health care services in both metropolitan and country areas that provide ongoing management and support services.

Enablers for Action 20

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce

Pathways to action

Build the capacity, through workforce, funding and collaboration with other services, of primary health care to provide coordinated management, secondary prevention and ongoing care for Aboriginal clients with established disease. This must include:

- Utilisation of interdisciplinary team care;
- A comprehensive approach to spiritual and physical health and wellbeing, encompassing social and emotional wellbeing and considering protective factors for CV health;
- Strengthen CV health knowledge and understanding;
- Delivery of education and support for lifestyle modification and risk factor management (i.e., nutrition, physical activity and smoking cessation), rehabilitation and secondary prevention activities;
- Support from cardiac and stroke specialists;

ACTION 21: Establish culturally appropriate models of care and protocols for palliative and end of life care specifically for Aboriginal clients.

Rationale

- There is a lack of palliative and end of life care services that are recognised as culturally appropriate and safe; and
- There are opportunities for improving palliative and end of life care.

Pathways to action

Develop a model of palliative and end of life care for Aboriginal people with advanced symptoms that are refractory to optimal treatment. The model must:

- Facilitate advanced care planning;
- Involve clients, family and community, where appropriate, in discussion on end-of-life care decisions;
- Support increased workforce capacity in providing palliative and end of life care;
- Increase service coordination between palliative and cardiac /stroke services;
- Enable access to palliative care in the home and/or institutional setting as chosen by the client and their family/carer; and
- Support return to Country where appropriate.

The protocol should be based on the models of care, and should be implemented in primary health care, hospitals and aged care services.

Enablers for Action 21

- Governance: Aboriginal leadership and partnerships
- Sustainable funding
- A strong heart and stroke workforce
- Community engagement
- Integrated and coordinated services

Enablers

ENABLER 1: Governance: Aboriginal Leadership and Partnerships

GOAL: Establish and maintain robust governance structures, led by Aboriginal professionals and organisations, equipped to foster partnerships and collaboration between the wide range of organisations and stakeholders responsible for implementing this Plan.

Rationale

- Responsible governance based on shared visions and values will be essential to the successful implementation of this Plan;
- Aboriginal leaders need to be involved on every level to fully embed core values such as Aboriginal self-determination and Aboriginal community governance;
- The structures and processes required to ensure the appropriate accountability, transparency and responsiveness of the decisions and actions associated with Aboriginal people with CVD, require the leadership of Aboriginal stakeholders from relevant professional and community backgrounds;
- Governance groups need to be actively engaged and respond flexibly and adaptively to complex and changing environments;
- Involvement of Aboriginal leadership in decisions associated with planning, delivering and evaluating the implementation of actions outlined in this Plan is critical to ensuring cultural safety and effectiveness of health

systems and services to improve heart and stroke; and

- Health system organisations such as funding bodies, policy makers and service providers need to commit to genuine, collaborative partnerships with Aboriginal communities and organisations to build on the strengths of each part of the system and the strengths of the community to create positive change and improvements in CVD outcomes.

Pathways to action

The governance structure must continue to:

- Recognise the diversity of health services which have a role to play in improving CVD outcomes for Aboriginal people and commit to building genuine partnerships and appropriate governance structures involving Aboriginal leadership;
- Involve representation from all key parties in the continuum of care for Aboriginal people, including representation of the Aboriginal community leaders, organisations, and professional stakeholders;
- Identify existing partnerships and governance structures such as statewide clinical networks, regional health services networks as well as existing community groups and forums to lever support for the implementation of this Plan;
- Include Aboriginal and Torres Strait Islander people who have a lived experience of CVD or have cared for someone with these conditions and demonstrate a commitment to listening to their voices;
- Integrate monitoring and reporting against Plan targets to quantify impact; and
- Maintain the SA Aboriginal Chronic Disease Consortium's Community Reference Group, with both metropolitan and country representation through ongoing engagement and involvement mechanisms to enable the Community Reference Group to oversee, guide and influence the implementation of this Plan.

