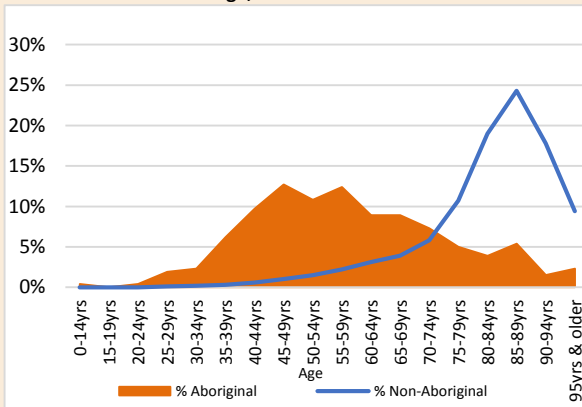
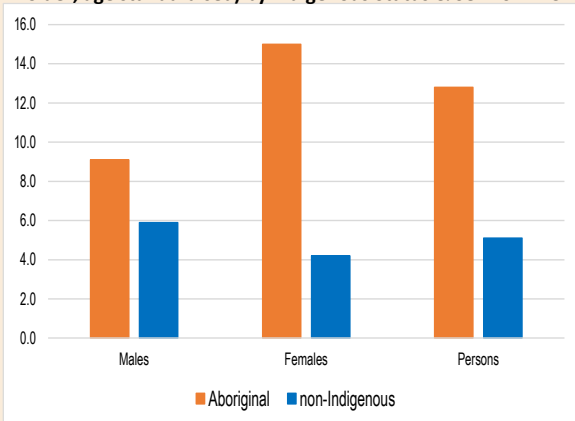




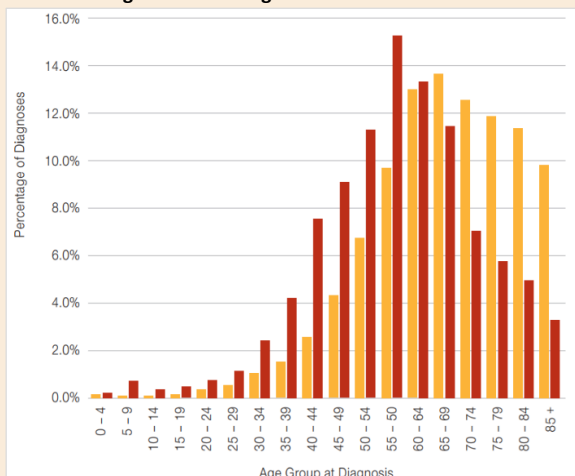
Deaths from cardiovascular disease, by Aboriginal status and age, SA 2006-2012



Prevalence (%) of Type II Diabetes in SA (persons 18yrs & older, age standardised) by Indigenous Status & Sex 2011-13



Age at cancer diagnosis in South Australia



Introducing the SA Aboriginal Chronic Disease Consortium

The gap in life expectancy that forms the daily reality for Aboriginal peoples is no new fact. Recent statistics show up to a 10.6 and 9.5-year life expectancy difference for Aboriginal males and females respectively when compared to their non-Aboriginal peers. A key factor contributing to this gap is the burden of chronic disease experienced within the Aboriginal community. More than one in three Aboriginal South Australians report having three or more long term health conditions.

In recognition of the vital importance of addressing disparities in chronic disease **three plans focusing specifically on diabetes, cancer and heart and stroke** in Aboriginal people have been developed with wide stakeholder and community support. These plans were completed on June 30 2016. Twelve months' later, priorities that affect all three conditions, "Across Plan Priorities", as well as "Condition Specific Priorities", have been included in the SA Aboriginal Chronic Disease Consortium Road Map for Action. The Road Map outlines the key strategies for implementation over the next 5 years and forms the work agenda for the SA Aboriginal Chronic Disease Consortium members.

