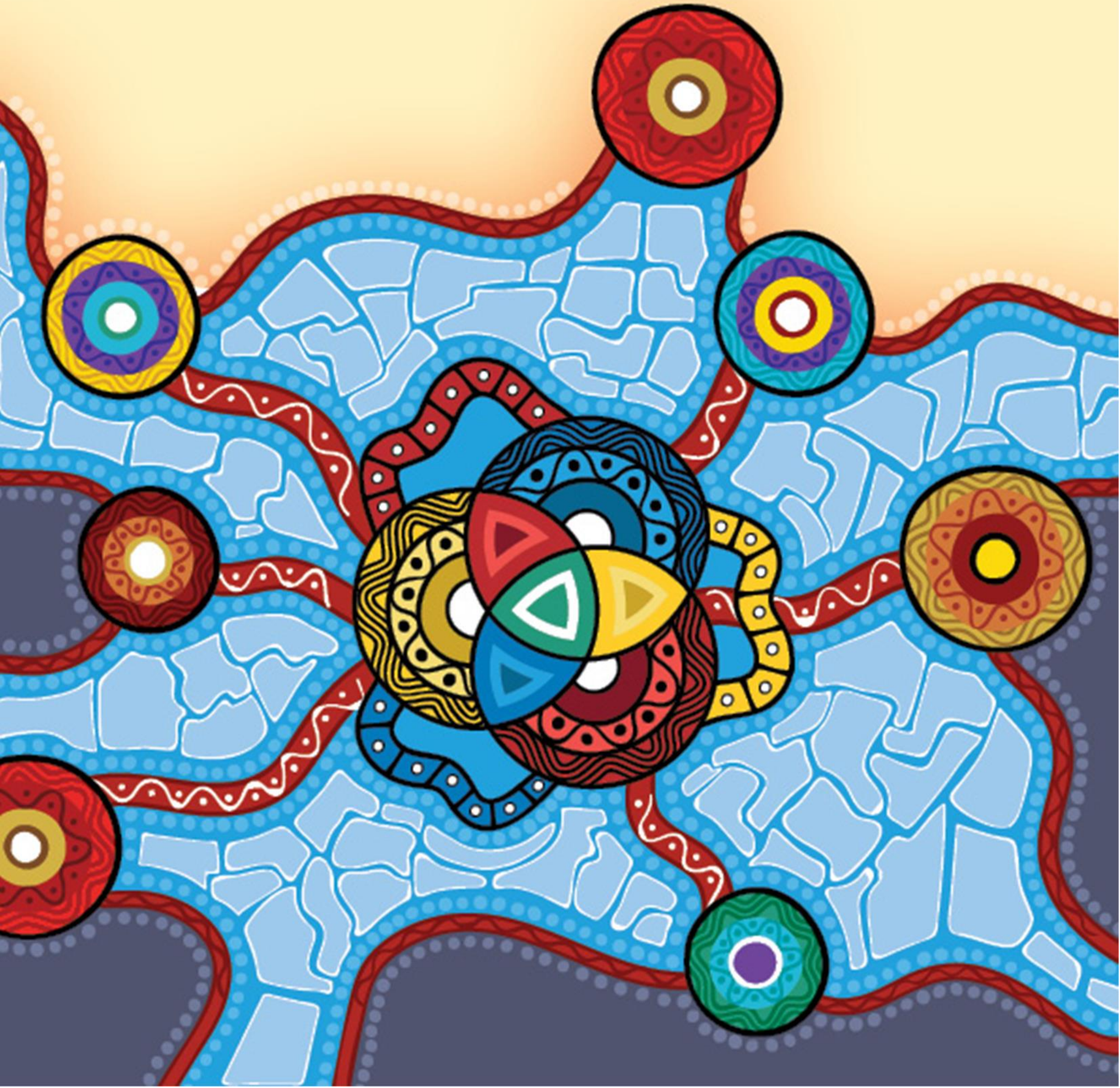
ROAD MAP FOR ACTION

JUNE 30, 2017

SA ABORIGINAL
CHRONIC DISEASE
CONSORTIUM



Government of South Australia
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.

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South Australian Aboriginal Chronic Disease Consortium Road Map 2017-2021

This Road Map has been developed by the SA Aboriginal Chronic Disease Consortium Coordinating Centre on behalf of the Executive Group, Community Reference Group, Cancer Leadership Group, Diabetes Leadership Group, and Heart and Stroke Leadership Group, in consultation with attendees of the May 18, 2017 Priority Setting Workshops. The contributions from all involved is gratefully acknowledged.

Use of the Term 'Aboriginal'

Use of the Term 'Aboriginal' As requested by the SA Aboriginal community, the term 'Aboriginal' is used respectively in this Plan as an all-encompassing term for Aboriginal and/or Torres Strait Islander people living in SA. 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.

This artwork represents the South Australian Aboriginal Chronic Disease Consortium and the interdependence of prevention, care and after care to achieving the best health outcomes for Aboriginal and Torres Strait Islander people. The three central overlapping meeting places signify the across plan priorities of the three plans. Diabetes is depicted by the blue meeting circle; heart and stroke by the red meeting circle; and cancer by the yellow meeting circle. The red, blue and yellow paths show the three plans collaborating and coming together to achieve the best health outcomes and the red paths show the Consortium reaching out to other organisations and communities, represented by the outer meeting circles, which are working together to maximise the effectiveness of the three plans. The small dots are the people going to the organisations and communities and being assisted by the work of the Consortium, and the pale blue puzzle pieces represent the organisations and communities giving the Consortium important feedback.

JORDAN LOVEGROVE Indigenous Artist, Dreamtime Creative Ngarrindjeri young man who combines intimate knowledge of Aboriginal communities and illustration skills to develop outstanding Indigenous artwork which is applied to a range of print and online communications.

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Acronyms

ACCHO	Aboriginal Community Controlled Health
AHCSA	Aboriginal Health Council of South Australia
ALO	Aboriginal Liaison Officer
APPO	Aboriginal Patient Pathway Officers
CanDAD	Cancer and Aboriginal Disparities and Data
CCC	Consortium Coordinating Centre
CHSA DS	Country Health South Australia Diabetes Service
CP	Cancer Plan
CREATE	The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange
CV	Cardiovascular
CVD	Cardiovascular Disease
DASSA	Drug and Alcohol Services South Australia
DECD	Department for Education and Child Development
DS	Diabetes Strategy
ESSENCE	Essential Service Standards for Equitable National Cardiovascular carE for Aboriginal and Torres Strait Islander people
H&S	Heart and Stroke
HbA1c	Glycated haemoglobin
iCCnet	Integrated Cardiovascular Clinical Network
LIME Network	Leaders in Indigenous Medical Education Network
MBS 715	Medicare Benefits Schedule item 715: Aboriginal and Torres Strait Islander Health Assessment
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NDS	National Disability Service
NGO	Non-Government Organisations
NHMRC	National Health and Medical Research Council
nKPI	National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care
NSQHS	National Safety and Quality Health Service Standards
NVDPA	National Vascular Disease Prevention Alliance
NPS	National Prescribing Service
PHC	Primary Health Care
PHN	Primary Health Network
PoC	Point of Care
RACGP	Royal Australian College of General Practioners
RDWA	Rural Doctors Workforce Agency
RFDS	Royal Flying Doctor Service
SAAS	South Australian Ambulance Service
SAATAC	SA Academic Health Science Translation Centre
SDH	Social determinants of health
T2DM	Type 2 Diabetes Mellitus

Section 1.

Creating the South Australian Aboriginal Chronic Disease Consortium

1. Introduction

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 (Australian Bureau of Statistics 2013). 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 (Brown A 2016). 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. They were completed on June 30 2016. The three plans outline priority areas and key activities for implementation over the next 5 years. SA Health funded the development of these plans.

2. High Level Across Sector Support to Implement the Three Plans

Following completion of the plans there were high level discussions with key stakeholders regarding their implementation. It was recognised that an "all of health sector" approach was essential if meaningful improvements against the plans were to be made. These discussions resulted in the establishment of the South Australian Aboriginal Chronic Disease Consortium (The Consortium), which sits within the National Health and Medical Research Council (NHMRC) accredited SA Academic Health Science and Translation Centre (the Translation Centre). The Consortium's purpose is to drive the implementation of the three plans. This approach was endorsed by the South Australian Aboriginal Health Partnership (SAAHP) and SA Health contributed seed funding to establish the Consortium's governance structure and Coordinating Centre.

Who are the South Australian Aboriginal Health Partnership (SAAHP)?

SAAHP is an executive level, cross-sector partnership which brings together the State and Commonwealth Governments and the Aboriginal Community Controlled Health Sector to improve Aboriginal health and wellbeing outcomes in South Australia.

What is the SA Academic Health Science and 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.

3. The South Australian Aboriginal Chronic Disease Consortium

Goal

To drive, coordinate and sustain the implementation of the South Australian Aboriginal Heart and Stroke Plan 2017-2021, the South Australian Aboriginal Diabetes Strategy 2017-2021 and the South Australian Aboriginal Cancer Control Plan 2016-2021. The implementation will address priorities specific to each plan, as well as priorities which span across the three plans.

Vision

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

The "Guiding Principles" are a combination of the principles identified during the development of the three plans and were developed with involvement of the Aboriginal community. These principles have been refined and endorsed by SA Aboriginal Chronic Disease Consortium Community Reference Group and will underpin all of the work of the SA Aboriginal Chronic Disease Consortium as it implements the three plans.

The principles include:

- 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

The approach to establishing the Consortium

The following factors were considered in the establishment of the Consortium:

- The diversity of health services and the people they serve;
- The need:
    - For representation from key parties involved in the continuum of care for Aboriginal people, including representation of the Aboriginal community;
    - For Aboriginal leadership on all working groups including co-chairs;
    - To work with and build on the existing clinical, professional and administrative structures that already have responsibilities to deliver quality services to Aboriginal people;
    - To build on the momentum established during the development of the three plans with key stakeholders including community members;
    - To work from the existing plans to prioritise and implement improvements in collaboration with Aboriginal communities; and
    - To have integrated monitoring and reporting against targets to quantify impact.

The Structure of the Consortium

The Consortium structure comprises of:

- The **Executive Group** who oversee the implementation of the three plans and report directly to the **SA Academic Health Science and Translation Centre Executive Management Group** and will have a reporting line to **South Australian Aboriginal Health Partnership**.
- The **Community Reference Group** who provide implementation guidance and will be representative of the Aboriginal community.
- The **three Condition Specific Leadership Groups** (Diabetes, Heart and Stroke and Cancer) who advise and support implementation of both the "Across Plan Priorities" and the "Condition specific priorities".
- The **Consortium Coordinating Centre** (CCC), funded by SA Health, who provides Operational and Executive support to the South Australian Aboriginal Chronic Disease Consortium.
- **Collaborating partner organisations** who will provide in-kind and/or financial contributions to support the implementation of the plans through the SA Aboriginal Chronic Disease Consortium.

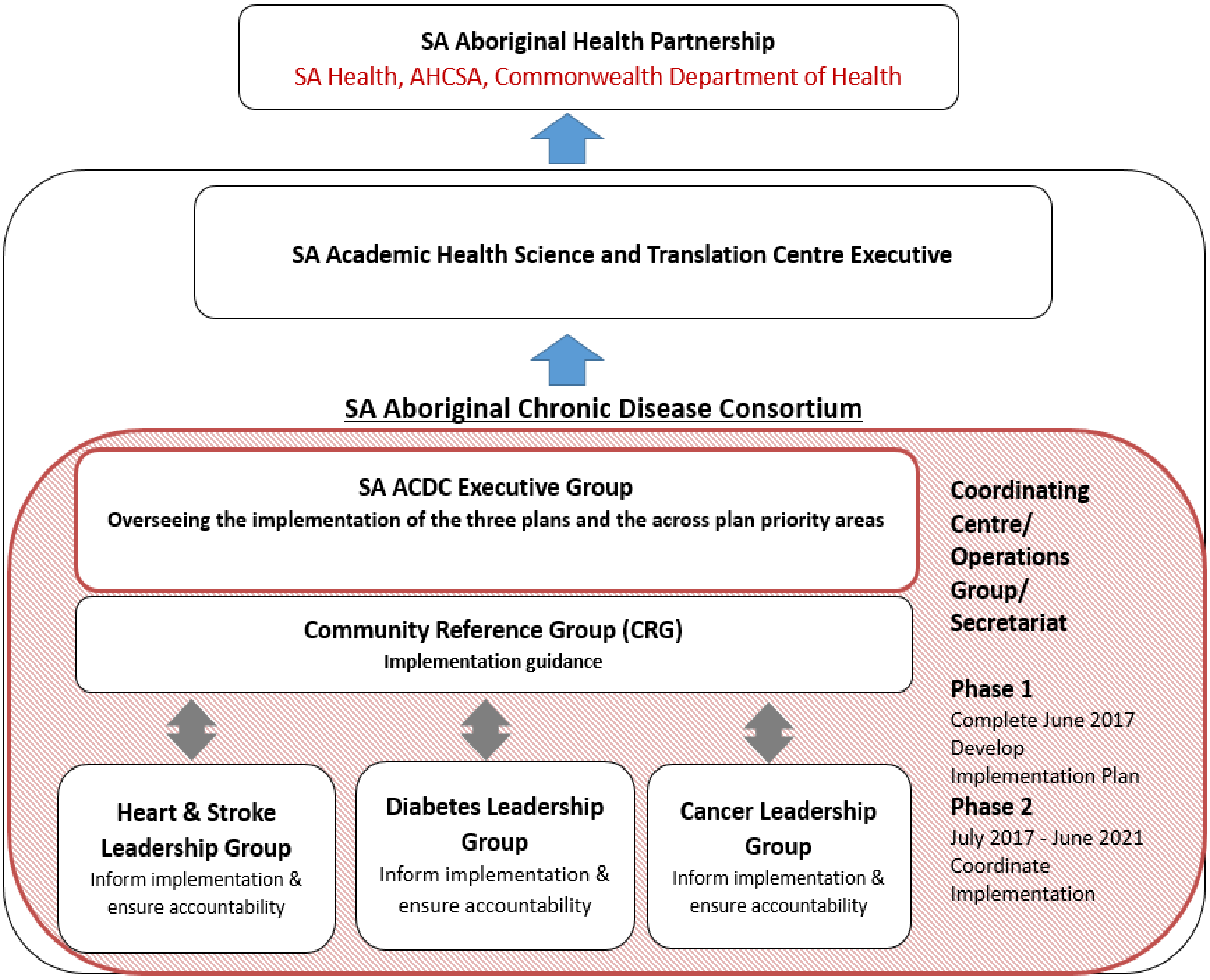


Figure 1

4. SA Aboriginal Chronic Disease Consortium launch

The SA Aboriginal Chronic Disease Consortium was officially launched on May 18 2017. Representatives from Aboriginal Health Council of South Australia, SA Health, Adelaide and Country Primary Health Networks, the Chairs of the Consortium Executive Group and the Consortium Community Reference Group all signed a "Statement of Commitment" to the effective implementation of the 3 plans.