ENABLER 2: Sustainable Funding

GOAL: Appropriate levels of funding to be available for implementation of projects and services within appropriate timeframes.

Rationale

- Aboriginal health funding needs to be allocated to projects and services which adhere to the principles of Aboriginal leadership and governance and preference the employment of Aboriginal professionals;
- There are multiple funding sources for Aboriginal health care across all sectors, from federal and state government agencies, which are often fragmented, insufficient and short-term;
- Accessing funding incurs significant operational costs, including identifying appropriate sources of funding, understanding eligibility criteria, and developing funding proposals;
- A further barrier to accessing funding are specific requirements such as financial co-contributions or short turnover times for submissions that prevent appropriate community and stakeholder consultation;
- Compliance with reporting requirements for multiple grant agreements, once secured, can also be a barrier, especially where funding levels are low.
- The short-term nature of many funding agreements allows for limited flexibility to undertake project or service planning and manage operational challenges such as recruitment of staff or staff turnover, engagement of community and other

stakeholders, establishment of formal partnerships with partner organisations and meeting delivery milestones. Negotiating extensions or variations to funding agreements can also come at a significant operational cost;

- Workforce sustainability and appropriate training, professional development and career opportunities are difficult to maintain when funding is limited. The costs associated with the development and maintenance of professional networks to sustain high quality models of care and improve health outcomes is also significant;
- Community engagement also requires appropriate resourcing over the lifetime of services and projects. Similarly, sufficient budgets are required to evaluate projects and services; and
- Out-of-pocket costs for the individual, such as gap payments for medicines, general practice or specialist care, as well as costs associated with transport and accommodation for Aboriginal people from rural or remote communities, can be prohibitive for accessing health services, and reimbursements or subsidy schemes are often difficult to navigate.

Pathways to action

- Advocate for adequate levels of funding and resources and adequate timeframes to support the implementation of this Plan;
- Advocate for the inclusion of Aboriginal leadership, governance, and workforce as part of funding eligibility criteria. Aboriginal community engagement should also be a prerequisite to developing proposals, to ensure cultural appropriateness and safety and that the proposed project or service associated with the implementation of this Plan meet community priorities and expectations;
- Funding bodies to provide easily accessible information and support for service providers to submit successful funding proposals;

-
- Funding bodies to streamline reporting requirements and the processes to meet other accountability requirements wherever possible to reduce the administrative burden of managing funding agreements. Embedding flexibility in the management of these agreements is also critical, for example to allow for revision of timeframes, milestones, and ability to carry over or re-allocate funding as priorities shift or newly emerge;
 - Increase knowledge amongst service providers of funding sources and increase their capacity to access funding and manage funding agreements;
 - Identify and promote the uptake of existing funding sources, including through the MBS, hospital loading for Aboriginal clients, and CTG;
 - Provide Aboriginal people with relevant information about reimbursements and supplementary schemes to reduce out-of-pocket expenses; and
 - Work with funding bodies to acknowledge the need for sufficient planning, community engagement, workforce development and evaluation and the flexibility required in deliverables and funding across the life of the project.

ENABLER 3: A Strong Heart and Stroke Workforce

GOAL: Increase the capacity and capability of the Aboriginal and non-Aboriginal workforce to provide high quality, culturally responsive, collaborative CVD care.

