

NSW Aboriginal Chronic Conditions Area Health Service Standards

Cardiovascular disease, diabetes, kidney disease,
chronic respiratory disease and cancer



Cover illustration: Melonie Wall

This design represents NSW Health and the Aboriginal Health & Medical Research Council of NSW standing united at the centre from which the four *NSW Aboriginal Chronic Conditions Area Health Services Standards* stem. The Standards are represented like ripples on a pond that travel to reach the outer. The ripples then become waves, releasing a greater energy, which builds a current powerful enough to sweep away the burden of Aboriginal chronic conditions. The entire design is surrounded by a pattern of dots, which represents all the Aboriginal and non-Aboriginal people that are working together to improve the health of Aboriginal people and communities in NSW.

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Executive summary

Background

Chronic conditions are a major problem facing the health care system. Over three million Australians, or nearly one in seven, suffer from a chronic condition. Furthermore, chronic conditions are a significant contribution to morbidity and mortality incidence in Australia.

Of particular note is the disproportionately high burden of chronic conditions in the Aboriginal community. Diabetes-related death and illness is 10 times more for Aboriginal people than non-Aboriginal people. Aboriginal people die six years before their non-Aboriginal counterparts from cardiovascular disease. Most of the increased morbidity and premature mortality is due to the increased prevalence of chronic conditions such as cardiovascular disease, diabetes, kidney disease, respiratory disease and cancer. The uneven burden of social, economic and environmental circumstances in which many Aboriginal people live (poverty, poor housing and inadequate food supply) place Aboriginal people at greater risk for chronic conditions. The health disadvantage begins early in the life cycle continuing into childhood and throughout adult life.

Risk factors for chronic conditions such as high blood pressure, smoking, physical inactivity and poor nutrition continue to occur at higher rates in Aboriginal populations. In addition Aboriginal people have had a consistently poor level of access to appropriate health care services. Early intervention and population health mechanisms are failing to prevent poor health in Aboriginal communities. Primary health care services are under-utilised for a complex range of reasons, including lack of bulk billing, transport issues and discrimination. As a consequence many Aboriginal people are presenting to health services late in the course of their diseases and experience significantly higher rates of preventable complications and death. Aboriginal people are also not receiving the same level and quality of care for the diagnosis and treatment of illness as the rest of the Australian population.

Improvement in health outcomes for Aboriginal people is contingent upon effective action in all of the domains influencing health and well being, including employment, housing and education. Collaboration with intersectoral organisations impacts significantly on the determinants of health. Health services, for their part, including government and non-government services such as Aboriginal Community Controlled Health Services, general practitioners and professional organisations, play a significant role in both treating and preventing ill health for the Aboriginal population. There have been a number of relevant initiatives and frameworks that have provided scaffolding for the *NSW Aboriginal Chronic Conditions Area Health Service Standards* (see Figure 1 on page ii).

NSW Aboriginal Chronic Conditions Area Health Service Standards

The *NSW Aboriginal Chronic Conditions Area Health Service Standards* have been developed to improve the health outcomes of Aboriginal people in NSW. The Standards augment the Clinical Service Frameworks in heart failure, respiratory disease and cancer developed by the NSW Chronic Care Program and take a broader chronic conditions approach to include cardiovascular disease, diabetes, kidney disease and chronic respiratory disease. The Standards aim to:

- improve health outcomes for Aboriginal people by setting evidence-based standards of practice for Area Health Services to be implemented through local Area Aboriginal Health Partnerships and in collaboration with a range of other services and organisations
- optimise the accessibility and appropriateness of health services and programs for the prevention and management of chronic conditions through these partnerships.