SA ABORIGINAL CHRONIC DISEASE CONSORTIUM

STATEMENT OF COMMITMENT

The vision of the South Australian Aboriginal Chronic Disease Consortium is 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 three plans.

We, the undersigned, commit on Thursday, 18 May 2017 to supporting and implementing the work of the South Australian Aboriginal Chronic Disease Consortium for the next five years.

Professor Steve Wesselingh
South Australian Academic Health Science and Translation Centre

Professor Alex Brown
Wardliparingga Aboriginal Research Unit SAHMRI

Ms Kerri Reily
Country Health SA Local Health Network

Mr Shane Mohor
Aboriginal Health Council of South Australia

Ms Vickie Kaminski
SA Health

S.A.Miller
Mr Kym Thomas
Aboriginal Community Reference Member

Ms Sandra Miller
Aboriginal Community Reference Member

Ms Deb Lee
Adelaide Primary Health Network

Mr John Buckskin
Country Primary Health Network

Section 2.

SA Aboriginal Chronic Disease Consortium Road Map for Action

1. Developing the Road Map for Implementation of the 3 plans - The Strategy Prioritisation Process

Recent work in the Aboriginal Chronic Disease Consortium has involved extensive consultation regarding the priorities in each of the three plans; Diabetes, Heart & Stroke and Cancer. The aim of this consultation process has been to reach a consensus regarding the priority actions for the Consortium for the next 5 years. The consultation process targeted the identification of priorities within each of the 3 plans as well as the overarching Across Plan Priorities.

The priority identification process was conducted in 5 key stages:

1) Prioritisation of each plan individually by the condition specific Leadership Groups and members of the Community Reference Group;
2) Roundtable Workshop 1 on May 18th with key stakeholders and experts to rank priorities in each plan and identify Across Plan Priorities;
3) Roundtable Workshop 2 on May 18th validation (or otherwise) and refine the initial Across Plan Priorities;
4) Critique the emerging Road Map by all of the Condition Specific Leadership groups and the Community Reference Group;
5) Critique and sign off by the Consortium Executive Group.

At the Consortium Executive Group on June 16 it was agreed:

- All strategies in the Road Map should be progressed as resources become available and monitored over time.
- The following six approaches should be considered to help define the role of the Consortium Coordinating Centre (CCC) in relation to the Consortium partners.
    - Partner – CCC will share responsibility for design and implementation of initiatives with other key organisations and stakeholders.
    - Lead – CCC will lead the initiative and hold core responsibility for implementation.
    - Advocate – CCC will advocate with the Aboriginal community, health services and other key Consortium partners around priority action areas.
    - Lever – CCC will utilise existing policy, research, reorientation and funding opportunities and political will to instigate positive change within services and organisations.
    - Support – CCC will provide a supporting role to other services and organisations in delivering action/interventions.
    - Coordinate – CCC will coordinate delivery of the actions detailed in the Roadmap.
- Immediate focused effort should be invested into the second action in the Prevention and Early Detection Priority Action Area:
    - ➢ *"Undertake a state wide approach to improve risk factor identification and screening rates"*
- The next steps would be to:
    - ○ Finalise the Road Map and high level implementation plan for SA Health by June 30 2017.
    - ○ Engage all partners by inviting them to map current activities against priority strategies.
    - ○ Commence specific strategy work plans including convening time limited "Action Groups" to progress strategy development and engagement of key stakeholders across the health landscape.

2. The Structure of the Roadmap for Action

The Roadmap has 10 Priority Areas that cover 27 Priority Strategies. Figure 2 provides an overview of the Road Map.

The Priority Areas include:

- **7 Across Plan Priority Action Areas covering 21 priority strategies**
  - **Strengthen Social and Emotional Wellbeing** addressing social and cultural determinants of health (3 Strategies)
  - **Prevention and Early Detection** addressing health promotion and screening activities (2 Strategies)
  - **Acute Management** to optimise care provision and ensure equity in service delivery in the acute phase of treatment (3 Strategies)
  - **Ongoing Management** enabling effective coordination and collaboration following initial treatment (2 Strategies)
  - **Improve Access to Services** to enhance health service effectiveness and usage (5 Strategies)
  - **Improve Workforce** to address capacity building and enhancing the Aboriginal workforce (3 Strategies)
  - **Monitoring and Evaluation** to guide policy, resource allocation and future research (3 Strategies)
- **3 Condition Specific Priority Action Areas with 6 priority strategies**
  - **Heart and Stroke** (2 Strategies)
  - **Diabetes** (2 Strategies)
  - **Cancer** (2 Strategies)

The Roadmap acknowledges that:
  - Strengthening Social and Emotional Wellbeing is a precursor to achieving all other action areas;
  - Prevention and Early Detection, Acute Management & Ongoing Management are all components of the continuum of care and focus on specific services areas; and
  - Improve Access to Services, Improve Workforce, Monitor and Evaluation are to be considered as underpinning the entire continuum of care and as such will be relevant to all service areas.

It is important to note that while Priority Action Areas have been individually defined in the Roadmap, there is potential for significant overlap with achievements in one area being likely to impact on delivering successful outcomes in another. Also there will be flexibility for the Consortium to consider implementing other strategies that are not currently included in the Road Map. These opportunities may fall into two categories including strategies that are in one of the 3 plans but are not a current Road Map priority and strategies that are not in the 3 Plans but have the potential to contribute to achieving the vision of the Consortium and require consideration given the current political and service landscape. These opportunities would be reviewed under the direction and guidance of the Executive Group, Community Reference Group or Condition Specific Leadership Groups.

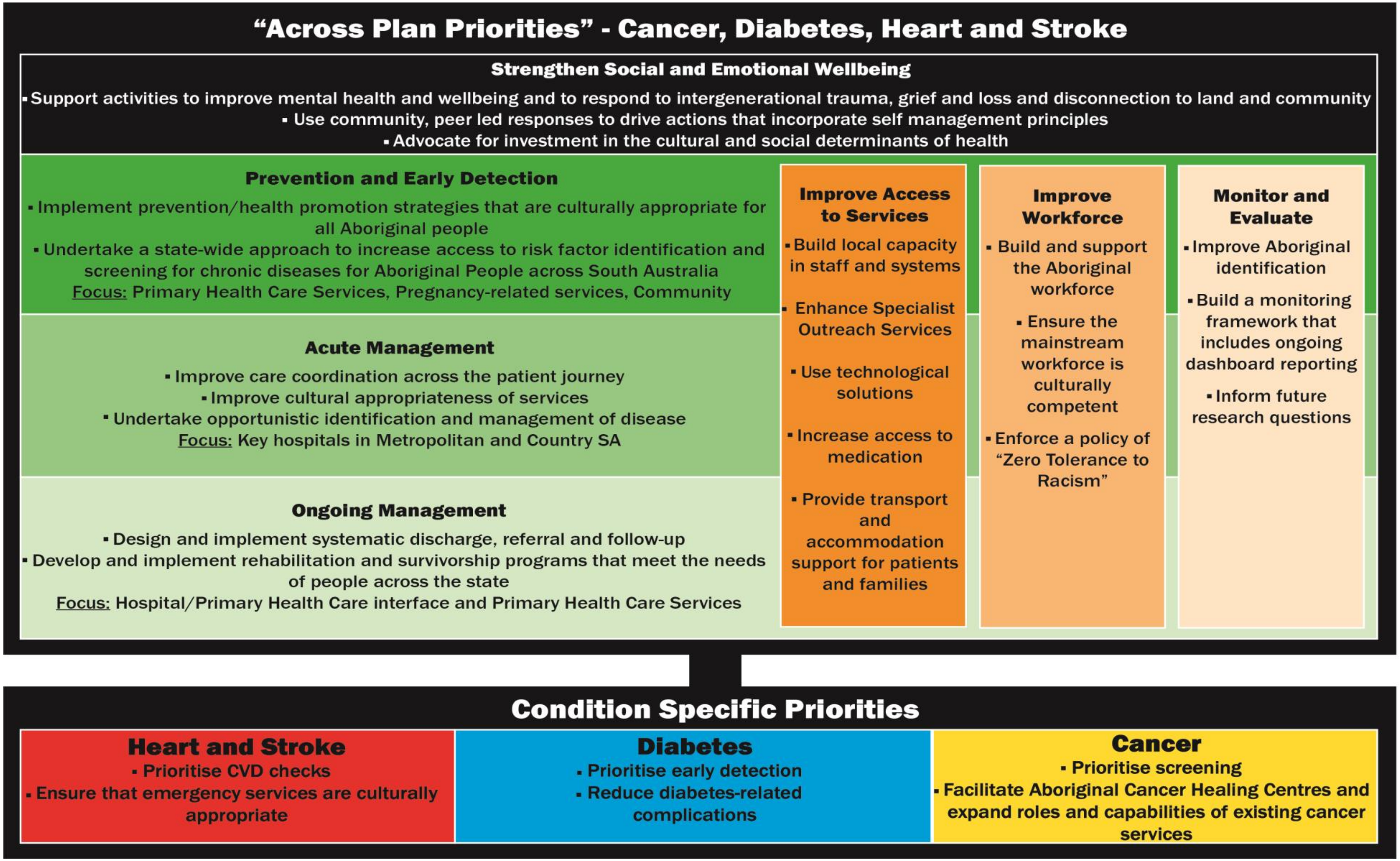
The Roadmap has the following structure:

- A description of each Priority Action Area with a definition and a rationale.
- A description of each Strategy with a rationale, specific actions, the potential role of the Consortium Coordinating Centre (CCC), the potential partners; and the proposed feasibility of those actions. Actions are mapped to strategies in each condition specific plan and the Executive Summary of each plan has been included as Appendices.

Whilst commentary is provided around feasibility it should be noted that this will be further explored in the next phase of implementation with the relevant key partners.

3. Overview of the Road Map for Action

SA Aboriginal Chronic Disease Consortium Road Map



"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 Services
- 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

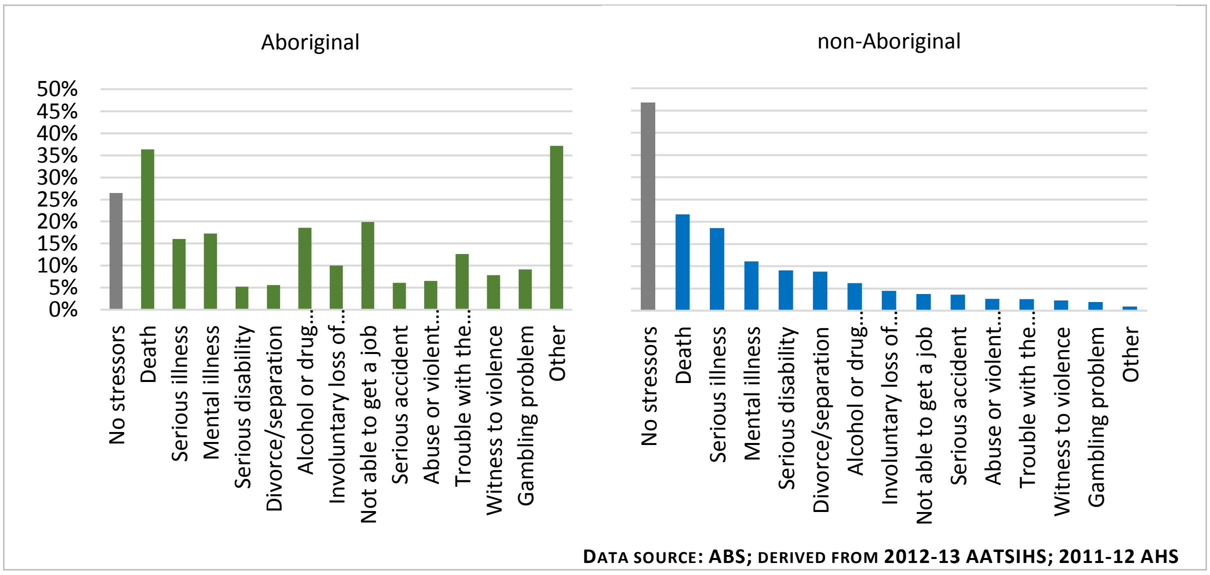
Cancer

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

The Road Map - Across Plan Priorities
Priority Action Area – Strengthen Social and Emotional Wellbeing

What is Strengthen Social and Emotional Wellbeing?

Historical policies have had a profound impact on the Aboriginal community through the forced separation of families, removal from land and loss of culture impacting on social and emotional wellbeing across the generations. Any action, intervention or advocacy efforts in Aboriginal health that do not consider the historical context in which the Aboriginal community live will not be effective in achieving health equity for the community. Both Aboriginal males and females report significantly higher levels of psychological distress than non-Aboriginal people. Additionally, Aboriginal peoples more often experience multiple stressors from a range of sources and events when compared to non-Aboriginal people (Figure 3).