Vision of the SA Aboriginal Chronic Disease Consortium

To reduce the impact of chronic disease experienced by Aboriginal and Torres Strait Islander people living in South Australia through the delivery of collaborative, appropriate, well-coordinated, evidence based strategies to successfully implement the priorities in the South Australian Aboriginal Cancer Control Plan 2016-2021, South Australian Aboriginal Heart and Stroke Plan 2017-2021, and the South Australian Aboriginal Diabetes Strategy 2017-2021.

Guiding Principles of the SA Aboriginal Chronic Disease Consortium

- Aboriginal health is everybody's business
- Aboriginal leadership is essential
- Prioritise community participation
- Culturally safe care is essential
- Aboriginal primary care is a key driver of improved outcomes
- Family must be a focus/partners in care & interventions
- To improve health, the impact of the social barriers must be addressed
- Services must be consistent, available and accessible
- Activities must recognise and respect cultural diversity
- Use partnerships to plan, deliver and evaluate healthcare
- Provide holistic care which recognises comorbidities
- Focus on coordination and continuity of care
- Ensure commitment and accountability



South Australian Academic Health Science and Translation Centre

The implementation of the three plans has been supported by the South Australian Aboriginal Health Partnership (SAAHP). SAAHP is an executive level, cross-sector committee which brings together the State and Commonwealth Governments and the Aboriginal Community Controlled Health Sector to improve Aboriginal health and wellbeing outcome in South Australia.

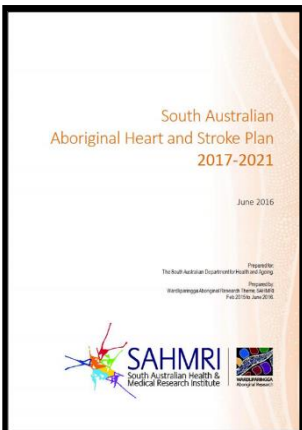
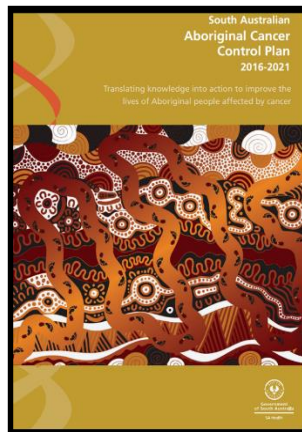
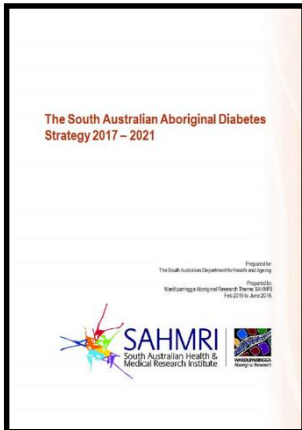
SAAHP's support has led to the creation of the South Australian Aboriginal Chronic Disease Consortium (SA ACDC), which sits within the newly established, NHMRC accredited SA Academic Health Science and Translation Centre (the Translation Centre).

The Translation Centre represents a partnership between SA Health, South Australian Health and Medical Research Institute (SAHMRI), University of Adelaide, Flinders University, University of South Australia, Aboriginal Health Council of South Australia, Health Consumers Alliance of South Australia, Adelaide Primary Health Network, Country SA Primary Health Network and Cancer Council SA. The Translation Centre has 9 priority areas of which one is Aboriginal Health. It is a virtual centre that is administered by SAHMRI.