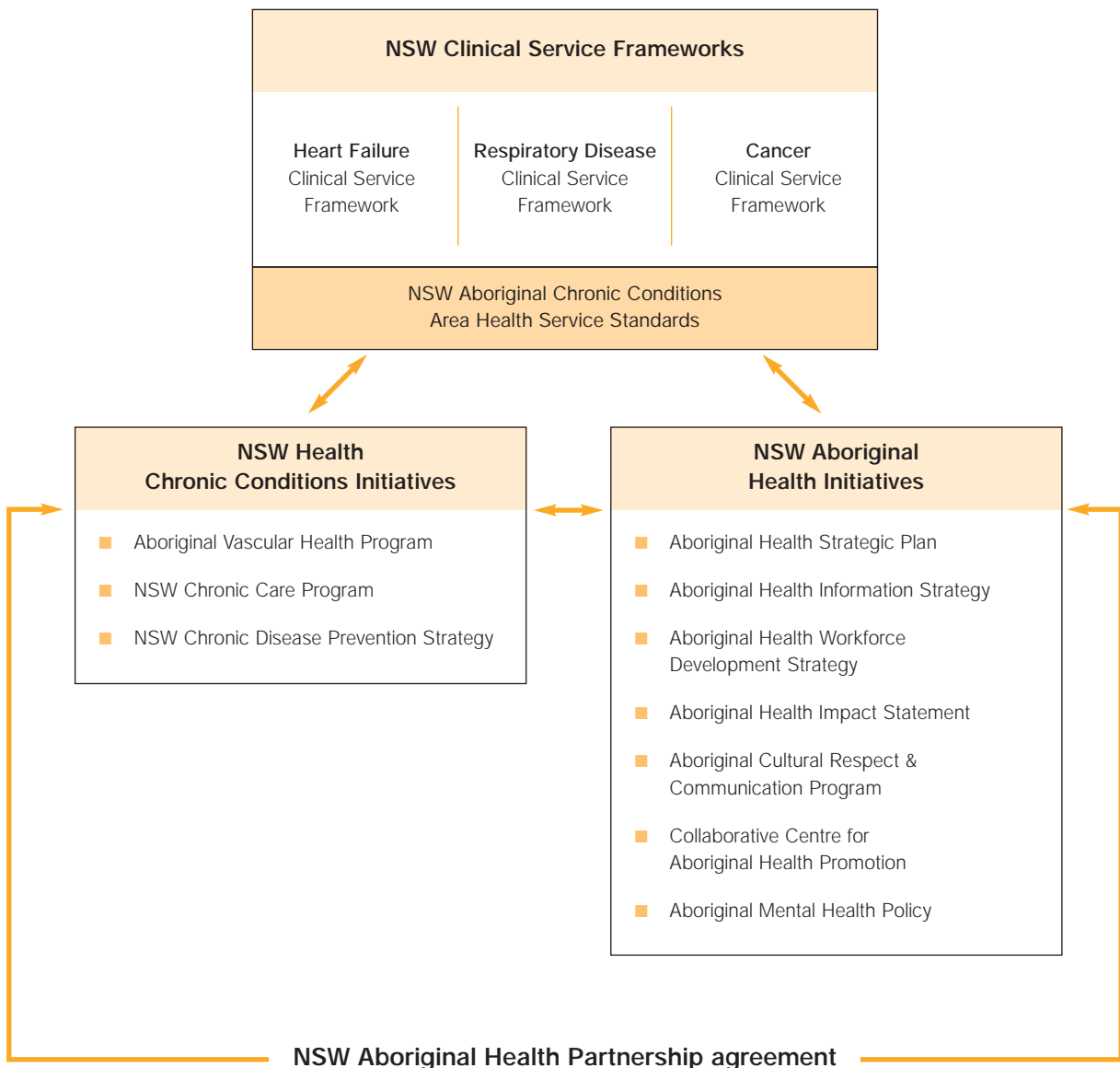
Executive summary

The *NSW Aboriginal Chronic Conditions Area Health Service Standards* are based on the available evidence of effectiveness or principles of best practice for chronic conditions interventions for Aboriginal populations. They are designed to assist health service providers enhance their current services through incorporating evidence based approaches. The Standards incorporate the principles of:

- self management and self determination of Aboriginal people
- promoting Aboriginal community participation

- placing individuals and community at the centre of care
- emphasising a primary health care approach
- fostering an integrated, coordinated approach across the continuum of care
- fostering multi-disciplinary care.