Data source: ABS; derived from 2012-13 AATSIHS; 2011-12 AHS

Figure 3: Family stressors reported by SA Aboriginal and non-Aboriginal respondents

Aboriginal leader Rob Riley addressed this in a keynote speech at the Australian Psychological Society Conference:

"The current problematic mental health status of Aboriginal people can be traced directly to denial of social justice. The history of this denial is best told in the underlying issues report to the Royal Commission into Aboriginal Deaths in Custody. This report is the most comprehensive analysis of the myriad of social welfare variables, identified by the Aboriginal community as being fundamental issues that have perpetrated welfarism and that have maintained the co-dependency between the community and the bureaucracy, which I sum up as 'administrative genocide'. Aboriginal people have not been empowered to make decisions about their lives and the lives and futures of their children" - Rob Riley 1995

It is important to consider the Aboriginal definition of health when reflecting on social and emotional wellbeing

'…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' (National Aboriginal Health Strategy Working Group 1989)

Why is Strengthening Social and Emotional Wellbeing important?

Psychosocial factors are gaining increasing recognition in their role in chronic disease. Not only are they recognised as a contributor to the burden of chronic disease, particularly cardiovascular disease, but as a potential explanation for the substantial health disparities experienced (Brown, Walsh et al. 2005). They are a fundamental aspect of any efforts aimed to improve health and wellbeing for Aboriginal peoples.

Priority Action Area – Strengthen Social and Emotional Wellbeing		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Support activities to improve mental health and wellbeing and respond to intergenerational trauma, grief and loss and disconnection to land and community		
Rationale Historical government policy has had intergenerational impacts on mental health and wellbeing (Commissioner Elliott Johnston 1991). The impact of the Stolen Generations must be considered and addressed within the Aboriginal community. Moreton-Robinson have described Indigenous relationships with land as an 'ontological belonging; whereby spiritual beliefs are based on ancient systems that tie one into the land, to other members of the groups, and to all things of nature' (Moreton-Robinson 2003). Connection to land is inextricably linked to health and wellbeing, and is an important area for the Consortium to acknowledge and action. **Actions** 1. Work with PHN to identify opportunities to develop partnerships with mental health services already funded (aligned to strategies: across plans priority) 2. 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 (aligned to strategies: across plans priority) ***Feasibility*** *This will require extensive collaboration, partnership and commitment from a number of organisations. Will likely require additional resource allocation and service reorientation.*	Partner Support Support Lever	PHN's SA Health AHCSA CREATE
Strategy 2: Use community, peer led responses to drive action that incorporate self-management principles		
Rationale Community, peer-led and self-management models enable empowerment, engagement and health literacy of clients whilst removing potential negative consequences of ineffective health communication and management when solely accessing health services. South Australia has examples where these approaches have been successful and valuable from a community perspective. Peer-led models offer the potential for capacity and skills building within the Aboriginal community. **Actions** 1. 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 (aligned to the guiding principles of the across plan priorities) ***Feasibility*** *Current work exists in this area and is valued by community, feasible in regards to policy and program advocacy. Added resources may require additional service commitment and funding.*	Support Lead Advocate	All

Priority Action Area – Strengthen Social and Emotional Wellbeing		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 3. Advocate for investment in the cultural social determinants of health		
Rationale In order to effectively address the health disparities experienced by Aboriginal people, action must be taken at the level of the social and cultural determinants of health (Marmot and Allen 2014). They are defined below: *'The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.'* (World Health Organisation 2017) *"The cultural determinants of health originate from and promote a strength based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health including education, economic stability and community safety"* (Ngarie Brown 2014) Aboriginal Doctor Ngarie Brown sums up why this area is vital: *"A 'social and cultural determinants' approach recognises that there are many drivers of ill-health that lie outside the direct responsibility of the health sector and which therefore require a collaborative, intersectoral approach"* (Ngarie Brown 2014)		
Actions		
1. Advocate for investment in education and housing initiatives to support Aboriginal families (Align with strategies: across plan priorities).	Advocate Lever	DECD Housing SA
2. Advocate for the sustainable funding and expansion of the Aboriginal Environmental Health Program delivered through SA Health in remote Aboriginal communities (Align with strategies: across plan priorities).	Advocate Lever	SA Health Local Govt
3. Engage with local councils to influence planning and development policies to consider and address health impacts for Aboriginal communities under the Public Health Act (Align with strategies: across plan priorities).	Advocate Lever Coordinate	SA Health Local Govt
Feasibility *Aligns with current state and national priorities, engagement is highly feasible.*		

The Road Map - Across Plan Priorities

Priority Action Area – Prevention and Early Detection

What is Prevention and Early Detection?

Preventative health measures extend across the disease spectrum and are divided into three categories: (The Royal Australian College of General Practitioners 2006)

1. Primary Prevention – health promotion and prevention of illness
2. Secondary Prevention – early detection of illness and prompt intervention
3. Tertiary Prevention – minimising complications, impairments and suffering caused from existing illness

Examples of primary prevention include social media campaigns around healthy living and information provision regarding risk factors (tobacco, alcohol, physical activity and nutrition). Secondary preventative measures include timely and effective screening for high blood pressure or cardiovascular risk factors, performing opportunistic tests and screening; such as testing glucose for diabetes or screening for cancers using accepted screening protocols and tools. Tertiary preventative measure include interventions to reduce the onset of complications, such as performing regular foot and kidney checks for people with diabetes.

Why is Prevention and Early Detection important?

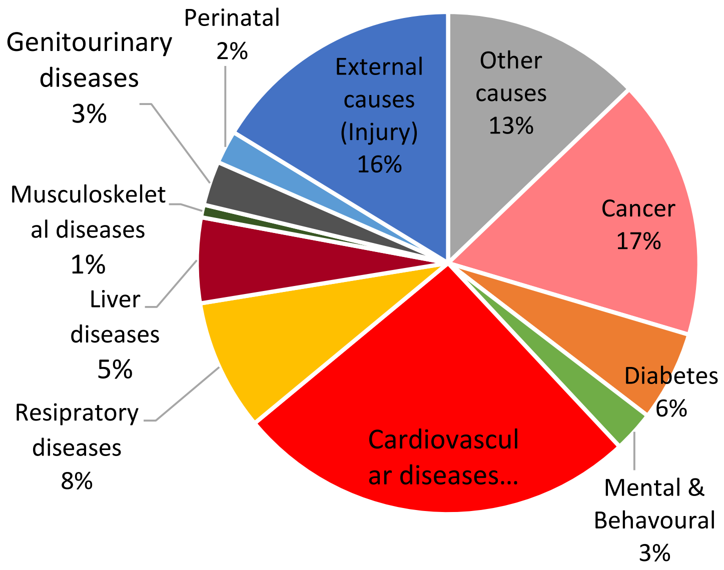
Primary and secondary prevention measures can and should play an integral part in working to address the high rates of chronic disease within the Aboriginal community.

Figure 4 demonstrates the high proportion of deaths attributable to chronic diseases (cardiovascular diseases, cancer, diabetes, respiratory and liver diseases). Alone, these conditions are responsible for almost two thirds of all deaths within the Aboriginal community.

Although each of the chronic diseases are different in their location, character and treatment, they share common risk factors and predictors of illness. Streamlined action at these shared factors holds the potential for large scale meaningul impact on chronic disease burden.

Prevention and early detection measures are not limited to those in direct receipt of the intervention – there is potential for intergenerational impacts on health and wellbeing, supported by literature exploring the foetal origins of disease (Barker 1995, Tank and Jain 2016). It also is likely to have a ripple effect, impacting families and community members who interact with those involved in health promotion and prevention activities. The potential for such measures to not only benefit community today but our future generations is why prevention and early detection takes first priority.

Investing in primary prevention and early detection is strongly supported by the Aboriginal community and health professionals across all plans and networks.



Data source: Cause of Death Unit Record File for South Australia provided by the

Figure 4

Priority Action Area - Prevention and Early Detection		
Focus: Primary Health Care Services, pregnancy related services and community	**CCC Approach**	**Potential Partners**
Strategy 1: Implement prevention/health promotion strategies that are culturally appropriate for all Aboriginal people		
Rationale Strong evidence exists to demonstrate that preventative health strategies improve health outcomes (NACCHO/RACGP 2012). To be effective, strategies must meet the needs of the community served and be delivered in a manner that is appropriate and acceptable to them (World Health Organisation 1978). Consideration of the historical, cultural and social context of Aboriginal community is required in order for health prevention and promotion strategies to be effective. The use of strength based approaches is preferred. Data from 2011-2013 reflected the potential preventable hospitalisation rate for Aboriginal people to be 3.4 times higher than non-Aboriginal people. (Australian Health Minister's Advisory Committee 2014).		
Actions 1. 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 (Aligned with strategies: CP:1, DS:1.1,H&S: 5,9)	Partner Advocate Lever	AHCSA PHC services SA Health RDWA PHNs RFDS All NGO's DASSA
2. 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.	Partner/ Lever	AHCSA, DASSA, PHN's SA Health
Feasibility *Implementation of the identified priority action areas will require new funding however there are many current activities that can be included.*		
Strategy 2: Undertake a state wide approach to improve risk factor identification and screening rates		
Rationale Modifiable risk factors, or those risk factors that an individual can change, are an important target for chronic disease prevention. Importantly, common risk factors can place an individual at risk of multiple chronic diseases, providing an opportune area for large scale impact. Such risk factors include sedentary behaviour, low fruit and vegetable consumption, unsafe alcohol intake, tobacco smoking and social and emotional distress. An individual with multiple risk factors is typically at higher risk of disease than an individual with fewer risk factors. Other modifiable risk factors that are also impacted by lifestyle changes and medication management include blood pressure and cholesterol. These are included in a cardiovascular health check. Diabetes is also a risk factor for heart disease and stroke. On average, Aboriginal people experience a higher number of risk factors when compared to the non-Aboriginal population		

Screening to identify early signs of disease needs to be considered. This includes screening for diabetes, cardiovascular diseases and various cancers including breast, bowel, cervical and skin. An effective state-wide approach to improving risk factor identification and screening will empower communities to minimise the impact of chronic disease acutely experienced by individuals and their families.		
Actions		
1. 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. (Aligned with strategies: CP:1,3, DS:1.1, 2.1, H&S: 6)	Coordinate	AHCSA PHNs ACCHOs Private GP SA Health funded primary care services
Feasibility *Initially this will require getting an Action Group established to determine and draft the approach.* *While limited new funding would be required to coordinate and promote this initiative, funding models are in place for primary care services to claim for the checks through a comprehensive well health check MBS 715.* *Additionally, there is significant interest from state-wide cancer screening services/projects and other programs that could be integrated into service delivery.*		

The Road Map - Across Plan Priorities
Priority Action Area – Acute Management

What is Acute Management?

When considering acute care in the context of health system delivery, time to care is critical. Typically acute care management services are used to treat sudden, unexpected and often emergent episodes of illness that can lead to death or disability without rapid intervention (World Health Organisation 2017).

Standard domains used in acute care and management are demonstrated in Figure 5.

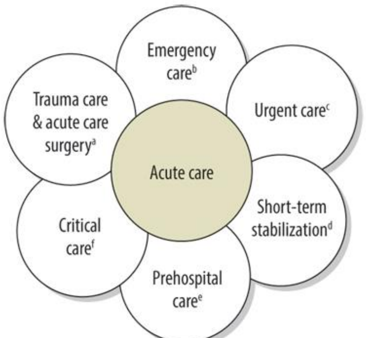


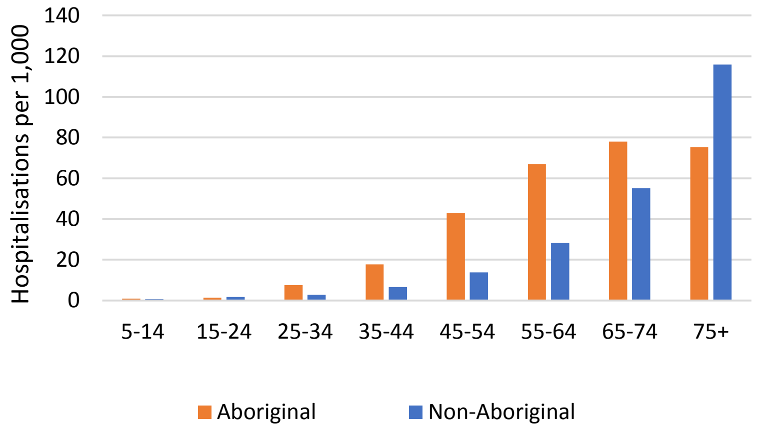
Figure 5

Why is Acute Management important?

Acute care plays an important role in chronic disease management, and for some patients may offer a valuable opportunity to commence appropriate management and address preventative health issues (Steinman and Auerbach 2013).

Hospital care is a key service provider of acute management and there are high rates of hospitalisation of Aboriginal people for chronic disease conditions at relatively young ages (See Figure 6). Heart and Stroke patient journeys often start with an emergency event and while cancer and diabetes are not typically time critical emergencies, timely access to treatment is important in preventing complications and reducing severity of disease.

Given the high rates of hospitalisation and the large potential for impact, ensuring acute management is optimised and effective is a high priority for addressing the burden of chronic disease within the Aboriginal population. It is important to understand the younger age profiles of Aboriginal heart and Stroke patients who present in the acute setting.



Data source: ISAAC Unit Record File provided by SA Health (unpublished) extracted for the SA State of Aboriginal Heart Health Project 22 Nov 2015.