Rationale

- There is agreement from government and Aboriginal community controlled peak bodies that an appropriately skilled, available and responsive Aboriginal and Torres Strait Islander health workforce is critical. Aboriginal healthcare providers connect community members to health care and bring a combination of clinical, cultural and community development skills. Their understanding of holistic care and ability to work as cultural brokers and health system navigators while providing culturally safe care, facilitates access in a disparate health system²⁰;
- It is important to recognise that the Aboriginal workforce is diverse and includes many roles such as AHW/P, Aboriginal maternal infant care workers, Aboriginal liaison officers, Aboriginal cultural consultants, care navigator roles etc;
- Aboriginal Health Practitioners have a particularly high level of clinical skills and are trained to work autonomously. In recognition of this they must meet practice standards and be registered under the Australian Health Practitioner Regulation Agency (AHPRA)²⁰;
- Cardiovascular disease is everybody's business, and it is important that all staff working with Aboriginal communities have a foundation understanding of CVD in the context of Aboriginal people's unique history and the impact of colonisation. Furthermore, CVD management should consider factors such as earlier onset of CVD and the additional social, emotional, and cultural requirements of Aboriginal people with CVD;
- To improve outcomes for Aboriginal people it is critical that AHWs and AHPs and other Aboriginal workforce are integrated into interdisciplinary heart and stroke care teams as this will lead to improved access and uptake of services, more effective diagnoses and treatments and earlier intervention and prevention.²⁰ For this to occur we need to educate non-Aboriginal clinicians about their clinical and cultural roles within the interprofessional care team and build the capacity of the Aboriginal workforce to fulfill these roles;
- There is a gap in the knowledge and skills in the current workforce in delivering health/ CVD education and health promotion initiatives to community;
- There is variable access to training sources that are timely, proximal, appropriate and cost effective. It is important that Aboriginal staff can access disease specific education within their Certificate IV and through ongoing professional development. As part of this there need to be clear career pathways, recognition and remuneration according to skill level, and access to clinical support for Aboriginal staff who have an interest in specialising in heart and stroke education and management; and
- Equip the workforce to deal with social and emotional wellbeing in the context of heart and stroke.

Pathways to action

- Support the Aboriginal and non-Aboriginal workforce to develop the skills, knowledge and competencies required to provide culturally responsive heart and stroke care and education;
- Grow and sustain the roles that support and optimise heart and stroke care coordination for Aboriginal people;
- Establish strong clinical leadership with primary healthcare services to drive positive and evidence-based changes in prevention, early detection and management;
- Ensure that non-Aboriginal staff complete cultural safety training;
- Train the non-Aboriginal workforce to know what Aboriginal specific information they need to be aware of when an Aboriginal client presents to clinic and how to work collaboratively with the Aboriginal health care team to meet the client's needs;
- Establish clear transition pathways for Aboriginal students into the workforce;
- Ensure Aboriginal staff can access clear career pathways to specialise in heart and stroke education and management;
- Actively aim for relevant staff to have specifically allocated time to attend training sessions and manage chronic disease;
- Build awareness and capacity of AHW/Ps to deliver client and community education across the heart and stroke care continuum, including support AHW/Ps to undertake relevant heart and stroke related training;
- Advocate for culturally appropriate RTO capacity / options for the state especially for Certificate IV including capacity for optional units such as CVD;
- Take a conscious approach to embedding the Aboriginal workforce as core members of the collaborative heart and stroke care team;
- Include Aboriginal specific positions in cardiac and stroke specialisations;

Develop and implement strategies to increase the heart and stroke specialist workforce in areas of need, particularly western and northern Adelaide, and the far west and north of South Australia. This needs to include nurses, allied health workers and cardiologists. Efforts must include:

- The training and education sector;
- Improved employment incentives; and
- Support of local capacity building.

ENABLER 4: Transport and Accommodation Support

GOAL: Improve access to health care through transportation (ensuring Aboriginal people have safe and appropriate home-to-care-to-home journeys) and culturally appropriate accommodation options for Aboriginal people.