Figure 1. Relationship between the *NSW Aboriginal Chronic Conditions Area Health Service Standards* and other NSW Health initiatives



Standard	Demonstration of compliance	Responsibility
1.	A coordinated local approach to the prevention and management of chronic conditions within the Aboriginal population	
1.1a	Area Health Services will include Aboriginal chronic conditions as a standing agenda item on Local Area Aboriginal Health Partnership meetings, Area Chronic Care Program meetings and other relevant groups (by December 2005).	AHS
1.1b	Area Health Services to have identified areas where Aboriginal chronic conditions can be addressed (by June 2006), Area Health Services will incorporate Aboriginal chronic conditions into AHS strategic and service plans across relevant local services (eg diabetes services, health promotion) (by December 2006). Area Health Services will establish or identify local working groups with terms of reference agreed to by the group members and the Local Area Aboriginal Health Partnership (by December 2005). Area Health Services working groups will have demonstrated progress in addressing Aboriginal chronic conditions (by December 2006).	AHS AHS AHS AHS
1.2	Area Health Services will have developed a local Aboriginal chronic conditions activity profile (by June 2006).	AHS
2.	Targeted Aboriginal chronic conditions health promotion initiatives across the life-course and chronic conditions continuum	
2.1	Area Health Services will have collaboratively developed health promotion plans between Area Health Services, Aboriginal Health including Local Area Aboriginal Health Partnership and Health Promotion Units. These will be cross-referenced to evidence or principles of best practice and its implementation (by December 2006).	AHS
2.2	Area Health Services will have documented the processes for planning, coordination and evaluation in the collaborative health promotion plans developed in 2.1 (by December 2006).	AHS
2.3a	NSW Health in partnership with Aboriginal Health & Medical Research Council will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions (by June 2006).	NSW Health/ AH&MRC
2.3b	Area Health Services will have available in accessible locations culturally appropriate information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions (by June 2007).	AHS
3.	Effective systems for the diagnosis and care of Aboriginal people with, or at risk of, chronic conditions	
3.1	Area Health Services will establish accessible early detection services for Aboriginal people with, or at risk of, chronic conditions (by December 2007).	AHS
3.2a	Area Health Services will develop locally agreed referral pathways for Aboriginal people with, or at risk of, chronic conditions (by June 2007).	AHS
3.2b	NSW Health will support implementation of assessment and management tools to assist Area Health Services in monitoring referral and utilisation (by December 2006). Area Health Services will establish mechanisms to monitor referral and utilisation of services by Aboriginal people (by December 2007).	NSW Health AHS
3.3a	NSW Health will develop prototypes for protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people (by June 2006). Area Health Services will have collaboratively developed locally agreed clinical protocols for Aboriginal people with, or at risk of, chronic conditions eg health assessment tools (by June 2007).	NSW Health/AHS NSW Health/AHS
3.3b	Area Health Services will develop and implement appropriate training to support the implementation of the protocols (by December 2007).	AHS
3.4	NSW Health will develop and disseminate appropriate chronic conditions self-management models for Aboriginal people (by December 2006). Area Health Services will establish Aboriginal chronic conditions self-management initiatives (by December 2006).	NSW Health NSW Health/AHS
3.5a	NSW Health in partnership with Aboriginal Health & Medical Research Council will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions (by June 2006).	NSW Health/ AH&MRC
3.5b	Area Health Services will have available in accessible locations culturally sensitive information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions (by June 2007).	AHS
4.	Enhanced capacity of the Aboriginal health workforce to address chronic conditions prevention and management	
4.1	Area Health Services will ensure that Aboriginal Health Workers who have roles in chronic conditions management are working in partnership with Area chronic care initiatives and relevant service providers (by June 2006). All Area Health Services will establish working relationships with Aboriginal Health Workers to have clearly articulated roles and competency-based position descriptions in order to form part of a multi-disciplinary team to work in chronic condition management (by December 2007).	AHS AHS
4.2	NSW Health will develop a proforma to identify the current skills, knowledge and experience of Aboriginal Health Workers as a basis for ongoing training and career development plans (by December 2005). Area Health Services will establish ongoing training plans for Aboriginal Health Workers working in chronic conditions management (by June 2007). Area Health Services to ensure that ongoing training and support of Aboriginal Health Workers in chronic conditions management has occurred (by June 2008).	NSW Health AHS/AH&MRC AHS

Implementation

The NSW Aboriginal Health Partnership has endorsed the *NSW Aboriginal Chronic Conditions Area Health Service Standards*. It is expected that Areas will work collaboratively with Local Area Aboriginal Health Partnerships to develop plans for Area implementation. The NSW Aboriginal Chronic Conditions Advisory Group will have an overarching role in overseeing the development of strategies for statewide implementation.