Figure 6: Age-specific hospitalisation rate for CVD, by Aboriginal status, July 2010 - June 2015

Priority Action Area – Acute Management

Focus – Key hospitals in metropolitan and country South Australia	**CCC Approach**	**Potential Partners**
Strategy 1: *Improve care coordination across the patient journey*		
Rationale Given the environmental and social contexts for Aboriginal people, patient journeys for care are often complex and involve multiple health services. Coordinated approaches work to ensure patient management is optimised, eliminating potential harmful gaps in care (Kelly, Wilden et al. 2016). Care coordination works to improve communication between relevant parties and assists the process of shared decision-making, a key aspect to patient-centred care and implementation best practice (Wong, Caesar et al. 2009). Additionally, care coordination is particularly important for Aboriginal patients whom often may have multiple comorbidities and multiple health services involvement in care planning. Currently in the in-hospital environment care coordination for Aboriginal patients and their families is typically championed by Aboriginal Hospital Liaison (ALO) teams, Aboriginal Patient Pathways Officers (APPO), Aboriginal Cancer Coordinators and all staff supporting patient discharge. However, anecdotally there is a critical shortage of trained, skilled staff and resources to support Aboriginal staff and their families with high needs in hospitals. Cancer and Cardiovascular coordinators are highlighted in the plans along with the importance of ALO services.		
Actions 1. 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. (Aligned with strategies: CP: 5, 7, H&S18).	Coordinate and Partner	SA Health Hospitals Country Health SA SAAS RFDS
Feasibility *Some ALO services, APPO and Cancer Coordinators are already scattered across the state but additional resourcing will be needed to service hospitals where the need is great. Implementation should be based on learnings from previous programs.*		
Strategy 2: Improve cultural appropriateness of services		
Rationale Building cultural competency is an effective strategy to address health service inequalities, improve patient access and optimise health outcomes for Aboriginal people (Bainbridge R 2015). The ability of a service to deliver culturally competent care goes beyond individual behaviours to encompass institutional attitudes, policies, practices and knowledge. Culturally appropriate services are being increasingly recognised as fundamental to improving health outcomes for Aboriginal people, with one example of this being the recently updated actions within the National Safety and Quality Health Service Standards. To achieve culturally appropriate services, Aboriginal peoples must be empowered in determining what		

Priority Action Area – Acute Management		
Focus – Key hospitals in metropolitan and country South Australia	**CCC Approach**	**Potential Partners**
cultural appropriateness looks like and lead and/or be extensively involved in service delivery. Australian case studies have demonstrated where interventions to improve cultural appropriateness positively influenced health service access (Hayman, White et al. 2009, Marley, Nelson et al. 2012).		
Actions 1. Mandate cultural training for all staff at all levels across all Consortium partners and any agencies funded by consortium partners (Aligned with strategies: CP:1, 7, 5,8, H&S 1, 20, DS:1.1) **Feasibility** *Implementation of the National Aboriginal and Torres Strait Islander Cultural Respect Framework 2016-2026 which aims to provide a foundation and guide a nationally consistent approach to building culturally responsive health care design and delivery, coupled with the NSQHS Standards Version 2 including an action that requires cultural training in all Health Service Organisations being released on January 1 2018, is therefore prudent to prioritise this action.* *While there will be financial costs associated with introducing this training, it is important to note that there are SA resources available and learnings from other states where it is already mandated. Prioritising staff time to undertake training must be considering as well as tiered approach.*	Advocate Lever	SA Health PHN's AHCSA
Strategy 3: Undertake opportunistic identification and management of disease		
Rationale Given Australia's historical and socio-economic context, Aboriginal people access health services at lower rates than non-Aboriginal peoples and experience high burdens of chronic disease. Power imbalances, mistrust and lack of appropriate service delivery models all contribute toward reduced access to health services. Opportunistic identification and management of disease seeks to maximise health outcomes for individuals who access services infrequently. It requires appropriate resource allocation to be achievable, including time and trained staff. Additionally, clarity around what best practice opportunistic interventions look like is needed across the health system to ensure a coordinated and effective approach.		
Actions 1. Develop a protocol across Consortium partners to embed opportunistic identification and management of disease across the health sector. (aligned with strategies CP: 6, DS:2.1,2.2,3.3) This should build on compulsory reporting and mandating compulsory fields in data collection systems. **Feasibility** *Initially this will require getting an Action Group established to determine and draft the protocol.*	Lead and advocate	SA Health PHN's RACGP

The Road Map - Across Plan Priorities
Priority Action Area – Ongoing Management

What is Ongoing Management?

Ongoing management in this context is synonymous with a tertiary prevention approach. The overall aim of ongoing management is to reduce complications, disability, suffering and death from illness. Given the chronic nature of the diseases targeted by the Consortium, ensuring ongoing management processes optimise health outcomes in an effective and appropriate manner is crucial.

Ongoing management can be delivered and led by health services in addition to self-management and peer-led support models. Effective models for ongoing management promote collaboration, multidisciplinary approaches and patient engagement (Conway, Tsourtos et al. 2017).

Why is Ongoing Management important?

A chronic disease diagnosis can often persist for most of a person's life and can have profound impacts on a person's physical, emotional, social and spiritual wellbeing.

Efforts to provide ongoing management for Aboriginal people with chronic disease need to consider the Aboriginal worldview and provide tailored care to the individual, their family and community. Therefore, appropriate ongoing management addresses the identified needs and may include action at the social, physical and environmental level.

The content of ongoing management might be slightly different for each condition however there are many similarities in the way chronic disease patients are managed and the lifestyle modifications that are supported. The ongoing management of diabetes should include managing the condition itself and associated risk factors such as weight, diet, blood pressure and lipids in order to reduce the incidence of diabetes-related complications, such as cardiovascular, renal and eye diseases, limb amputations and strokes.

For heart and stroke, ongoing management should include referral to primary care for ongoing oversight, condition specific rehabilitation and ongoing management of risk factors.

For cancer, ongoing management should include supporting patients through treatment, supporting risk factor management and other survivorship activities.

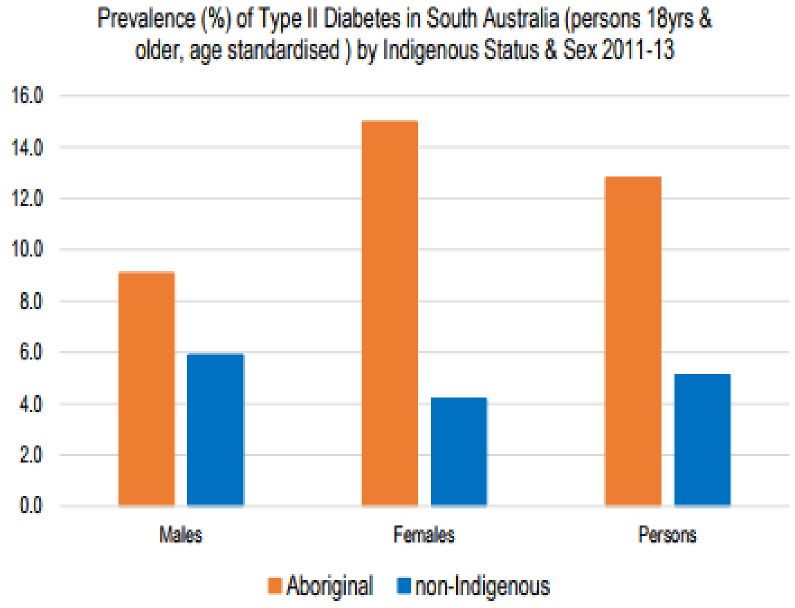


Figure 7

Priority Action Area – Ongoing Management		
Focus – Hospital/Primary Health Care interface, Primary Health Care Services	**CCC Approach**	**Potential Partners**
Strategy 1: ***Design and implement systematic discharge, referral and follow-up***		
Rationale Hospital discharge processes are an important and necessary step in the health care journey for all patients. The transition period from hospital care to home/primary care/supervised care or other institutions holds a transfer of knowledge and responsibility fundamental to ensuring continuity of care. Ineffective care planning and discharge process can negatively impact patient satisfaction, wellbeing, result in adverse events and lead to hospital readmission (Kripalani, Jackson et al. 2007). This impacts the overall health and wellbeing of the Aboriginal population. Problems in the discharge pathway for Aboriginal patients are well documented. To date a functional system does not exist to link hospitals, patients and their primary care services.		
Actions 1. 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 (aligned with strategies: H&S:19, 1, CP:5, DS:3.8)	Coordinate Partner Advocate	SA Health AHCSA GP's
2. Develop agreed protocols for follow up care post discharge with patient and primary care providers and other providers of ongoing care (aligned with strategies: H&S:18, DS: 1.4 ,3.8)	Coordinate Partner Advocate	SA Health AHCSA GP's
Feasibility *The implementation of these priorities requires limited new funding. It will require a concerted effort for coordination and promotion of the initiative across the workforce.*		
Strategy 2: ***Develop and implement rehabilitation and survivorship programs that meet the needs of people across the state***		
Rationale All heart and stroke patients should receive rehabilitation post discharge. Aboriginal patients with diabetes require support to manage medication and lifestyle. The Australian Cancer Survivorship Centre views an individual to be a cancer survivor from the time of their diagnosis and then throughout their life (Australian Cancer Survivorship Centre 2017). The importance of survivorship programs for Aboriginal people living with chronic disease, particularly cancer, has been voiced by the Aboriginal community. The need to emphasise that chronic disease does not equal a death sentence is critical in optimising health and wellbeing for community members and changing community perceptions. Many of the lifestyle risk factors are common to all conditions. The need for good medication management, surveillance and self-management using family centred models are important.		
Actions		

Priority Action Area – Ongoing Management		
Focus – Hospital/Primary Health Care interface, Primary Health Care Services	**CCC Approach**	**Potential Partners**
1. 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 (Aligned with strategies: DS:3.5, H&S:21, 20, CP:6) ***Feasibility*** *Implementing the above priorities requires significant new funding and effort across the health system, including the community controlled sector. It will require a concerted effort for coordination and promotion of the initiative across the workforce.*	Lead Partner Advocate	SA Health AHCSA PHN's

The Road Map - Across Plan Priorities
Priority Action Area – Improve Access to Services

What is Improve Access to Services?

Accessible health services meet the 4 A's of accessibility (Ware 2013):

Physically available: This refers to whether a service can be physically available for an individual and can be impacted by geographical location, transport availability and resource allocation.

Affordable: Service affordability refers to all costs associated with accessing a health service including; transport fees, consultation fees and associated costs (e.g. medications and medical imaging). The impact of service costs can be compounded when people are from a low socio-economic background and have multiple co-morbidities that require ongoing financial investment. Medicare and Pharmaceutical Benefits Scheme benefits exist for Aboriginal people through the Closing the Gap Scheme, specifically aimed to address the impact of cost on health. Ensuring these services are readily available for eligible people is important, along with managing additional consult fees.

In addition, many private general practice models are business driven to generate economic profit. As a result, time allocation is balanced with income generation; this is approached differently in the community controlled sector that have salaried medical practitioners and are not primarily concerned with profit.

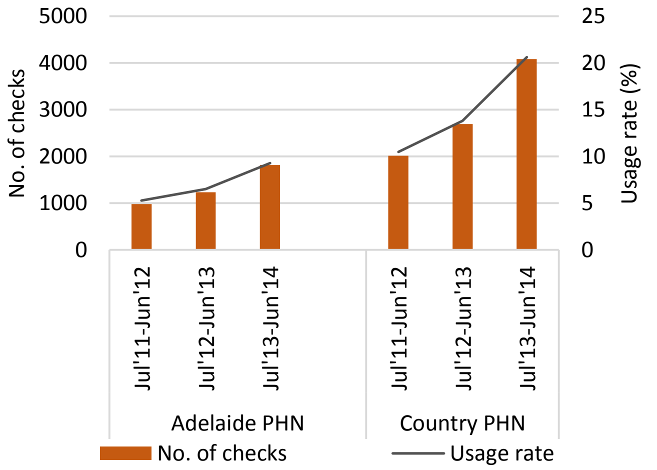
Acceptable: The acceptability of a health service reflects whether a service is acceptable to the patient, and reflects the cultural competency of the organisation and staff.

Appropriate: Appropriate health services reflect whether or not the care that is provided to the individual meets their needs and optimises health outcomes. Factors that may impact on appropriateness include availability of targeted services for Aboriginal people, availability of multidisciplinary services in an easily accessible location and respect for diverse worldviews and health beliefs.

Why is Improving Access to Services important?

In 2008, the NATSISS reported approximately 26% of Indigenous people 15 years and over who lived in non-remote areas had difficulty accessing health services (Australian Bureau of Statistics 2008, Ware 2013). This is contrasted with only 2.6% of the general population reporting difficulty in accessing health services.

In South Australia, whilst rates are increasing, there remains a low uptake of the Medicare Benefits Schedule item 715 – the Aboriginal health check (Figure 8, (Australian Institute of Health and Welfare 2017) This reflects the substantial room for improvement in service access, which holds the potential for significantly improving health outcomes though preventative measures and early detection as outlined in the first priority action area of this document.