Rationale

- Many community members, both in metropolitan Adelaide and rural and remote communities refer to transport and accommodation as a barrier to accessing primary health, allied health and specialist services;
- SA Health and the Rural Support Service provides a transport and accommodation subsidy through the Patient Assistance Transport Scheme (PATS).²¹ Subsidies are provided to assist clients, who are required to travel more than 100 kilometres each way, to access necessary and approved medical specialist services (the specialist must be registered in a speciality under the medical board of Australia) that are not available locally;
- The PATS Aboriginal Engagement Strategy has been established an ongoing Aboriginal Liaison Officer position to help support Aboriginal clients in accessing PATS subsidies.²¹ Changes for Aboriginal clients include:
 - » Providing subsidies in advance
 - » Removal of the concession card requirement for the first night of accommodation subsidy

- » Automatic approval for travel partner subsidies (escorts)
- » Grant payment for advocacy agencies who support clients to complete online claims
- SA Health has a list of short-term accommodation options for Aboriginal rural and remote clients who are visiting metropolitan hospitals for care.^{22,23} However, service providers are often unaware of what accommodation options are available.

Pathways to action

- Develop a transport process to ensure that Aboriginal clients have safe home-to-care-to-home journeys. The model must:
 - » Minimise out-of-pocket expenses to clients with health care needs;
 - » Provide transportation subsidies for clients attending appointments where PATS are unable to cover (i.e., visiting a non-medical specialist);
 - » Ensure that all clients have access to safe, culturally appropriate transportation that suits their medical condition;
 - » Coordinate transport with the health service;
 - » Ensure that all regional and remote clients who are transferred as an in-patient are transferred back to the closest hospital to their home, as an inpatient;
- Identify existing Aboriginal specific accommodation options and work with housing providers to determine how to share directory with service providers; and
- Advocate for increased culturally safe, appropriate, affordable and more Aboriginal accommodation options (including weekend accommodation options for families) to ensure that clients and family members can access health services as required.

ENABLER 5: Information and Communications Technology Solutions

GOAL: Invest in resources, coordination and systems for telehealth and virtual care. Also improve the utilisation and communication of information across patient information management systems.

Rationale

- Innovative technologies can help address specific challenges faced by health care including reducing cost and utilisation, delivering better outcomes in a lower cost environment, and improving access and the client experience;
- Innovative technologies, such as telehealth and home monitoring devices have shown to be effective. However, ICT relies on Wi-Fi bandwidth, workforce to be trained in use and the appropriate hardware and software to meet the needs of clinical staff and service users;
- As the efficacy and efficiency of ICT solutions are demonstrated, there should be core funding made available to enable these solutions to be common practice. Where core funding has been temporarily introduced during the COVID-19 pandemic, this should be maintained and expanded where it has been effective and cost-effective;
- There remains limited integration of ICT solutions in a systematic manner into models of care in SA;
- Some ACCHOs across SA, including AHCSA have the infrastructure for telehealth use. However, due to a lack of resources and funding, these facilities are not being utilised extensively; and
- The uptake of My Health Record at ACCHOs is limited and its use is dependent on receiving hospital discharge summary data.

Pathways to action

- Invest in resources, coordination and systems for telehealth with the aim of embedding it into routine models of care;
- Ensure all health care services statewide have access to functional telehealth;
- Identify funding mechanisms to support innovative technologies so that these services become sustainable;
- Identify what supports are required to embed My Health Record in general practice, allied health, specialists, ACCOs, all community health centres and hospitals. A clear role out strategy should include;
 - » All health services can clearly explain personal control of and potential benefits from My Health Record, to overcome clients' fears;
 - » Targeted and culturally appropriate promotion of My Health Record;
- Ensure hospitals provide discharge summary data to ACCHOs in a timely manner; and
- Provide ongoing support for staff on the use of patient practice software systems, including new and visiting staff.

ENABLER 6: Community Engagement

GOAL: Meaningful engagement of Aboriginal people, families and communities must underpin the design and implementation of projects and services associated with this Plan.

- A well planned engagement plan must target appropriate stakeholders, taking into consideration Aboriginal language groups and traditional custodianship of Country, key Aboriginal Elders and community leaders and the dynamics and relationships that make up the social and cultural fabric of the community; and
- Community engagement enables health system planners, policy makers and health service providers to action the priorities outlined in this Plan in a way that ensures respect for community values and mindful of community dynamics and cultural norms.