Key steps in effective implementation

At the Area level, key steps in effective implementation include:

- identifying key stakeholders for Aboriginal chronic conditions – including those within the Area Health Service and community setting (Aboriginal Community Controlled Health Services) and Aboriginal community organisations and members
- establishing a local implementation team for the *NSW Aboriginal Chronic Conditions Area Health Service Standards* with appropriate Aboriginal representation (including Aboriginal Community Controlled Health Services). In addition, links should be established between this team and teams for the Chronic Care Program
- developing specific strategies and policies to establish, strengthen and/or maintain Local Area Aboriginal Health Partnerships
- establishing effective ongoing collaboration between local Aboriginal Community Controlled Health Services, Divisions of General Practice and other relevant organisations and community groups
- identifying local priorities for Aboriginal chronic conditions
- developing locally agreed protocols and implementation strategies for the *NSW Aboriginal Chronic Conditions Area Service Standards*
- taking an evidence-based approach to improving Aboriginal chronic conditions
- establishing multi-disciplinary networks with Aboriginal representation, and effective communication, between acute care, primary care and community health sectors (including Aboriginal Community Controlled Health Services)
- establishing monitoring and evaluation strategies for the Standards at the area level
- developing collaborative links with training and education organisations such as AH&MRC – Aboriginal Health College, TAFE, universities, or the newly established NSW Institute of Rural Clinical Services and Teaching
- supporting professional up-skilling and education programs for Aboriginal Health Workers and others, including Aboriginal Cultural Respect and Communication programs to improve the cultural competency of Area Health Services
- supporting the implementation of related strategies and programs within the Area, such as the NSW Aboriginal Employment Strategy, the Aboriginal Workforce Development Strategy and the Aboriginal Health Information Strategy.

For specific advice or consultation on the implementation of the Standards in your Area Health Service contact:

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Introduction

Chronic conditions such as cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer are the major cause of morbidity and mortality among Aboriginal people.* Moreover, the rates of illness and death related to these conditions are significantly higher in Aboriginal populations compared with non-Aboriginal populations.

A complex interaction of historical, social, economic and environmental factors contribute to these higher rates of disease (see Figure 2).

NSW Health has been working towards excellence in the provision of health services to Aboriginal people. It is well documented that a comprehensive primary health care model is the most effective approach to manage Aboriginal chronic conditions. The *NSW Aboriginal Chronic Conditions Area Health Service Standards* enhance the provision of comprehensive primary health care through establishing partnerships, linkages and collaboration with Aboriginal Community Controlled Health Services (ACCHSs). The Standards are consistent with the recommendations of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*.¹

Many cooperative arrangements have been formed such as the Partnership Agreement between NSW Health and the Aboriginal Health & Medical Research Council of NSW (AH&MRC). At the area level Local Aboriginal Health Partnerships between Area Health Services (AHSs) and ACCHSs are important to engage Aboriginal communities and provide holistic culturally respectful health services. A variety of different initiatives and programs within NSW relevant to the prevention and management of chronic conditions in Aboriginal people are in place such as the NSW Chronic Care Program and the NSW Aboriginal Vascular Health Program.

The *NSW Aboriginal Chronic Conditions Area Health Service Standards* aims to improve health outcomes for Aboriginal people by setting evidence-based standards of practice for Area Health Services to be implemented through Local Area Aboriginal Health Partnerships and in collaboration with a range of other services and organisations.

* The term Aboriginal is used throughout the document to represent both Aboriginal and Torres Strait Islander people.

Background

Chronic conditions in Aboriginal people

The Aboriginal people of NSW are a diverse population made up of different kinship and language groups. In NSW in 2001, two per cent of the total population were estimated as Aboriginal, accounting for about 29 per cent of the total Aboriginal population of Australia.²

Aboriginal people experience significantly greater morbidity and premature mortality due to, among other things, the increased prevalence of chronic conditions such as cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer compared with non-Aboriginal people. While Indigenous status is believed to be substantially under-reported in NSW, there are consistently higher rates of hospital separations and death for Aboriginal people with these chronic conditions. This is especially the case among younger population groups, which reflects the shorter life expectancy of Aboriginal adults.³ The mortality rate for cardiovascular diseases in Aboriginal people is two times the rate of non-Aboriginal people. The difference is greater in the 25–64 year old age group where death rates are 7–10 times those of non-Aboriginal people.³ The hospital separation rates for Aboriginal people with chronic respiratory diseases was four to five times the rate of non-Aboriginal people and for diabetes it was over five times the rate.³