Data source: AIHW analysis of Medicare Australia Statistics, 2015

Figure 8

Priority Action Area – Improve Access to Services		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Build local capacity in staff and systems		
Rationale It is vital to build quality services for Aboriginal people that are located where there is the greatest need in terms of geographical location so patients and their families can access services as close as practical to their homes. Building local capacity includes building both an effective workforce and effective systems that drive, support and monitor activities. Visiting specialist services must be integrated into local models of care to enable local systems and staff to be effective in supporting patients in an ongoing and sustainable manner.		
Actions 1. 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 (aligned with strategies: CP: 5, DS: 1.4, H&S:21).	Partner Advocate Coordinate	SA Health AHCSA PHN's Universities
Feasibility *New funding required to develop and deliver training packages specifically in diabetes, cancer and heart and stroke care for Aboriginal people.* *Improve facilitation of multi-disciplinary teams as needed*		
Strategy 2: Enhance Specialist Outreach Services		
Rationale Specialist services are delivered in a variety of settings across Australia. In 2009-2010, Indigenous Australians had lower usage rates of Medicare-reimbursed services than non-Indigenous peoples despite higher rates of chronic disease (Australian Institute of Health and Welfare). Living in a rural and remote geographical location can pose additional barriers when accessing specialist care. Effective and appropriate models of health care delivery embrace specialist services being more accessible in patient's home environments. This enables people to stay connected with country and family, which is vital when significant community obligations and commitments exist that may prevent someone from travelling too far away from their home. Service outreach models have been shown to be effective in settings where there is significant disadvantage and access barriers. Models that are sustainable are well organised, responsive to community needs and integrate effectively with primary health care structures (Gruen, Weeramanthri et al. 2002).		
Actions 1. Facilitate specialist services to the ACCHO sector where gaps exist in high need areas. (aligned to strategies: CP:5,H&S:21, DS:1.4)	Partner Advocate Lever	AHCSA PHN RDWA SA Health
2. Explore opportunities to link specialists, SA Health and the ACCHO sector through tele-medicine (aligned to strategies: CP:5,H&S:21, DS:1.4)	Partner Advocate Lever	AHCSA PHN

Priority Action Area – Improve Access to Services		
Strategy	**CCC Approach**	**Potential Partners**
Feasibility *Outreach specialist services are currently funded; coordination, partnerships, advice and support may facilitate increased access to services across ACCHO sector in areas of high need. Therefore, this recommendation may not require significant new funding.* *Tele-medicine resources exist across the health system – potential to map against areas where increased proportions of Aboriginal people reside to inform an improved system. May not require large investment of new funding.*		RDWA
Strategy 3. Use technological solutions		
Rationale Recent innovations in health technology can be utilised to enhance access to health and self-management practices. Point of care technologies can be used for prompt screening, diagnosis and management purposes resulting in increased access to primary health care and emergency services. When considering heart specific services, access to point of care testing for troponin and other relevant diagnosis testing is available through the CHSA iCCnet sites. Additionally, ACCHO's have an established PoC system for Diabetes. It is evident that PoC technologies could be used much more widely especially in regional and remote South Australia. Tele-health services (video and telephone conferencing) can improve access to services by reducing travel time to appointments for those living in regional and remote locations, building capacity in local services and providing more services. There are good examples across Australia where specialist clinicians, health services and patients are effectively linking using telehealth techniques for consultations and rehabilitation services.		
Actions 1. Develop a model of point of care testing accessible to all Aboriginal people across South Australia, irrelevant of geographical location (Aligned to strategies: DS:2.2)	Advocate Lever Coordinate	SA Health PHN's
2. 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 (Aligned to strategies: CP:5, H&S:21, DS:1.4)	Partner Advocate Lever	SA Health AHCSA PHN RDWA
Feasibility *As PoC testing is currently offered in an adhoc way, this opens the opportunity to make it a consistent, high functioning system that is informed by a state-wide PoC model.* *Tele-medicine resources exist across the health system – potential to map against where significant proportions of Aboriginal people reside to inform an improved system. May not require large investment of new funding.*		

Priority Action Area – Improve Access to Services		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 4. Increase access to medications		
Rationale Costs of medications is an additional and often hidden economic barrier to accessing health care and achieving good health outcomes (Ware 2013). Removing this barrier to health is an important step toward achieving equity in access to healthcare. There are programs (Closing the Gap and S100) that support subsidised/free medication for Aboriginal patients through registered services but these could be better utilised and more accessible.		
Actions		
1. Advocate and facilitate discussion with SA Health regarding the removal of co-payments of medication on discharge from public hospitals across SA (Aligned to strategies: DS:3.7, CP:5).	Advocate Partner	SA Health
2. Develop a Partnership Project with National Prescribing Service (NPS) to improve services in Primary Care for managing risk factors and treating patients post discharge (Aligned to strategies: DS3.7, CP:5).	Partner Advocate Lever	Consortium Commonwealth
Feasibility *As considerable cost analysis work has already been undertaken it would not require significant financial investment to scope and commence advocacy in this area.* *Relationship building with the NPS has commenced. A case for partnership would need to be developed and pitched. If successful, NPS would be a valuable and significant partner.* *Establish partnership with NPS to scope up a project for improving medication availability through primary care services. Would not require significant financial investment in scoping out project.*		
Strategy 5. Provide Transport and accommodation support for patients and families		
Rationale Transport is a critical factor that determines whether health care can be accessed, particularly for Aboriginal people living in rural and remote areas (Kelly, Dwyer et al. 2014). Long distance travel can be tiring, costly, frightening and logistically challenging (Kelly, Dwyer et al. 2014). Often arranging and supporting travel is a time consuming process that is not well supported by the health system. (Kelly, Dwyer et al. 2014) Accommodation poses similar challenges for Aboriginal patients from rural and remote areas who may find themselves in an unfamiliar environment, particularly if there are challenges to accessing financial resources to get accommodation. Research has demonstrated that patients have often cancelled their treatment plans if there was not adequate accommodation options or support provided (Shahid, Finn et al. 2011).		

Priority Action Area – Improve Access to Services		
Strategy	**CCC Approach**	**Potential Partners**
Actions 1. Develop a transport model which ensures Aboriginal people have safe home-to-care-to-home journeys (Aligned to strategies: CP:7, DS and H&S: enablers for effective implementation) Develop or enhance step-down units to meet the clinical and cultural demands of regional, remote and interstate Aboriginal patients (Aligned to strategies: CP: 7, DS and H&S: enabler for effective implementation). ***Feasibility*** *A significant revision of policy and new funding would be required to provide a culturally responsive transport model to meet the service demand of the Aboriginal population requiring assistance in South Australia.*	Lead Partner Advocate	SA Health Commonwealth PHN
2. Develop or enhance step-down units to meet the clinical and cultural demands of regional, remote and interstate Aboriginal patients (Aligned to strategies: CP: 7, DS and "H&S: enabler for effective implementation). ***Feasibility*** *Ongoing funding is required to enhance step-down units in Ceduna and Port Augusta to meet current cultural and clinical demand.* *Significant funding investment is required to establish new step-down facilities in areas of high need.*	Coordinate Partner Advocate	SA Health Commonwealth

The Road Map - Across Plan Priorities
Priority Action Area – Improve Workforce

What does Improve the Workforce involve?

Improving the health workforce encompasses enhancing resourcing and numbers of trained staff delivering services, increasing the participation of Aboriginal people in the health workforce and improving the skills, knowledge and capacity of the health workforce to deliver appropriate care to Aboriginal people.

Critical to achieving this vision is a skilled, knowledgeable and effective health workforce. The health workforce can be broadly defined as:

> *"all people engaged in actions whose primary intent is to enhance health"*
>
> *(World Health Organisation 2017)*

The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 and National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework share the following vision of

> *'an Australian health system that is free of racism and inequality, and where all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable; and that the health system is comprised of an increasing Aboriginal and Torres Strait Islander health workforce delivering culturally-safe and responsive health care'*
>
> *(Commonwealth of Australia 2013, Aboriginal and Torres Strait Islander Health Workforce Working Group 2017)*

Why is Improving the Workforce important?

In order to effectively prevent and manage chronic health conditions, a skilled, knowledgeable and appropriate health workforce is required. This is a longstanding area that has been acknowledged for intervention, with the Royal Commission into Aboriginal Deaths in custody making recommendations around improving the education of healthcare practitioners in relation to Aboriginal health issues in 1991 (Commissioner Elliott Johnston 1991).

Fundamental to ensuring the appropriateness of health services for Aboriginal people is strong leadership and representation by Aboriginal people within the health workforce.

In 2006, approximately 4,891 Indigenous Australians were employed in health related occupations representing approximately 1% of the workforce (Australian Bureau of Statistics 2006). In 2015, there were 3,187 nurses and midwives employed in Australia who identified as Aboriginal and/or Torres Strait Islander. This represents 1.1% of all employed nurses and midwives who provided information in this area (The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives 2015).

This is well below population parity, and could be argued needs to be higher than population parity given the substantial disadvantage and health burden experienced.

This is summed up in the Cultural Respect Framework Domain 3 Workforce Development and Training that states:

> *'Health services and organisational culture support and promote building a workforce that is appropriately skilled, supported and resourced to influence and provide accessible, culturally responsive and safe services for Aboriginal and Torres Strait Islander peoples and communities'*
>
> *(National Aboriginal and Torres Strait Islander Health Standing Committee 2016)*

Priority Action Area – Improve Workforce		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Build and support the Aboriginal workforce		
Rationale Aboriginal representation across all health professionals remains disproportionate to the total population. SA has set a 2% Aboriginal workforce target and is currently only at 1%. Having insufficient Aboriginal workforce impacts on the care received by Aboriginal people within the health care system.		
Actions 1. Develop a strategy which supports Aboriginal workforce activities currently being undertaken across Consortium partners. ***Feasibility*** *Significant work is currently occurring across Consortium partners. Key players need to be brought together to determine a coordinated pathway forward.*	Coordinate Partner Advocate	All Consortium partners
2. 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). ***Feasibility*** *Some curriculum development work has already occurred in these chronic disease areas. Limited resources will be needed to map current activities and understand what is needed.*	Advocate Partner Lever	SA Health AHCSA LIME Network Universities
Strategy 2: Ensure the mainstream workforce is culturally competent		
Rationale Cultural competency reflects a broader concept to describe a number of interventions and approaches with the aim to improve health service effectiveness to care for people of ethnic minorities, in this case Aboriginal communities. (Truong, Paradies et al. 2014) The mainstream workforce has been highlighted as the priority for action as the governance structure and culture is different when compared to Aboriginal Community Controlled Organisations and other services specifically tailored to the Aboriginal community. This is important as Aboriginal people frequently access mainstream primary and tertiary health services. It also advocates for widespread appropriateness of health services as opposed to placing the responsibility to care for Aboriginal people solely on the community controlled sector.		
Actions 1. Mandate cultural training across all Consortium partners and any agencies funded by consortium partners (Aligned with strategies: CP:1, 7, 5,8, H&S 1, 20, DS:1.1) ***Feasibility*** *This action will require a significant effort and resource commitment from across Consortium partners. However, it will support the implementation of the new NSQHS Aboriginal Actions and the implementation of National*	Partner Advocate Support Coordinate	All Consortium partners SAATAC Partners

Priority Action Area – Improve Workforce		
Strategy	**CCC Approach**	**Potential Partners**
Aboriginal and Torres Strait Islander Cultural Respect Framework across the health sector.		
3. Enforce a policy of 'Zero Tolerance to Racism'		
Rationale Freedom from discrimination is a universal human right (World Health Organisation 2017). Effects of historical policies promoting segregation, discrimination and marginalisation are still experienced today. Racism can be defined as: 'organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups (Paradies, Ben et al. 2015). Research highlights the Aboriginal community experience racism at higher levels than non-Aboriginal peoples (Dunn 2003, Paradies, Ben et al. 2015). A recent systematic review has demonstrated that racism is associated with poorer physical and mental health outcomes (Paradies, Ben et al. 2015). Racism can occur on many levels (internalised, interpersonal, systemic) and can impact health from a number of fronts (access to services, access to treatment and health resources, adverse cognitive and emotional processes) (Paradies, Ben et al. 2015). Action to improve Aboriginal health outcomes that does not address the pervasive effects of racism across all levels will ultimately fail the Australian community.		
Actions 1. 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 (aligned with strategies: underpinned in all three plans).	Lead Partner Advocate Support Lever	All Consortium partners
Feasibility *This will require significant leadership, training and culture change within all services however there is already a legislative framework in place to support action in response to addressing racism in health care.*		

The Road Map - Across Plan Priorities
Priority Action Area – Monitoring and Evaluation

What is Monitoring and Evaluation?
Monitoring and evaluation processes cover a broad range of activities in the health sector. In essence, monitoring systematically collects both qualitative and quantitative information against pre-defined targets.

It is a valuable process to reflect current trends and activities occurring within a health service organisation, research study and/or national health interventions to name a few. Monitoring processes can reveal areas of excellence in health service delivery, potential gaps and areas for improvement.

Evaluation processes utilise monitoring regimes to critically appraise and assess whether a particular service, intervention or program is reaching defined targets or is effective in its delivery. Evaluation processes are diverse in nature depending on what is being evaluated. In general, the intent of an evaluation is to identify strategies for improvement.

Why is Monitoring and Evaluation important?

Monitoring is important in Aboriginal health as it allows for a solid evidence base to advocate for changes in policy and resource allocation which can have significant effects on health service delivery and ultimately, improve patient outcomes.

Monitoring and evaluation processes are recognised in the three plans, with Figure 9 indicating the process for change management outlined in the Cancer Control Plan.