Rationale

- The engagement of Aboriginal people, families and communities is essential to ensure that projects and services to address CVD are relevant for Aboriginal people and meet community standards and expectations²⁴;
- Genuine engagement demonstrates integrity through deep listening, and respect for cultural knowledge and community decisions, which is key to the principle of Aboriginal self-determination²⁴;
- Cultural values need to be embedded in the process of engagement. The process of yarning enables collective decision-making and needs to be included in the engagement approach, alongside individual consultations. Considerations of gender and age specific consultations and community members' cultural responsibilities (e.g., caring for Country, kinship bonds, caring for others and cultural belief systems) are also critical to ensure cultural safety²⁵;
- Reciprocity and long-term relationships are key to successful and meaningful engagement. Community needs to be kept informed about the impact of their engagement on the design and delivery of projects and services and be given an opportunity to provide oversight on a long-term basis^{24,25};

Pathways to action

- The purpose of the engagement must be well defined, and the engagement approach tailored to meet the objectives of the engagement and the requirements of community stakeholders²⁶;
- Involving the appropriate stakeholders and ensuring that the target communities are adequately represented and included in the engagement is also critical. The community may be a Traditional Owner group, or it may be regional or national. Other factors such as gender or age might determine, who the community is, or a particular professional background.²⁵ For the purposes of this Plan, members of the community, who are affected by CVD or have a lived experience, including carers and family members, need to be considered;
- The level of engagement needs to be determined based on the purpose, and the means of engagement chosen accordingly. "Levels of engagement" are well described in the International Association for Public Participation (IAP2) Spectrum of Public Participation (see diagram 2)²⁶;

- The means of engagement need to be negotiated with community representatives, to ensure that the “right” approach is chosen to allow for Aboriginal people’s voices to be heard. Opportunities for collective engagement through yarning circles should be considered as well as individual engagement. Involvement of Aboriginal leaders in undertaking the engagement also needs to be carefully considered and community dynamics and sensitivities taken into account^{24,25,26}; and
- A commitment to reciprocity needs to be actioned through a long-term commitment to maintain the community engagement

and ensure that the community maintains a level of oversight and ability to continuously influence the implementation of projects and services. Community reference groups or similar mechanisms should be maintained for the duration of projects and services, so the community can oversee the work, ensure their voices are heard, their feedback is incorporated, and integrity maintained. Wherever possible, the community should be empowered to understand the health system and policy context as well as the financial implications associated with the work (e.g., financial limitations, expenditure, any costs and savings associated with the work).^{24,25}

IAP2 Spectrum of Public Participation



IAP2’s Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public’s role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION					
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

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Diagram 2: IAP2 Spectrum of Public Participation²⁶

ENABLER 7: Integrated and Coordinated Services

GOAL: Achieve continuity of care for Aboriginal people with CVD through culturally responsive, integrated and coordinated services.

Rationale

- Continuity of Care is defined by the World Health Organization (WHO) as the degree to which people experience a series of discrete healthcare events as coherent and interconnected over time and consistent with their health needs and preferences. A health system, characterised by integrated and coordinated services, focussing on CVD and working collaboratively and harmoniously across multiple providers within interdisciplinary teams and across care settings and sectors, is essential to effectively and holistically address the needs of Aboriginal people affected by CVD, their families and communities²⁷;
- Continuity of Care needs to occur on a number of levels to achieve better quality and address the disparities in health outcomes related to CVD²⁷:
 - » **Interpersonal** – which refers to the relationship between health service providers, clients and their families or carers, provides a key contact person to assist clients navigating their care, and a commitment by all service providers to meet the clients' and their families' physical, social, emotional and cultural needs;
 - » **Longitudinal** – or continuity over a period of time, which is enabled by discharge and care planning, integrated referral and follow-up systems and by the support from a navigator role to support the clients' journey;
 - » **Cardiovascular disease management** – integrated and coordinated case management across services and sectors (i.e., primary, secondary, tertiary), interdisciplinary team care approaches to enable a collaborative focus on the clients' need over the duration of their care, joint care planning and monitoring of progress;
 - » **Informational** – focussing on communication between health service providers and the clients' and families as well as between services, sectors and within interdisciplinary team, which includes effective patient information management and shared records as well as standardised assessments and models of care for CVD management.²⁷
- Access to culturally responsive integrated and coordinated services enables support for chronic disease self-management, early intervention and prevention of complications and improved outcomes;
- Fragmentation of a health system with a large number of service providers across primary, secondary and tertiary care and from government and non-government, including Aboriginal community-controlled, sectors is a common occurrence, as are siloed approaches by health care providers from different professional and specialist background. Opportunities for integration and coordination need to be sought and maximised to achieve better quality and continuity of care, improved health outcomes and also efficient use of resources;