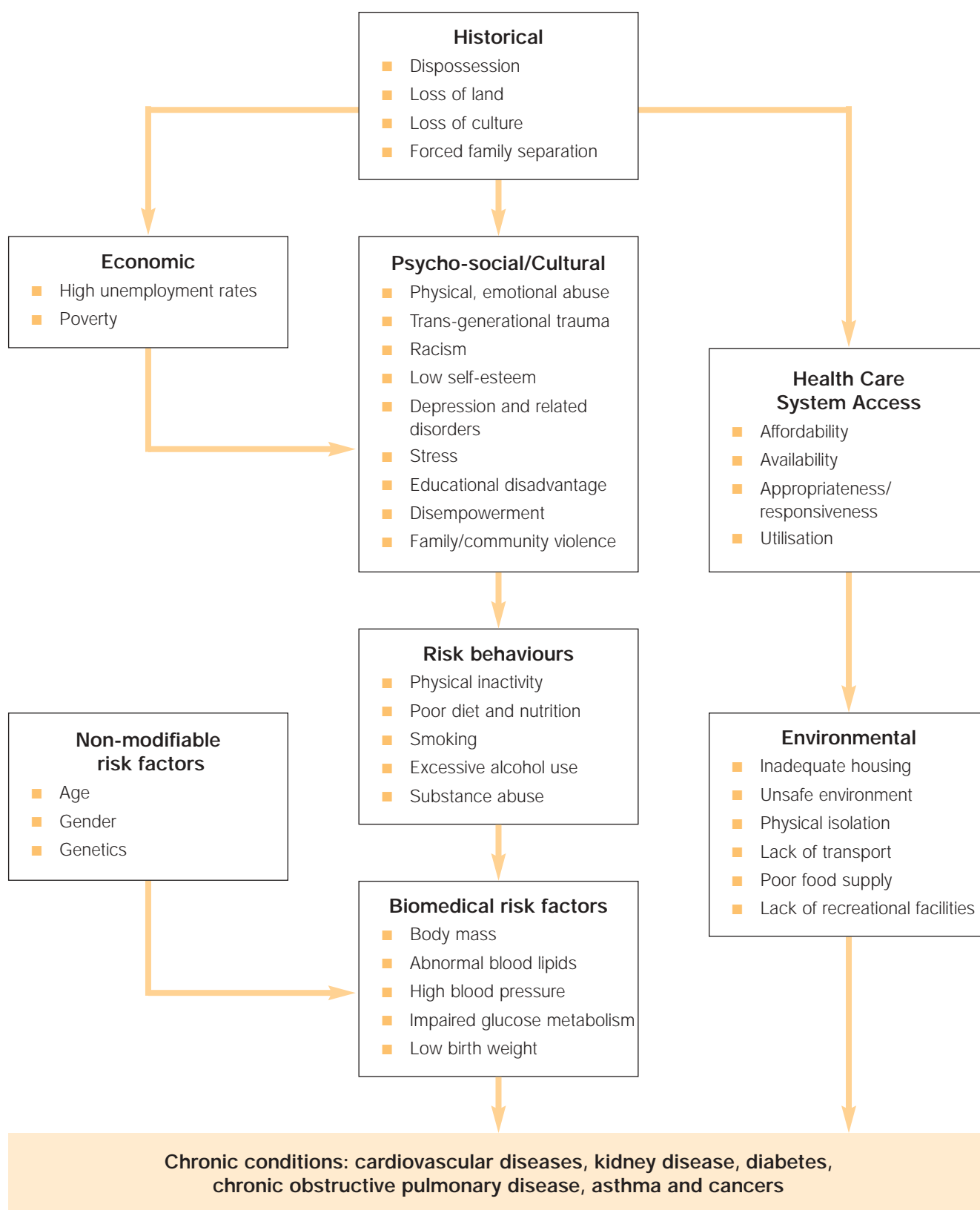
Frequently, chronic conditions are experienced with co-morbidities from the same group of diseases or others. This is especially the case for Aboriginal people. In addition, people with chronic and complex conditions often present with, or develop, depression, anxiety or other related mental health disorders as a clinical component. There is now strong evidence of the relationship between coronary heart disease and psychological distress.⁴ Aboriginal people in NSW have been found to experience significantly elevated levels of psychological distress.⁵ Rates of violence, substance abuse and other forms of self-harming behaviours are indicators of the impact of mental health of Aboriginal people.