Figure 9: South Australian Aboriginal Cancer Control Plan 2016-2021 Change Management Model

Priority Action Area – Monitor and Evaluate		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Improve Aboriginal Identification		
Rationale Improving the identification of Aboriginal and Torres Strait Islander people across all aspects of the health system is very important for many reasons including providing culturally appropriate care; improving responses to specific care needs, support early identification of risk factors and disease through opportunistic screening, drive reform around service provision, inform research and evaluation and to attract appropriate funding based on need. All people should be asked about their Aboriginal and Torres Strait Islander status at point of entry to the Health Service Organisation. While this question is already mandated in hospitals and in some other services the culture around asking this question must change for both administrators and clients to ensure it is asked on a consistent basis.		
Actions 1. Develop a Consortium partners commitment to implementing a mandatory standard identification question across all services and funded services (aligned to strategies: across plans priority)	Lever Support Co-Ordinate	All Consortium partners
2. Explore where gaps exist in other services (for example Emergency Services, private General Practice services and Pathology Services	Lead Partner Advocate	PHN's RACGP SA Health
Feasibility *This will require significant leadership, training and culture change within all services however resources and policies should already be in place to support action.*		
Strategy 2: Build a monitoring framework that includes ongoing dashboard reporting		
Rationale This action facilitates continuous quality improvement and allows for systematic accountability and transparency of service delivery. Dashboard monitoring can be used for a variety of purposes and enables effective and timely review of data to ensure health services can improve performance indicators and quality of service provision.		
Actions 1. 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 (aligned to strategies: across plans priority)	Lead Coordinate Lever	SA Health PHN's Wardliparingga
Feasibility *Resources will need to be allocated to support the compilation of the indicator set, the data analysis and ongoing monitoring.* *This will build on the Indicator Frameworks that already exist at a National and State level.*		

Priority Action Area – Monitor and Evaluate		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 3. Inform future research questions		
Rationale Quality research informs policy and best practice implementation. Good data ensures that the right questions are being explored, and action and resources channelled to appropriate domains. **Action** 1. 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. ***Feasibility*** *No specific resources will be needed to develop a registry and start to collect research questions and brief proposals.*	Lead	Consortium partners Wardliparingga SAHMRI

The Road Map – Condition Specific Priorities
Priority Action Area – Heart and Stroke

Condition Specific Priorities – Heart and Stroke		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Prioritise CVD checks		
Rationale There is strong evidence to support cardiovascular risk assessment and management for Aboriginal people. A cardiovascular risk assessment indicator is now part of the Indigenous primary health care national key performance indicators (nKPIs) for Aboriginal Community Controlled Health Organisations (Australian Institute of Health and Welfare 2017). Cardiovascular risk assessment and subsequent management in state funded Aboriginal Health Services and private general practice is unknown but is likely to be below standard given the current Adult Health Check data (15% of adults had an Adult Health Check recorded in SA). Blood pressure and cholesterol checks, as independent risk markers, are being undertaken in some primary care settings but management levels are unclear. Cardiovascular risk assessment and management has been a successful focus of work in the Northern Territory. **Actions** 1. Work with the risk assessment and early detection project to ensure CVD checks are included. **Feasibility** With the nKPI in place with ACCHO's and evidence building on how to successfully undertake CVD checks with Aboriginal people, some of the required infrastructure is in place. With limited investment CVD Checks can be integrated into a more comprehensive "Well health check" to tangibly improve health outcomes.	Coordinate	AHCSA ACCHOs SA health funded services PHN funded services Private sector GPs NVDPA Heart Foundation Stroke Foundation RFDS PHNs
Strategy 2: Ensure that emergency services are culturally appropriate		
Rationale After adjusting for different age profiles, Aboriginal people were 60% more likely than non-Aboriginal people to be hospitalised for a principal diagnosis of CVD (July 2010-June 2015). From 2006-2012, the Royal Flying Doctors Service (RFDS) undertook 137 primary evacuations and 424 inter-hospital transfers from SA for people identified as Aboriginal for CVD. Aboriginal identification of patients is not formally or systematically collected/registered during the emergency phase of their journey. Transfer and retrieval processes are not systematically culturally appropriate, and there is often limited communication with family and community.		

Condition Specific Priorities – Heart and Stroke		
Strategy	**CCC Approach**	**Potential Partners**
There is often poor coordination between the referring and referral hospital which creates barriers in the provision of best practice care, as well as impeding effective care coordination. **Actions** 1. Establish a system to identify Aboriginal or Torres Strait Islander status at the first point of medical contact 2. Develop and implement a transfer and retrieval services protocol that responds to the clinical and cultural needs of Aboriginal people 3. Work with all emergency services to improve the cultural competence of their services. ***Feasibility*** *Relationships are in place with all relevant services. There will be a need to work with in partnership to find meaningful, functional and realistic solutions.*	Advocate Lever Coordinate	SA Health SAAS iCCnet RFDS Heart Foundation Stroke Foundation

The Road Map – Condition Specific Priorities
Priority Action Area – Diabetes

Condition Specific Priorities – Diabetes		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Prioritise early detection		
Rationale As highlighted in the first sections, early detection of diabetes is a priority. There are well established approaches to early detection as there is a substantial prediabetes phase that provides a good opportunity for interventions around prevention. The RACGP National Guide to a preventive health assessment for Aboriginal people state that early detection and screening activities for type 2 diabetes is safe, accurate and cost-effective. There are established management options, with diabetic patients shown to be able to reduce their mortality by 50% with intensive treatment of multiple cardiovascular risk factors. **Actions** 1. Engage health services to establish accessible and appropriate models of early diabetes detection for Aboriginal people. 2. Increase Aboriginal health workforce trained to deliver early detection interventions. 3. Increase community access to early detection interventions. ***Feasibility*** *Strong evidence base exists regarding best practice implementation of early detection, and resources & service infrastructure exists. Service delivery and models of care require reorientation and investment in the Aboriginal community to enhance access and prioritise early detection efforts.*	Advocate Lever Coordinate	AHCSA ACCHO’s Diabetes SA SA Health CHSA PHN’s
Strategy 2: Reduce diabetes related complications		
Rationale Aboriginal people experience complications of diabetes at much higher rates when compared to non-Aboriginal peoples including eye, renal, foot and heart complications. Reducing diabetes related complications will have significant impacts on mortality, morbidity and quality of life within the Aboriginal community. Achieving this strategy will work to reduce health related costs of diabetic complications; including provision of dialysis, hospital and medication related costs. **Actions** 1. Improve access to interventions aimed to minimise burden of complications (allied health, interventions targeting cardiovascular risk factors, treatment/medications). 2. Increase Aboriginal workforce skilled in diabetes management. 3. Provide community based models of tertiary health prevention.	Advocate Lever Coordinate	AHCSA ACCHO’s Diabetes SA SA Health CHSA PHN’s

Condition Specific Priorities – Diabetes		
Strategy	CCC Approach	Potential Partners
Feasibility *Some actions will be readily implemented as they utilise existing infrastructure and resources. Partnership and collaboration between community, health service and policy makers will enable community health models to be actioned in a reasonably short amount of time. Others will require longer time commitments and resource investment (such as increasing the Aboriginal workforce).*		

The Road Map – Condition Specific Priorities
Priority Action Area – Cancer

Condition Specific Priorities – Cancer		
Strategy	**CCC Approach**	**Potential Partners**
Strategy 1: Prioritise screening		
Rationale Cancer has been approximated to account for 6% of the health gap between Aboriginal and non-Aboriginal people. There is a strong case to screen for all cancers that are appropriate for screening to identify and to commence treatment and management as early as possible. **Actions** 1. Provide cancer screening opportunities that are accessible, affordable, appropriate and acceptable to the Aboriginal community. 2. Invest in increasing the Aboriginal health workforce to engage in cancer screening activities ***Feasibility*** *Prime opportunity to action around cervical screening with updated guidelines to be released in the near future. Evidence, infrastructure and resources exist to provide preventative and screening activities within the cancer space. Requires a service reorientation to ensure screening is appropriate and accessible to community. Will likely be impacted by action to address access and workforce, previously described in this document.*	Advocate Lever Coordinate	AHCSA ACCHO's SA Health SACS Cancer Council PHN's
Strategy 2: Facilitate Aboriginal Cancer Healing Centres		
Rationale The community and cancer leadership group recognise the value of shifting away from a medicalised treatment model to one that promotes health, wellbeing and healing. Cancer healing centres are envisioned to be an environment that address the biopsychosocial and spiritual aspects of health and wellbeing, providing key management such as chemotherapy in conjunction with other holistic interventions and supports as required by the community. **Actions** 1. 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. 2. Advocate for resource allocation to be directed to healing, wellness and survivorship approaches in cancer care and service delivery. ***Feasibility*** *Feasibility will be dependent on the local service and their readiness and capacity to integrate healing and spiritual models of health into their model of service delivery.*	Advocate Lever Coordinate	AHCSA ACCHO's SA Health SACS Cancer Council PHN's

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Appendix 1: South Australian Aboriginal Heart and Stroke Plan 2017-2021

Executive Summary

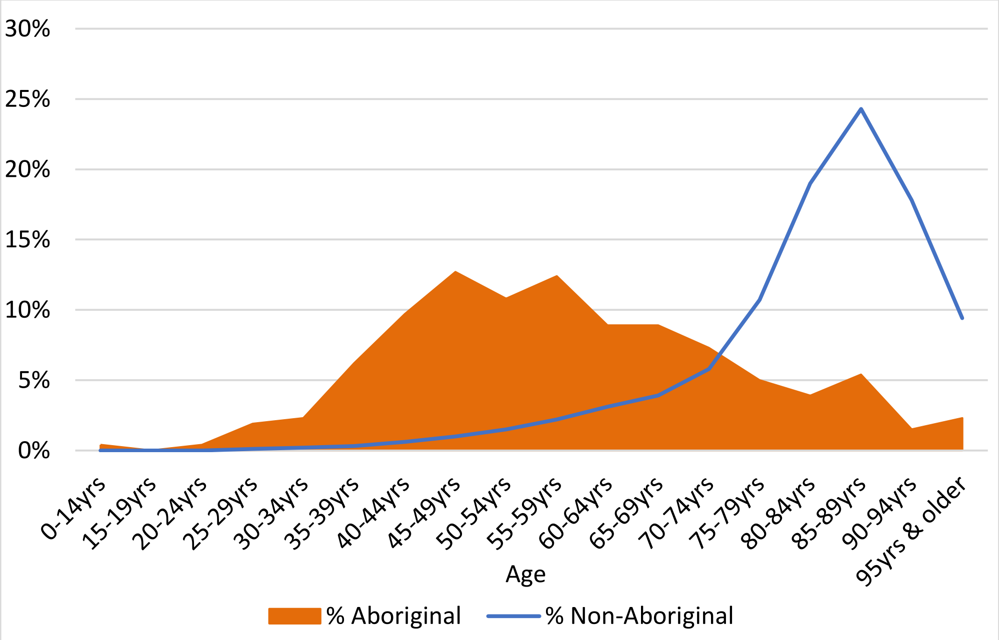
The SA Aboriginal Heart and Stroke Plan 2017-2021 was developed in 2015/16 by a project team at the Wardliparingga Aboriginal Research Unit at the South Australian Health and Medical Research Institute (SAHMRI). The development of the plan, commissioned by SA Health, reflects South Australia's response to an Australian Health Ministers Advisory Council project, Better Cardiac Care for Aboriginal and Torres Strait Islander people. The project was guided by an expert Steering Committee, a Community Reference Group, two Key Stakeholders Roundtables and numerous consultation meetings with service delivery agencies, policy makers and non-Government organisations.

The purpose of the Plan is to guide the delivery of evidence-based services for the prevention and management of those at risk of, and with, cardiovascular disease in South Australia. The vision of the Plan is to improve cardiovascular (CV) care and reduce cardiovascular morbidity and mortality for Aboriginal and Torres Strait Islander Peoples in South Australia.

The targets in the plan are:

- To reduce the age-standardised (recognises differences in population age structures) mortality rate for cardiovascular conditions;
- To increase identification and management of those at high cardiovascular risk;
- To reduce the rate of 30 day and 12 month unplanned re-hospitalisations following an acute heart or stroke event.

There is strong evidence that the project is needed, with cardiovascular diseases (heart and stroke) representing the largest cause of death for Aboriginal South Australians (26%). Aboriginal people experience heart disease and stroke at significantly younger ages than non-Aboriginal South Australians. The greatest disparities exist in the young age groups (25 to 54 years). See figure 1 below.



Data source: Cause of Death Unit Record File for South Australia provided by the Australian Coordinating Registry (unpublished) extracted for the SA State of Aboriginal Heart Health Project 30 July 2015.

Figure 1: Deaths from CVD (I00-I99), by Aboriginal status and age, SA 2006-2012

Additionally, Aboriginal people are 60% more likely to be hospitalised for a principal diagnosis of CV disease than non-Aboriginal people. Importantly, the Aboriginal community in South Australia are very committed to supporting disease prevention and management messages, especially with respect to surviving and managing acute heart and stroke events.

The Plan focusses on ‘evidence-based, culturally appropriate cardiovascular services’ that should be provided across the life course and continuum of care. Twenty-two service strategies have been identified, with some requiring either minor or major service reorientation while others require new investment. The definition of ‘culturally appropriate cardiovascular care’ is described. Extensive input from the Community Reference Group and other key stakeholders has aided the development of this underpinning definition. Importantly, the Plan is based on a strong and current evidence base that is articulated in the Essential Service Standards for Equitable Cardiovascular CarE (ESSENCE). The Plan also identifies six ‘essential enablers’, with eleven related strategies, that need to be addressed to ensure successful implementation of the service strategies.

Evidence-based, culturally appropriate cardiovascular services

Cross-sector services
1: Review and reorient current mechanisms to improve delivery of culturally appropriate comprehensive primary health care services
2: Develop a state-wide model for delivering cardiovascular care to Aboriginal people, with enhanced regional and remote service networks. Port Augusta should host a regional coordination centre that coordinates and enhances services for Aboriginal people in the far north and west of SA
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 state wide 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
13a: Maintain and expand iCCnet CHSA to provide coordinated services from first medical contact to definitive care for regional and remote Aboriginal patients with acute heart disease
13b: Implement a regional system of care from first medical contact to definitive care for regional and remote Aboriginal patients with stroke or TIA
14a: Provide best practice clinical and cultural care for Aboriginal heart disease patients 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 patients at the Royal Adelaide Hospital, Flinders Medical Centre, Lyell McEwin Hospital, Women's and Children's Hospital, Riverland General Hospital, Mount Gambier and Districts Health Service, Whyalla Hospital and Health Service, Port Augusta Hospital and Ceduna Hospital
15: Establish 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 patients and their families throughout their journey of care

16: Establish systems and services at the new Royal Adelaide Hospital that prioritise the needs of metropolitan, regional and remote Aboriginal people receiving care for heart disease and stroke

17: Develop a state-wide approach to a rheumatic valvular surgery centre of excellence

Ongoing care

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

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

20: Establish a model of culturally appropriate, evidence-based cardiac and stroke rehabilitation services

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

22: Establish culturally appropriate models of care and protocols for palliative and end of life care specifically for Aboriginal patients

Essential enablers for effective strategy

Governance and systems coordination

1: Establish a SA Aboriginal Heart and Stroke Plan governance group aligned with Transforming Health and in partnership with the SA Advanced Health Research and Translation Centre

Sustainable funding

2: Establish a governance group to identify sustainable funding to support the implementation of the Plan

Sustainable workforce development

3: Introduce mandatory training and demonstration of cultural competence of all cardiovascular health care providers

4: Increase the Aboriginal health workforce in number and capacity across the continuum of heart and stroke care

5: Increase the heart and stroke specialist workforce in western and northern Adelaide, and the far west and north of South Australia

6: Increase awareness of health professionals about the extent and impact of heart disease and stroke

Transport and accommodation support

7: Improve transport services to ensure Aboriginal people have safe home-to-care-to-home journeys

8: Provide 24/7 step-down units in southern and northern Adelaide Local Health Network (LHN), Port Augusta and Ceduna

Information and communications technology solutions

9: Invest in resources, coordination and systems for tele-health, point of care testing, virtual care and video-conferencing

10: Improve the utilisation and communication of information across patient information management systems

Monitoring and evaluation

11: Develop and implement a monitoring and evaluation framework for the SA Aboriginal Heart and Stroke Plan

The architecture and content of the Plan provides a road map for service providers across South Australia to improve the cardiovascular outcomes of Aboriginal and Torres Strait Islander peoples living and receiving cardiovascular care in this state. It recognises the importance of a coordinated, multi-pronged, culturally inclusive approach. The implementation of this Plan has the potential to make real and lasting improvements to help close the life expectancy gap between Aboriginal and non-Aboriginal people.