-
- The SA Government is committed to integrated care through its Wellbeing SA Integrated Care Strategy which includes three priority areas²⁸;
 - » putting people at the centre of their care;
 - » delivering connected care and
 - » working together as a system.
 - Within the PHNs, integrated and coordinated care is supported through a number of initiatives including the Integrated Team Care Program that supports Aboriginal and Torres Strait Islander people who live with complex chronic conditions; and
 - The SA Aboriginal Chronic Disease Consortium, through its governance structures and implementation of projects to implement this Plan, provides an opportunity for coordination and collaboration with a wide range of stakeholder organisations and community stakeholders.
 - Focus on interdisciplinary (rather than multidisciplinary) team care approaches, to integrate separate professional discipline approaches into a single consultation, including a team approach to assessment, diagnosis, intervention, setting short- and long-term management goals together with clients and families and jointly monitor progress²⁹;
 - Explore opportunities to enhance care coordination through dedicated Aboriginal coordinator/navigator roles and aim to allocate the care providers to clients, to establish long-term relationships;
 - Work towards integration and alignment of patient information management systems, to enable better flow of information and follow-up of clients-in-common;
 - Implement multi-agency service agreements, Memoranda of Understanding, Memoranda of Administrative Agreements and other formal partnerships between services and organisations, to facilitate collaboration on operational matters such as project planning, contract management and reporting; and
 - Explore opportunities for collaboration to improve integration and care coordination across chronic disease areas.

Pathways to action

The following should be considered to achieve better service integration, coordination, and partnerships:

- Engage with the SA Aboriginal Chronic Disease Consortium, Wellbeing SA, Aboriginal community and other key partners to co-design standardised assessments and shared models of care, that enhance the delivery of integrated and coordinated chronic disease care;
- Improve discharge planning and establish agreed referral pathways, communication between professionals and across organisations, including through integrated case management and patient information management to better integrate within and between services and sector;

GOAL: Monitor and evaluate the implementation of the Plan and health system changes that result in better health care of Aboriginal people.

Rationale

- Monitoring and evaluation of this Plan is currently occurring through the SA Aboriginal Chronic Disease Consortium;
 - The existing monitoring and evaluation framework needs to be revised to include indicators and areas that are not currently in the framework;
 - An improvement is needed in the timely release of data to enable effective monitoring and evaluation;
 - It will be important to have in place good systems to monitor the impact of collective efforts at a population level;
 - Aboriginal people should be involved in determining what is important to them and must be involved in monitoring and evaluating the impact of policy initiatives on health and wellbeing;
 - The continuous quality improvement (CQI) process aims to improve the quality of Primary Health Care (PHC), using evidence-based frameworks. Ideally, it is inclusive of all staff and allows for the objective analysis of clinical health results and a staff review of systems, which are used to inform positive improvements in healthcare; and
 - CQI results do show that there are varying degrees of quality across PHC services. Those PHC services in most need should be supported to improve the quality of care they provide.
- ### Pathways to action
- Review and modify the existing monitoring and evaluation framework to measure and report on the impact of the SA Aboriginal Heart and Stroke Plan. The following should be monitored and evaluated:
 - Implementation of actions;
 - The CCC partner projects that address priority areas and actions of the Plan;
 - Community involvement and intersectoral partnerships;
 - A process to adapt to the new needs of community; and
 - Maintain an up-to-date evidence based.
 - Develop a system to evaluate the provision of culturally safe care on an ongoing basis in all areas of the health system, including private general practice and its impact on service use by Aboriginal people (use the cultural safety in healthcare for Indigenous Australians: monitoring framework as a guide³⁰);
 - Improve processes to accurately identify Aboriginal status across pathways of care (i.e., primary, secondary and tertiary levels of care);
 - Ensure reliability of data on participation rates in screening;
 - Monitor and respond to changes in geographical distribution of the Aboriginal community for future planning and include forced migration to metropolitan areas for health service reasons;
 - Support ongoing engagement and implementation of CQI processes and systems in all PHC services in SA;
 - Integrate CQI into all health services;
 - Investigate with the PHNs establishing a CQI program within the private general practice sector that includes performance-based payments and annual reporting against the national key performance indicators;