Factors contributing to the poor health of Aboriginal people

Compared with non-Aboriginal Australians, the adult life expectancy of Aboriginal people in NSW is reduced by 20 years for males and 18 years for females.³ The social, economic and environmental circumstances in which many Aboriginal people live (poverty, poor housing and inadequate food supply) place Aboriginal people at greater risk for chronic conditions. This can lead to the increased possibility of the uptake of risk behaviours, which in turn may lead to physiological risk factors for chronic conditions (see Figure 1). For Aboriginal people, health disadvantage begins early, from before birth continuing into childhood and extending through adult life.

Risk factors for chronic conditions continue to occur at higher rates in Aboriginal populations. For example, in NSW in 1997–1998 Aboriginal people smoked at approximately twice the rate of non-Aboriginal people,⁶ obesity rates are significantly higher in Aboriginal populations and nutrition is much poorer.⁷ Systematic stress is the daily experience of many Aboriginal people,⁸ and relates to, among other things, the ongoing effects of poverty, widespread grief and loss, racism and discrimination, and a history of dispossession, broken families and the stolen generations. Psychosocial conditions such as stress, depression and isolation are more prevalent in Aboriginal people and show a strong relationship to chronic conditions such as heart disease.⁴ Not only are poorer levels of mental health associated with a higher prevalence of chronic conditions, the experience of chronic conditions are risk factors for mental health problems such as depression and anxiety. The emergence of a mental health disorder can significantly impact on important factors relating to treatment and recovery such as the motivation to attend services and the ability to make significant changes in health behaviours and levels of self-care.

Figure 2. Factors contributing to chronic health conditions in Aboriginal communities* 8a



* Developed through the NSW Aboriginal Vascular Health Program Working Group.

Background

In addition, Aboriginal people have had a consistently poor level of access to appropriate health care services. Mainstream services and models of care have generally not been tailored to meet the unique health needs of Aboriginal people and communities, with the generation of policies and practices often systematically disadvantaging Aboriginal people.⁹ Early intervention and population health mechanisms are failing to prevent poor health in Aboriginal communities. Mainstream primary health care services are under-utilised for a complex range of reasons, including lack of bulk billing, transport issues and discrimination.¹⁰ As a consequence, many Aboriginal people are presenting to health services late in the course of their diseases and as a result, experience significantly higher rates of preventable complications and death.³ Aboriginal people are also not receiving the same level and quality of care for the diagnosis and treatment of illness as the rest of the Australian population.¹⁰ Analysis of Australian hospital inpatient data shows that diagnostic and therapeutic procedures occur less often in Aboriginal and Torres Strait Islander people compared

with other Australians, despite their greater burden of disease.^{11,12} Further, access to and use of palliative care services by Aboriginal people is limited compared with the rest of the Australian population, and in NSW most palliative care services have little knowledge of the needs of Aboriginal people, nor do they have relationships with Aboriginal Community Controlled Health Services.¹³

Improvement in health outcomes for Aboriginal people is contingent upon effective action in all of the domains influencing health and well being, including employment, housing and education. Intersectoral initiatives through local area partnerships with relevant organisations have the potential to impact significantly on the determinants of health. Health services, for their part, including government and non-government services such as ACCHSs, general practitioners and professional organisations, play a significant role in both preventing and treating ill health.

NSW Aboriginal health partnerships and agreements

Under national and state Aboriginal health framework agreements, mainstream health services are expected to provide enhanced access for Aboriginal people which reflects their higher level of need.^{1,14} In NSW, Area Health Services in partnership with Aboriginal Community Controlled Health Services are responsible for developing and delivering appropriate health services and programs to ameliorate chronic conditions in Aboriginal people.

The NSW Aboriginal Health Partnership was formed through an agreement between the Aboriginal Health & Medical Research Council the peak body representing Aboriginal Community Controlled Health Services in NSW, and the NSW Government through the NSW Department of Health.² The Partnership aims to ensure that the expertise of Aboriginal communities is brought to the health care process through the development of agreed positions on health policy, strategic planning and broad resource allocation issues for Aboriginal health. This ensures that there is appropriate input and participation from Aboriginal Community Controlled Health Services in the planning, development, implementation and evaluation of health policies and initiatives.