Appendix 2: The South Australian Aboriginal Diabetes Strategy 2017-2021

Executive Summary

Diabetes mellitus is serious health condition that affects a growing number of people daily across the world. It is a significant health concern in Australia, where one person every five minutes is diagnosed with diabetes.[i] This long-term condition, disproportionately affects Australia's Indigenous people. In 2012, one in 20 Australian adults had diabetes and for everyone, three Aboriginal and Torres Strait Islander adults had diabetes.[ii] Gestational diabetes disproportionately affects Aboriginal and Torres Strait Islander women and is increasing within the population. Indigenous children are eight times more likely to develop diabetes than non-Indigenous children, and are also more likely to have type 1 diabetes.[iii] It is a leading cause of death and disability in the Australian population and the annual cost impact of diabetes is $14.6 billion.[i] Diabetes not only affects the individual, but their family and the community.

There are three types of diabetes; type 1 diabetes, type 2 diabetes and gestational diabetes. Each is increasing in prevalence. Type 2 diabetes accounts for over 85% of all diabetes. This strategy addresses type 2 diabetes and gestational diabetes.

This Strategy has been designed to specifically meet the needs of Aboriginal people in South Australia. It was developed by Aboriginal people and people in policy and service provision positions. The development was governed by a multi-disciplinary, multi-sector Diabetes Steering Committee that included Aboriginal community representatives. Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute coordinated the development and undertook the research that informed the Strategy.

The recommendations in this Strategy prioritise a state-wide response to diabetes and guide potential health care reforms for diabetes and related conditions. South Australia has a world class health system, however, it does need to improve its ability to serve the Aboriginal population. This Strategy recommends enhanced use of existing infrastructure, systems and initiatives, complete implementation of evidence based guidelines, and strengthening the enablers to achieving these. Whilst many of the recommendations are becoming established or are established and need improvement, there are recommendations that will require new investment including the mechanisms to implement this Strategy.

Successful implementation of this Strategy will require a responsible governance structure and people who are committed and demonstrate the will to make a positive difference in the lives of Aboriginal people in South Australia. It will only be achieved through a coordinated approach across the South Australian Department for Health and Aging, the Aboriginal community controlled health sector, the peak body of which is the Aboriginal Health Council of South Australia, Adelaide and Country SA Primary Health Networks, and non-government organisations, particularly Diabetes SA. Success will require building and maintaining relationships with the Aboriginal community in South Australia and partnering with them to implement this Strategy. The implementation will be diverse, reflective of the Aboriginal population.

The SA Aboriginal Diabetes Strategy has six high-level goals, 23 recommendations with suggested pathways to achieve them and nine enablers. The six goals are aligned with the National Diabetes Strategy[iv] and the pathways to achieve these goals have been informed by scientific and cultural evidence and knowledge, the SA Aboriginal community and service providers. The six goals are:

- **Goal 1. Reduce the incidence of type 2 diabetes and gestational diabetes.** It is essential that a diabetes strategy for Aboriginal people includes prevention. To achieve this goal, population-based diabetes prevention campaigns specifically developed with and for the Aboriginal population will need to be implemented. Prevention efforts must have a particular focus on reducing early life exposure to diabetes in utero as a major intervention for preventing the 'vicious' intergenerational cycle of this condition. Improving pre-conception health and care during and after pregnancy will contribute to achieving this.

Prevention efforts must also focus on all age groups, increase the consumption of fruits and vegetables and water rather than sugary drinks, increase the health knowledge base of the Aboriginal population, and increase the use of primary health care health services for health maintenance. There is strong support for pre-diabetes programs among the Aboriginal community. Tailored initiatives for groups within the Aboriginal population that are at higher risk of developing type 2 diabetes and associated complications must be considered. It is imperative that the incidence of diabetes in pregnancy is reduced within this population group to reduce the pre-disposition to diabetes later in life.

- **Goal 2. Detect type 2 diabetes early.** Earlier detection of type 2 diabetes results in earlier management of the condition which can prevent or slow progress to diabetes-related complications. Increasing the number of Aboriginal people receiving annual health checks with necessary referrals and/or follow-ups will help achieve this goal. Having available Point of Care Testing for intermediate health outcomes including HbA1c will allow for immediate diagnosis and referrals for the appropriate management of type 2 diabetes. To successfully achieve this goal, the workforce and the Aboriginal community must have a shared understanding of signs and symptoms of diabetes, the importance of early detection and how it is performed. Innovative approaches to increasing access to primary care services will need to be implemented, there will need to be an increase in the use of, and optimising, existing care arrangements and incentives and services must be equipped to manage the findings.
- **Goal 3. Improve diabetes care and reduce complications.** Correct management of type 2 diabetes can significantly improve quality of life for individuals and their families, and increase life expectancy**.** It requires a multi-disciplinary approach, involving family and well-functioning social and welfare support structures. A state-wide diabetes model of care that is flexible to account for diversity across the population and geographical areas will facilitate the implementation of this goal. There is an urgent need to improve and strengthen the way diabetes and its associated complications is managed. Patients must be invited to become more involved in their care, and including families is key to successful management. The primary care system must continually improve and innovate and technology must support the workforce to achieve evidence-based diabetes care and continuity of care between primary care providers, and hospitals. Increasing access to culturally safe health and social services for Aboriginal people, and a strong multi-disciplinary workforce is a priority.
- **Goal 4. Reduce the incidence and impact of diabetes in pregnancy.** Everyone in SA must have an opportunity for the best start in life. Evidence shows that babies born to mothers with diabetes in pregnancy are at increased risk of developing type 2 diabetes later in life compared to those born to mothers without diabetes in pregnancy. Gestational diabetes also increases the likelihood of mothers developing type 2 diabetes. This goal focuses on both women who have diabetes and become pregnant and those who develop diabetes in pregnancy. A comprehensive, state-wide evidence-based approach to preventing and managing lifestyle risk factors and diabetes in both parents preconception and in pregnancy is necessary and should be a component of the state-wide model of diabetes care. Aboriginal women who are pregnant must be supported to self-monitor their blood glucose at home. Service providers and mothers must together identify and have a clear understanding of the care pathway during pregnancy. Continuing care post pregnancy for both the mother and the baby must be offered and the uptake of this increased. It will be important to build on the success of the Aboriginal Family Birthing Program.
- **Goal 5. Reduce the incidence of and better manage type 2 diabetes among priority groups.** Aboriginal children and adolescents, those with an intellectual and/or physical disability, those who have mental health conditions, prisoners, the homeless and frequent hospital users have been identified as priority groups within the Aboriginal community. To achieve this goal, it will be important to gain a better understanding of the diabetes prevention and management needs of these priority groups. This will help with tailoring programs that reduce incidence, increase early detection and improve on-going management among these groups. It will be necessary to work with multiple organisations, including for example, the education department, disability services, correctional services, and with Aboriginal organisations and Leaders. Different healthcare responses will need to be considered for people living in

remote areas and the diversity of the Aboriginal population will require innovative and flexible approaches to reducing diabetes incidence in this population.

- **Goal 6. Strengthen research, data usage and population health monitoring.** South Australia is well positioned to become a world leader in research. In order to implement evidence-based practices and make informed health policy decisions, SA needs to progress diabetes research with the Aboriginal community for a better understanding of the drivers of the diabetes epidemic and why the outcomes of diabetes in the Aboriginal community in terms of premature ill-health and mortality are much worse than those in the non-Aboriginal community. Enhancing data capacity and usability, particularly within the primary health care sector and connectivity between primary care and the hospital will be essential to improving the continuum of care, using existing knowledge to inform practice, and to monitor and evaluate efforts at a state-wide population level.

Figure 1 provides an overview of the Strategy's principles, goals, recommendations and enablers.

South Australia has the opportunity to become a national leader in improving the life expectancy of Aboriginal people by reducing the impact of type 2 diabetes in this population. This Strategy is a useful foundation for an implementation plan and can inform and guide this important work.

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[i] Diabetes Australia. About Diabetes [Internet]. [updated 2015, cited 20 Jul 16]. Available from: https://www.diabetesaustralia.com.au/diabetes-in-australia

[ii] AIHW. Diabetes [Internet]. [updated 2016 May, cited 2016 Jul 20] Available from: http://www.aihw.gov.au/diabetes/

[iii] Burrow S, Ride K. Review of diabetes among Aboriginal and Torres Strait Islander people [Internet]. 2016. Australian Indigenous HealthInfoNet. [cited 2016 Jul 20]. Available from: http://www.healthinfonet.ecu.edu.au/chronic-conditions/diabetes/reviews/our-review

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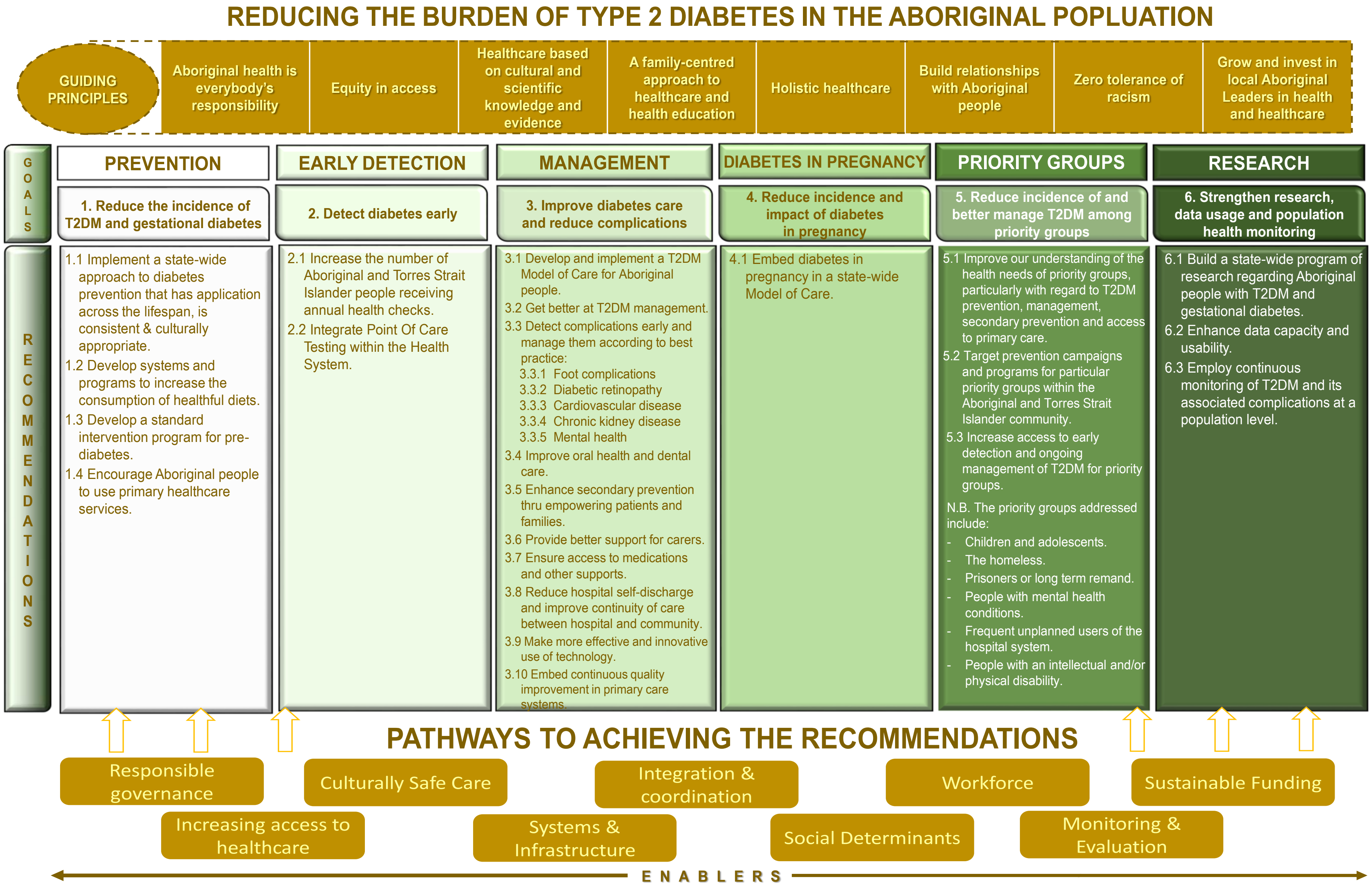
Figure 1 Overview: of the SA Aboriginal Diabetes Strategy 2017-2021



REDUCING THE BURDEN OF TYPE 2 DIABETES IN THE ABORIGINAL POPLUATION

GUIDING PRINCIPLES

- Aboriginal health is everybody's responsibility
- Equity in access
- Healthcare based on cultural and scientific knowledge and evidence
- A family-centred approach to healthcare and health education
- Holistic healthcare
- Build relationships with Aboriginal people
- Zero tolerance of racism
- Grow and invest in local Aboriginal Leaders in health and healthcare

GOALS

RECOMMENDATIONS

PREVENTION

1. Reduce the incidence of T2DM and gestational diabetes

1.1 Implement a state-wide approach to diabetes prevention that has application across the lifespan, is consistent & culturally appropriate.