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- All SA Health services to complete an Aboriginal Health Impact Statement for all Aboriginal CVD services, projects, and programs;
 - Measure performance across the system, including health promotion, primary health care, diagnostic services, specialist services, acute services, rehabilitation services and secondary prevention services, and the transition between these service sectors; and
 - Establish a centralised register to report on patient outcomes in all cardiac and stroke units.

Monitoring Progress of the SA Aboriginal Heart and Stroke Plan 2022–2027

The table below list the **5 priority areas** with **21 actions** and **8 enablers** of this Plan. To map the progress made against action, a traffic light system approach will be used. Red indicates that there is no work that has commenced against this action, yellow shows that the action has commenced but is not completed and green highlights that the action is completed.

STAGE	ACTION	OUTCOME
Cross Sector Services	1. Review and reorient current mechanisms to improve delivery of culturally appropriate comprehensive primary health care services.	Enhancing services that have touch points across the continuum of care to help facilitate a connected network approach to service provision.
	2. Develop a statewide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks based on greatest demand or need.	
	3. Maintain and expand the existing SA Rheumatic Heart Disease Control Program.	
	4. Enhance care for the identification, acute and ongoing care of children and adolescents with heart disease and stroke by paediatric cardiology services, with effective transition pathways into adult cardiology services.	
Primary Preventive Care	5. Establish sustainable heart, stroke and diabetes awareness and prevention campaign/s across SA.	Promotion of healthy lifestyles, prevention of disease, and assessment and management of risk and early disease as part of comprehensive primary health care.
	6. Increase the use of cardiovascular risk assessment and management in all primary care settings.	
Clinical Suspicion of Disease	7. Develop and implement a model of care and referral pathways to provide timely access to non-acute diagnostic services for identification and management of disease.	Timely diagnosis of heart disease and stroke associated risk factors and access to specialist services and support by specialists as close to the individual's home as possible.
	8. Establish a coordinated statewide specialist outreach service plan.	
Acute Episode Care	9. Increase awareness of the warning signs and symptoms of heart attack and stroke among the Aboriginal community and service providers.	
	10. Improve access to emergency care by reducing the out-of-pocket costs of ambulance services.	
	11. Establish a system to identify Aboriginal or Torres Strait Islander status at the first point of medical contact.	
	12. Develop and implement a transfer and retrieval services protocol that responds to the clinical and cultural needs of Aboriginal people.	