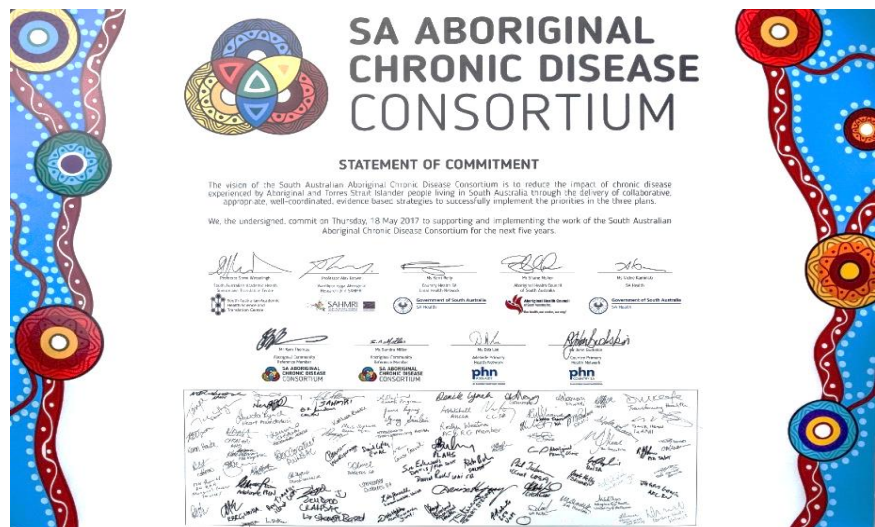
The SA Aboriginal Chronic Disease Consortium:

- Is housed within the Translation Centre at SAHMRI
- It has a high level Executive Group, a Community Reference Group and three condition specific Leadership Groups
- Members includes clinicians and service providers from both the acute and primary care sectors, policy makers, non-government organisations and advocates all who are committed to reducing the impact of chronic diseases on Aboriginal communities.
- The SA Aboriginal Chronic Disease Consortium Road Map for Action will be the framework to guide and prioritise activities and investment.

The SA Aboriginal Chronic Disease Consortium is very pleased to be working in a flexible, innovative and dynamic way with community to drive change.



SA Health



The South Australian Chronic Disease Consortium acknowledges that this has been funded and supported by the Government of South Australia through the Department for Health and Ageing. The content is solely the responsibility of the authors and does not necessarily represent the official views of the Government of South Australia.

The SA Aboriginal Chronic Disease Consortium Road Map for Action – Priorities, Strategies and Actions

The Road Map for Action was developed through extensive consultation with Consortium Working Groups and Community Members. There are 10 Priority areas and 27 Priority Strategies. It acknowledges that Strengthening Social and Emotional Wellbeing is a precursor to achieving all other action areas; Prevention and Early Detection, Acute Management, and Ongoing Management are all components of the continuum of care and focus of specific service areas; and Improve Access to Services, Improve Workforce, and Monitor and Evaluation are to be considered as underpinning the entire continuum of care and as such will be relevant to all service areas.

	Strategy	Action
Strengthen Social and Emotional Wellbeing	Support activities to improve mental health and wellbeing and respond to intergenerational trauma, grief and loss and disconnection to land and community	<ul style="list-style-type: none"> - Work with PHN to identify opportunities to develop partnerships with mental health services already funded. - Understand, acknowledge, promote and record the comprehensive approach of the ACCHO sector and the importance placed on supporting the social and emotional wellbeing of clients and their families.
	Use community, peer led responses to drive action that incorporate self-management principles	<ul style="list-style-type: none"> - Review current community, peer-led and self-management models and advocate for sustainable funding to support their implementation as part of prevention and ongoing strategies.
	Advocate for investment in the cultural social determinants of health	<ul style="list-style-type: none"> - Advocate for investment in education and housing initiatives to support Aboriginal families. - Advocate for the sustainable funding and expansion of the Aboriginal Environmental Health Program delivered through SA Health in remote Aboriginal communities. - Engage with local councils to influence planning and development policies to consider and address health impacts for Aboriginal communities under the Public Health Act.
Prevention and Early Detection	Implement prevention/health promotion strategies that are culturally appropriate for all Aboriginal people	<ul style="list-style-type: none"> - Develop a state-wide awareness campaign which includes messages specifically developed for Aboriginal people with a focus on warning signs, symptoms and preventative actions relevant to cancer, diabetes, and heart and stroke across the lifespan. - Recognise and build on current preventative activities including tobacco control and lifestyle programs that are currently being delivered across SA to be culturally appropriate and be able to reach all Aboriginal communities.
	Undertake a state wide approach to improve risk factor identification and screening rates	<ul style="list-style-type: none"> - Develop and implement a model of risk factor assessment and screening for cancer, heart and stroke and diabetes for Aboriginal people. This would include Cardiovascular Risk Assessment, screening for pre-diabetes and diabetes and screening for cancers across the lifespan. This should also include some focused screening for pregnant women.
Acute Management	Improve care coordination across the patient journey	<ul style="list-style-type: none"> - Work with key stakeholders to determine current level of workforce activities, demands and needs across cancer, heart and stroke and diabetes care. This must include entering and exiting the acute service as well as supporting care in hospital and increasing services to meet needs.