1.2 Develop systems and programs to increase the consumption of healthful diets.

1.3 Develop a standard intervention program for pre-diabetes.

1.4 Encourage Aboriginal people to use primary healthcare services.

EARLY DETECTION

2. Detect diabetes early

2.1 Increase the number of Aboriginal and Torres Strait Islander people receiving annual health checks.

2.2 Integrate Point Of Care Testing within the Health System.

MANAGEMENT

3. Improve diabetes care and reduce complications

3.1 Develop and implement a T2DM Model of Care for Aboriginal people.

3.2 Get better at T2DM management.

3.3 Detect complications early and manage them according to best practice:
  - 3.3.1 Foot complications
  - 3.3.2 Diabetic retinopathy
  - 3.3.3 Cardiovascular disease
  - 3.3.4 Chronic kidney disease
  - 3.3.5 Mental health

3.4 Improve oral health and dental care.

3.5 Enhance secondary prevention thru empowering patients and families.

3.6 Provide better support for carers.

3.7 Ensure access to medications and other supports.

3.8 Reduce hospital self-discharge and improve continuity of care between hospital and community.

3.9 Make more effective and innovative use of technology.

3.10 Embed continuous quality improvement in primary care systems.

DIABETES IN PREGNANCY

4. Reduce incidence and impact of diabetes in pregnancy

4.1 Embed diabetes in pregnancy in a state-wide Model of Care.

PRIORITY GROUPS

5. Reduce incidence of and better manage T2DM among priority groups

5.1 Improve our understanding of the health needs of priority groups, particularly with regard to T2DM prevention, management, secondary prevention and access to primary care.

5.2 Target prevention campaigns and programs for particular priority groups within the Aboriginal and Torres Strait Islander community.

5.3 Increase access to early detection and ongoing management of T2DM for priority groups.

N.B. The priority groups addressed include:

- Children and adolescents.
- The homeless.
- Prisoners or long term remand.
- People with mental health conditions.
- Frequent unplanned users of the hospital system.
- People with an intellectual and/or physical disability.

RESEARCH

6. Strengthen research, data usage and population health monitoring

6.1 Build a state-wide program of research regarding Aboriginal people with T2DM and gestational diabetes.

6.2 Enhance data capacity and usability.

6.3 Employ continuous monitoring of T2DM and its associated complications at a population level.

PATHWAYS TO ACHIEVING THE RECOMMENDATIONS

- Responsible governance
- Increasing access to healthcare
- Culturally Safe Care
- Systems & Infrastructure
- Integration & coordination
- Social Determinants
- Workforce
- Monitoring & Evaluation
- Sustainable Funding

ENABLERS

Appendix 3: South Australian Aboriginal Cancer Control Plan 2016-2021

Executive Summary

The South Australian Aboriginal Cancer Control Plan 2016-2021 builds on the work and achievements of the previous plan (Aboriginal Companion Document to the State-wide Cancer Control Plan 2011-2015[4]) from which we have observed improvements in care coordination, breast screening participation rates, development of nationally accredited education for Aboriginal health professionals and the establishment of the CanDAD partnership research project. Whilst these are significant achievements and worthy of celebration, they only represent the beginning of actions and outcomes that need to be delivered in South Australia. Identified barriers to cancer care for Aboriginal people span a broad range of logistical and sociocultural issues relating to access, the health system environment, distress due to separation from family and community and misunderstandings due to language and cultural differences. Evidence shows that existing models of care and service delivery can be improved to meet the needs of Aboriginal people resulting in them being more likely to participate in screening programs, reduce the experience of delayed or incomplete treatment, and improve engagement with the health system. The Plan sets the direction for the next five years with a focus on implementation and outcome monitoring of initiatives to reduce preventable cancers, detect cancer at an early stage and improve coordination and access to culturally sensitive Optimal Cancer Pathways. Alongside timely and effective diagnosis and treatment, current and evolving evidence, frameworks and technology will be used to ensure that supportive care (including palliative care and survivorship) needs are assessed and addressed. This will include initiatives that meet the diverse needs of age groups, community and location with a particular focus on accessibility for Aboriginal people living in remote parts of South Australia. The Plan identifies nine priority areas and a series of actions identified to achieve each priority and is intended to be a living document. Therefore, there will be opportunities to update, re-align priorities and strengthen it based on new data, evidence, review of progress and input from the South Australian Aboriginal community.

South Australian Priorities and Actions

PRIORITY

Awareness and Prevention
Increase Aboriginal peoples' awareness and understanding of cancer prevention and treatment strategies through culturally appropriate and effective programs.

Increase Aboriginal peoples' participation rates in Human Papilloma Virus (HPV) and Hepatitis B (Hep B) immunisation.

ACTIONS

1. Collaborate with Primary Health Networks in SA to improve knowledge within Aboriginal communities to act on cancer risk and symptoms through specific preventive programs.
2. Work with non-government organisations, other agencies and SA Aboriginal communities through narratives and positive stories to dispel myths and stigma around cancer, being respectful of cultural beliefs.
3. Monitor and report on HPV and Hep B immunisation rates in the Aboriginal population with an emphasis on data quality and currency to ensure accuracy and timeliness of reporting.
4. SA Health and Cancer Council SA will continue to work in partnership with Aboriginal Community Controlled Health Services, community organisations, Elders, and communities to decrease smoking prevalence and alcohol consumption in the Aboriginal population.
5. Support research and evaluation on smoking cessation and alcohol harm minimisation programs in Aboriginal communities to improve and gain an understanding as to why and how interventions work with Aboriginal populations
6. Pursue opportunities to collaborate on Public Health strategies to maximise, develop and monitor strategies that promote regular exercise, healthy weight and a diet rich in fruit and vegetables to not only decrease cancer incidence but also impact on or prevent many other chronic diseases.

South Australian Priorities and Actions (Cont)

PRIORITY

Screening and Early Detection
Increase Aboriginal peoples' participation rates in cancer screening programs.

ACTIONS

7. Work with the Aboriginal Community Controlled Health sector, Country SA Primary Health Network, the Country Health SA Local Health Network and Women's and Children's Local Health Network to increase screening rates for people living in rural and remote areas.

8. Prioritise initiatives that facilitate collaboration between cancer screening programs in SA to:
    - 8.1 Draw on learnings, experiences and resources to promote awareness of, overcome barriers to and encourage greater participation rates of Aboriginal South Australians.
    - 8.2 Enable SA Health to coordinate the monitoring and reporting of cancer screening participation rates for Aboriginal people across all programs for inclusion in state based evaluation reports.

9. Continue to promote screening through targeted programs such as the Well Women's Program (cervical screening) and assist women to visit the Breast Screen SA Mobile Screening Unit when it visits remote communities.

10. Implement and adapt relevant national cancer screening programs and resources to support participation of Aboriginal people in screening within SA.

11. Explore need for and potential implications of lowering age eligibility criteria for population screening programs for Aboriginal people given that cancer diagnoses on average occur at a younger age.

PRIORITY

Diagnosis and Staging
Ensure coordinated and timely access to diagnostic services.

ACTIONS

12. Include Aboriginal status on all screening, diagnostic pathology, radiology and other requests and reports to:
    - 12.1 Improve the reliability of data on participation rates in screening.
    - 12.2 Enable routine recording and monitoring of stage at diagnosis for all Aboriginal people.

13. Support initiatives that enable coordinated and timely access to diagnostic services for Aboriginal people, particularly those living in remote areas.

South Australian Priorities and Actions (Cont)

PRIORITY

Treatment

Continual improvement of access to safe, timely, optimal, equitable and culturally appropriate treatment services for Aboriginal people in South Australia.

ACTIONS

14. Monitor the number of Aboriginal people receiving treatment in the regional chemotherapy units throughout SA.
15. Monitor utilisation of telemedicine consultations for/by Aboriginal people to enable understanding of current usage and future potential whilst promoting ongoing and increased utilisation.
16. Utilise Clinical Service Capability Frameworks to guide and maximise access to safe and appropriate cancer care as close to home as possible.
17. Complete an Aboriginal Health Impact Statement while implementing new Optimal Care Pathways for SA.
18. Develop and utilise quality indicators that are sensitive to Aboriginal patient needs to monitor and evaluate care along Optimal Care Pathways.
19. Engage in activities and initiatives that promote greater understanding and collaboration between Aboriginal Traditional Healers and health professionals in SA.

PRIORITY

Care Coordination

Improve coordination, assessment, management and evaluation of clinical and supportive care needs for Aboriginal people with cancer

ACTIONS

20. Sustain and continue to develop the current and potential roles that support and optimise cancer care coordination for Aboriginal people.
21. Collaborate with Primary Health Networks' Closing the Gap programs to strengthen cancer coordination pathways across the cancer care continuum.
22. Continue to evaluate how Aboriginal and Torres Strait Islander Cancer Care Coordinator roles are integrated and utilised to facilitate adoption of Optimal Care Pathways and changing clinical or service needs.
23. Implement and monitor usage of appropriate assessment and screening tools to identify clinical and supportive care needs of Aboriginal people from diagnosis through to survivorship or end-of-life care.

South Australian Priorities and Actions (Cont)

PRIORITY

Supportive Care

Increase understanding of, provision of, and access to culturally appropriate supportive care for Aboriginal people with cancer and their families across the cancer care continuum.

ACTIONS

24. Scope opportunities for further collaborative research to understand and address specific needs of Aboriginal children, adolescents and young adults with cancer, cancer survivors and their families.
25. Identify, implement and evaluate culturally appropriate and acceptable tools and templates (including needs assessment tools) for Aboriginal people with cancer and cancer survivors to be incorporated within the SA Survivorship Framework and cancer registries.
26. Collaborate with Primary Health Networks to further promote and encourage the uptake of incentives available to GPs to provide supportive and follow-up care for Aboriginal people within the Primary Health Care setting and Aboriginal Community Controlled Health Sector.
27. Collaborate with Primary Health Networks to promote culturally appropriate, community based conversations about the care of Aboriginal people whose cancer is incurable, including conversations about the importance of identifying who would speak on the person's behalf, if they were unable.
28. Increase awareness and monitoring of the number of Aboriginal people in SA with cancer having an Advance Care Directive.

PRIORITY

Workforce

Build capacity of the health system to provide cancer care within a culturally safe environment, through optimal services for Aboriginal people with cancer in South Australia.

ACTIONS

29. Build awareness and capacity of Aboriginal Health Workers/Practitioners (AHW/Ps) to deliver patient and community education across the cancer care continuum, including supporting AHW/Ps to undertake relevant cancer related training.
30. Support initiatives that facilitate Aboriginal health services and community services to establish and maintain Aboriginal cancer support groups or Yarning Circles.
31. Monitor utilisation and outcomes of cultural awareness and competence training for cancer care providers to improve confidence in delivery of cancer care and communication with Aboriginal people in a culturally safe manner.

South Australian Priorities and Actions (Cont)

PRIORITY

Service Outcomes Data and Research
Develop a better evidence base to measure the effectiveness of cancer related services for Aboriginal patients. Identify areas of excellence, service gaps and inform opportunity to improve patient experience.

ACTIONS

32. Utilise or develop Aboriginal Cancer Measures of Experience (ACME) or Patient Reported Outcome Measures (PROM) to routinely capture the quality and outcomes of care from the perspective of Aboriginal patients to inform care delivery.
33. Develop a participatory monitoring, evaluation and learning framework to measure and report on the impact of the SA Aboriginal Cancer Control Plan 2016-2021 annually.
34. Implement strategies that improve state-wide cancer activity data collection and monitoring to inform and enable system and service level design that increases timely access to well-coordinated care with the most appropriate provider/carer and location.

PRIORITY

Collaboration and Consumer Engagement
Ensure sustainability of a coalition of health organisations and consumers to advocate for Aboriginal cancer control issues, in collaboration and led by SA Health.

ACTIONS

35. Support the continuation of the SA Aboriginal Cancer Control Governance Committee.
36. Actively engage with consumers and Primary Health Networks in cancer control decision making in SA.
37. Broaden existing partnerships between government, community, private and non-government organisations and other agencies to address the social determinants of health and support available for Aboriginal people with cancer, their carers and families.

Appendix 4: Organisations currently involved in the Consortium as of June 30 2017

Aboriginal Health Council of SA (AHCSA)

Aboriginal Health Directorate - Country Health SA, SA Health

Adelaide Primary Health Network

ANZ DATA – Australian & New Zealand Dialysis & Transplant Registry

Cancer Council SA

Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation (CKAHSAC)

Central Adelaide Local Health Network (CALHN)

Country Health SA - Integrated Cardiovascular Clinical Network (iCCnet)

Country Health SA Local Health Network (CHSALHN)

Country SA Primary Health Network (CSAPHN)

Diabetes SA

Flinders University - International Centre for Point-of-Care Testing

Heart Foundation

Northern Adelaide Local Health Network (NALHN)

Nunkawarrin Yunti

Pangula Mannamurna Aboriginal Corporation

Pika Wiya Health Service Aboriginal Corporation

Port Lincoln Aboriginal Health Service Incorporated (PLAHS)

Queen Elizabeth Hospital (QEH)

Royal Adelaide Hospital (RAH)

Royal Flying Doctor Service (RFDS)

Rural Doctors Workforce Agency (RDWA)

SA Ambulance Service (SAAS)

SA Health

SA Health - SA Cancer Service

SA Health - Transforming Health - Acute Coronary Syndrome (ACS) & Stroke

SA Health & Medical Research Institute - Translation Centre

SA Rheumatic Heart Disease Program

Sansom Institute, University of South Australia

Southern Adelaide Local Health Network (SALHN)

University of South Australia

University of South Australia - Podiatry

Women’s & Children’s Hospital Network (WCHN)