Acute Episode Care	13a. Maintain and expand iCCnet, Rural Support Service to provide coordinated services from first medical contact to definitive care for regional and remote Aboriginal clients with acute heart disease.	Equitable access to the best and most reliable acute health care possible, which delivers high quality, well configured, patient centred services in hospital.
	13b. Implement a regional system of care from first medical contact to definitive care for regional and remote Aboriginal clients with stroke or Transient Ischaemic Attack (TIA).	
	14a. Provide best practice clinical and cultural care for Aboriginal clients with heart disease at all South Australian hospitals, with targeted efforts at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Port Augusta Hospital and Ceduna Hospital.	
	14b. Provide best practice clinical and cultural care for Aboriginal stroke clients at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Riverland General Hospital, Mount Gambier, Districts Health Service, Whyalla Hospital, Port Lincoln Hospital, Port Pirie Hospital, Wallaroo Hospital and Naracoorte Hospital.	
Ongoing Care	15. Establish and maintain where existing, an Aboriginal heart and stroke Aboriginal Health Practitioner/Nurse Coordinator position at Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Port Augusta Hospital and Ceduna Hospital to support Aboriginal clients and their families throughout their journey of care.	Optimisation of transitions of care out of care out of hospital, rehabilitation, and the provision of ongoing preventative care.
	16. Develop a statewide approach to a rheumatic valvular surgery centre of excellence.	
	19. Establish a model of culturally appropriate, evidence-based cardiac and stroke rehabilitation services.	
	20. Build capacity in primary health care to provide coordinated management, secondary prevention and ongoing care for clients with established disease.	
	21. Establish culturally appropriate models of care and protocols for palliative and end of life care specifically for Aboriginal clients.	

ENABLERS	ACTIONS	OUTCOME
Governance: Aboriginal Leadership and Partnerships	Refer to 'Governance' section for a full list of actions.	Establish and maintain robust governance structures, led by Aboriginal professionals and organisations, equipped to foster partnerships and collaboration between the wide range of organisations and stakeholders responsible for implementing this Plan.
Sustainable Funding	Refer to 'Sustainable Funding' section for a full list of actions.	Appropriate levels of funding to be available for implementation of projects and services within appropriate timeframes.
A Strong Heart and Stroke Workforce	Refer to 'A Strong Heart and Stroke Workforce' section for a full list of actions.	Increase the capacity and capability of the Aboriginal and non-Aboriginal workforce to provide high quality, culturally responsive, collaborative CVD care.
Transport and Accommodation Support	Refer to 'Transport and Accommodation Support' section for a full list of actions.	Improve access to health care through transportation (ensuring Aboriginal people have safe and appropriate home-to-care-to-home journeys) and culturally appropriate accommodation options for Aboriginal people.
Information and Communication Technology (ICT) Solutions	Refer to 'ICT Solutions' section for a full list of actions.	Invest in resources, coordination and systems for telehealth and virtual care. Also improve the utilisation and communication of information across patient information management systems.
Community Engagement	Refer to 'Community Engagement' section for a full list of actions.	Meaningful engagement of Aboriginal people, families and communities must underpin the design and implementation of projects and services associated with this Plan.
Integrated and Coordinated Services	Refer to 'Integrated and Coordinated Services' section for a full list of actions.	Achieve continuity of care for Aboriginal people with CVD through culturally responsive, integrated and coordinated services.
Monitoring and Evaluation	Refer to 'Monitoring and Evaluation' section for a full list of actions.	Monitor and evaluate the implementation of the Plan and health system changes that result in better health care of Aboriginal people.

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Appendix A

We would like to thank the following groups and organisations for their contribution to the revision of the SA Aboriginal Heart and Stroke Plan 2022-2027. We thank you all for taking the time to share your insights.

- Aboriginal Executive Directors
- Aboriginal Health Council of South Australia (AHCSA)
- Adelaide Primary Health Network
- Australian Stroke Alliance
- Central Adelaide Local Health Network (CALHN)
- Flinders University
- Heart Foundation
- Heart and Stroke Leadership Group
- Northern Adelaide Local Health Network (NALHN)
- Rheumatic Heart Disease Control Program
- Royal Adelaide Hospital (RAH)
- Rural Support Services (RSS)
- SA Pharmacy
- Southern Adelaide Local Health Network (SALHN)
- Telethon Kids Institute
- University of South Australia



**SA ABORIGINAL
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