	Improve cultural appropriateness of services	- Mandate cultural training for all staff at all levels across all Consortium partners and any agencies funded by consortium partners.
	Undertake opportunistic identification and management of disease	- Develop a protocol across Consortium partners to embed opportunistic identification and management of disease across the health sector. This should build on compulsory reporting and mandating compulsory fields in data collection systems.
Ongoing Management	Design and implement systematic discharge, referral and follow-up	- Explore all current activities in SA Health to establish a central referral system and develop an agreed protocol which incorporates systematic discharge, referral and follow up care. - Develop agreed protocols for follow up care post discharge with patient and primary care providers and other providers of ongoing care.
	Develop and implement rehabilitation and survivorship programs that meet the needs of people across the state	- Develop ongoing management, rehabilitation and survivorship programs for patients and their families across the health care system, including the Aboriginal Community Controlled Health Service system.
Improve Access to Services	Build local capacity in staff and systems	- Work with Consortium partners to increase and build capability of health workforce and services specifically in diabetes, cancer and heart and stroke. Consider training opportunities for local staff that would offer standardised approaches across the state.
	Enhance Specialist Outreach Services	- Facilitate specialist services to the ACCHO sector where gaps exist in high need areas. - Explore opportunities to link specialists, SA Health and the ACCHO sector through tele-medicine.
	Use technological solutions	- Develop a model of point of care testing accessible to all Aboriginal people across South Australia, irrelevant of geographical location. - Develop systems, in partnership with Rural Doctors Workforce Agency, SA Health and the ACCHO sector to encourage increased use of tele-medicine for follow up appointments and other services.
	Increase access to medications	- Advocate and facilitate discussion with SA Health regarding the removal of co-payments of medication on discharge from public hospitals across SA. - Develop a Partnership Project with National Prescribing Service to improve services in Primary Care for managing risk factors and treating patients post discharge.
	Provide Transport and accommodation support for patients and families	- Develop a transport model which ensures Aboriginal people have safe home to care to home journeys. - Develop or enhance step-down units to meet the clinical and cultural demands of regional, remote and interstate Aboriginal patients.
Improve Workforce	Build and support the Aboriginal workforce	- Develop a strategy which supports Aboriginal workforce activities currently being undertaken across Consortium partners. - Develop chronic health conditions training curriculum to be incorporated into existing training (increasing the Aboriginal workforce and its capacity is an enabler across all three plans).
	Ensure the mainstream workforce is culturally competent	- Mandate cultural training across all Consortium partners and any agencies funded by Consortium partners.