At the local level, formal Area Aboriginal Health Partnerships have been developed to ensure that local Aboriginal Community Controlled Health Services are involved in the joint planning and delivery of health services to Aboriginal people and communities. Area Aboriginal Health Partnerships vary in their strength and capacity, and undertaking endeavours to further strengthen and maintain Area partnerships is an important step to improving Aboriginal health outcomes. The *NSW Aboriginal Health Impact Statement*, one of the key policy outcomes of the Partnership Agreement, requires that adequate negotiation and consultation occurs with Aboriginal communities in the context of the state or local partnership arrangements.¹⁵

A summary of the relevant Aboriginal health organisations and agreements for NSW is in Appendix A.

Case studies

Case studies are used throughout the Standards to illustrate specific aspects of programs or initiatives that are relevant to particular standards of practice. They demonstrate that different approaches can be taken to improving the prevention and management of chronic conditions in Aboriginal people and are reflective of community needs, priorities, resources and service arrangements.

The majority of the case studies are initiatives derived from NSW Aboriginal Vascular Health Program (AVHP) project sites. They represent snapshots in time of both rural and urban projects, which are developmental and evolving. The same principles illustrated in these case studies can be adopted in chronic respiratory disease and cancer as well.

The case studies will be further developed over time as more examples become apparent and evidence for the prevention and management of chronic conditions in Aboriginal people increases. This is especially the case in relation to health promotion and models of self-management that have limited studies to date.

Contact details for the case studies can be accessed on the web-site of the NSW AVHP at www.health.nsw.gov.au/living/atsi.html

NSW initiatives relevant to Aboriginal chronic conditions

A number of NSW Health initiatives relevant to the prevention and management of chronic conditions in Aboriginal people are being implemented. The NSW Chronic Care Program addresses the priority areas of cardiovascular disease, respiratory disease and cancer, with over 60 priority health programs implemented across Area Health Services in NSW.¹⁶ The development of Clinical Service Frameworks for heart failure, respiratory disease and cancer which define standards of care (clinical and operational) for health services and clinicians has been a major initiative of this program.¹⁷⁻¹⁹ Other important components of this program include *My Health Record*, a general practitioner engagement strategy and the NSW Chronic Care Collaborative.

In 2003, the *NSW Chronic Disease Prevention Strategy* was endorsed, targeting the prevention of cardiovascular disease, diabetes, cancer and chronic obstructive pulmonary disease, with Aboriginal health highlighted as a strategic focus for action.²⁰

The NSW Aboriginal Vascular Health Program (AVHP) is closely affiliated with the NSW Chronic Care Program and addresses the priority areas of cardiovascular disease, diabetes and kidney disease in Aboriginal populations as identified in the *NSW Aboriginal Health Strategic Plan*. The aim of the NSW AVHP is to work in collaboration with relevant organisations and service providers to improve the provision of high quality prevention and care services and programs to promote the vascular health of Aboriginal and Torres Strait Islander people in NSW. The program has adopted a multi-strategic approach, including service development through the establishment of a diverse range of project sites as well as workforce development, education and training and resource development.

There are currently more than 28 NSW project sites across the state, including eight NSW correctional facilities. The projects involve collaborative interventions involving partnerships between a range of players including mainstream Area Health Services, Aboriginal Community Controlled Health Services, Divisions of General Practice and other local service providers, TAFEs and universities. The models of care and service arrangements being implemented in these projects reflect aspects of the Standards of practice detailed in the *NSW Aboriginal Chronic Conditions Area Health Service Standards*. External evaluation of the NSW Aboriginal Vascular Health Program has identified several key areas that require strengthening, all of which are addressed in these standards of practice.²¹

Evidence for effective interventions in Aboriginal chronic conditions

There is accumulating evidence although limited, of effective interventions and services for preventing and managing chronic conditions in Aboriginal and Torres Strait Islander Australians. The evidence comes from a diverse range of initiatives set in a variety of contexts, focusing across the disease continuum from prevention and early detection through to clinical treatment and rehabilitation. The proportion of studies related to the diagnosis and care of Aboriginal people with chronic conditions is much greater than those that focus on disease prevention and health promotion, including action to influence the social determinants of health. In addition, the majority of the studies relate to diabetes, heart disease and renal disease rather than chronic respiratory disease or cancer.