	Enforce a policy of 'Zero Tolerance to Racism'	- Work with partners and other agencies to support multi-tiered 'Zero Tolerance to Racism' policy which incorporates a commitment from across Consortium partners at senior levels, with a long-term plan for implementation.
Monitor and Evaluate	Improve Aboriginal Identification	- Develop a Consortium partners commitment to implementing a mandatory standard identification question across all services and funded services. - Explore where gaps exist in other services (for example Emergency Services, private General Practice services and Pathology Services).
	Build a monitoring framework that includes ongoing dashboard reporting	- Develop an evidence based indicator set (Dashboard) that incorporates process, impact and health outcomes that can be populated and monitored on a regular basis. This should reflect the priorities of the Road map.
	Inform future research questions	- Work across Consortium partner organisations to determine primary research questions of importance relevant to cancer, heart and stroke and diabetes (aligned to strategies: across plans priority) and collect brief proposals on a research registry.
Heart & Stroke	Prioritise CVD checks	- Work with the risk assessment and early detection project to ensure CVD checks are included.
	Ensure that emergency services are culturally appropriate	- Establish a system to identify Aboriginal or Torres Strait Islander status at the first point of medical contact. - Develop and implement a transfer and retrieval services protocol that responds to the clinical and cultural needs of Aboriginal people. - Work with all emergency services to improve the cultural competence of their services.
Diabetes	Prioritise early detection	- Engage health services to establish accessible and appropriate models of early diabetes detection for Aboriginal people. - Increase Aboriginal health workforce trained to deliver early detection interventions. Increase community access to early detection interventions.
	Reduce diabetes related complications	- Improve access to interventions aimed to minimise burden of complications (allied health, interventions targeting cardiovascular risk factors, treatment/medications). - Increase Aboriginal workforce skilled in diabetes management. - Provide community based models of tertiary health prevention.
Cancer	Prioritise screening	- Provide cancer screening opportunities that are accessible, affordable, appropriate and acceptable to the Aboriginal community. - Invest in increasing the Aboriginal health workforce to engage in cancer screening activities.
	Facilitate Aboriginal Cancer Healing Centres	- Identify existing cancer treatment centres and develop strategies that will shift their approach away from disease management to promoting healing and wellness; this may include structural/environmental interventions, program delivery and staffing. - Advocate for resource allocation to be directed to healing, wellness and survivorship approaches in cancer care and service delivery.

While the Priority Action Areas have been separated for the purpose of defining the Road Map there is overlap, and it is anticipated that achievement in one area will likely impact on delivering successful outcomes in another.

For more information about the SA Aboriginal Chronic Disease Consortium and to be included in the SA ACDC Friends of the Consortium Network *contact - Wendy Keech, Executive Officer, Wendy.Keech@sahmri.com*

South Australian Aboriginal Chronic Disease Consortium Road Map for Action 2017-21

“Across Plan Priorities” – Cancer, Diabetes, Heart and Stroke

Strengthen Social and Emotional Wellbeing

- Support activities to improve mental health and wellbeing and to respond to intergenerational trauma, grief and loss and disconnection to land and community
- Use community, peer led responses to drive actions that incorporate self-management principles
- Advocate for investment in the cultural and social determinants of health

Prevention and Early Detection

- Implement prevention/health promotion strategies that are culturally appropriate for all Aboriginal people
 - Undertake a state wide approach to increase access to risk factor identification and screening for chronic diseases for Aboriginal People across South Australia
- Focus: Primary Health Care Services, Pregnancy related services, Community

Acute Management

- Improve care coordination across the patient journey
 - Improve cultural appropriateness of services
 - Undertake opportunistic identification and management of disease
- Focus: Key hospitals in Metropolitan and Country SA

Ongoing Management

- Design and implement systematic discharge, referral and follow-up
 - Develop and implement rehabilitation and survivorship programs that meet the needs of people across the state
- Focus: Hospital/Primary Health Care interface and Primary Health Care Services

Improve Access to Services

- Build local capacity in staff and systems
- Enhance Specialist Outreach Service
- Use technological solutions
- Increase access to medication
- Provide transport and accommodation support for patients and families

Improve Workforce

- Build and support the Aboriginal workforce
- Ensure the mainstream workforce is culturally competent
- Enforce a policy of 'Zero Tolerance to Racism'

Monitor and Evaluate

- Improve Aboriginal identification
- Build a monitoring framework that includes ongoing dashboard reporting
- Inform future research questions

Condition Specific Priorities

Heart and Stroke

- Prioritise CVD checks
- Ensure that emergency services are culturally appropriate

Diabetes

- Prioritise early detection
- Reduce diabetes related complications

Cancer

- Prioritise screening
- Facilitate Aboriginal Cancer Healing Centres and expand roles and capabilities of existing cancer services