Studies from Western Australia, Northern Territory and Queensland have shown moderate improvements in Aboriginal vascular health with potential gains in terms of life years saved, quality of life, and delay of progression to high-cost treatments.^{22–32} A number of key factors outlined below were found to contribute to the success of these programs, which are consistent with studies from other non-Australian Indigenous populations.^{33–40} Research into cancer screening delivery systems for Indigenous communities in Queensland suggested similar findings⁴¹ as did the systematic review of evidence on the management of non-insulin dependent diabetes in Aboriginal and Torres Strait Islander populations.⁴²

In addition, there have been several national reports which reviewed successful programs in Aboriginal health^{10,43} and the recent external evaluation of the NSW Aboriginal Vascular Health Program provides detailed context specific information relevant to NSW health services in both rural and urban settings.²¹ The findings are also consistent with the *Sydney Consensus Statement on Principles for Better Practice in Aboriginal Health Promotion* and recommendations for Indigenous peoples in the National Health Priority Areas reports on diabetes and cardiovascular disease.^{44–46}

While the majority of the intervention studies were undertaken in small rural or remote Aboriginal communities, some have been based in urban communities including several NSW Aboriginal vascular

health projects.^{21,31} Across the range of settings, it is clear that a combination of factors is necessary to establish, maintain and sustain initiatives for the prevention and management of chronic conditions in Aboriginal people. The key factors described below (not in order of importance) can be broadly classified into those that apply to Aboriginal health initiatives in general – from health promotion through to management of disease – and those which apply more specifically to initiatives for the early detection, diagnosis and management of chronic conditions and their associated risk factors.

Key factors relevant to initiatives in Aboriginal health in general

There are several key actions that are prerequisites for ensuring that Aboriginal health initiatives are most effective for Aboriginal people.

Aboriginal community support and involvement

All the studies indicate that Aboriginal community support and involvement is critical in the development, implementation, evaluation and sustainability of initiatives in Aboriginal health. Aboriginal community involvement is essential because it ensures programs and services meet the needs and priorities of the Aboriginal community and that they are delivered in a culturally sensitive manner. It is also consistent with the principles of self-determination, which ensures community ownership and management of Aboriginal health initiatives.

Effective local area partnerships and working groups

Strong sustainable local area partnerships with appropriate membership from a range of relevant organisations and the Aboriginal community are recognised as important factors in all of the studies. Formal and informal local area partnerships and building on existing partnerships, encourages consolidation of skills and human resources. Leadership is also an important factor in establishing and maintaining initiatives in Aboriginal health. Specific findings from the evaluation of the NSW AVHP indicated

that local area partnerships at multiple levels within Area Health Services – from high level executive support through to Aboriginal Health Workers (AHWs) – and operational local area Aboriginal health partnerships are important in progressing projects towards their goals and objectives.²¹

Participation and professional development of Aboriginal Health Workers

All of the studies emphasise the critical role that Aboriginal Health Workers (AHWs) play in the planning, implementation and evaluation of initiatives in Aboriginal health in both mainstream and Aboriginal Community Controlled Health Services. Further, when AHWs participate in the delivery of clinical services to Aboriginal clients, there is greater utilisation of services by the Aboriginal community. Comprehensive and ongoing training and education programs should be provided to AHWs, particularly in relation to clinical skills and protocols, along with appropriate clinical and cultural support. Two studies also suggest that review of the workplace and systems in which AHWs are operating should be undertaken regularly, in order that inclusive and sustainable work practices are implemented and most effective for AHWs.^{30,32}

Adequate resources and coordination between existing human, financial and physical resources and initiatives

Many of the studies emphasise that adequate resources are necessary for all stages of projects and that it is essential to coordinate new initiatives with existing services and programs, especially where networks have already been formed or services are already being used by Aboriginal people.^{22-25,27}

Effective planning and evaluation with feedback to the community

All of the studies indicate that thorough planning is vital to the success of programs. Undertaking evaluation strategies early in the program, especially where data is fed back to and discussed with staff and community, is noted to be helpful in maintaining community motivation and interest in the program, adjusting the program to suit the local circumstances and addressing

any unexpected issues.^{25,27,28} Planning for evaluation in the development of the initiative and allocating appropriate resources for evaluation is important.

Appropriate timeframes for the development and implementation of initiatives

All of the studies emphasised that successful programs in improving Aboriginal health require an extended period for development and implementation. Time needs to be allowed for the:

- development of effective local partnerships. Political issues both within and between Aboriginal communities, and between Aboriginal and non-Aboriginal organisations and individuals can extend the timeframe over which effective local area partnerships develop
- development of trust by Aboriginal people in institutions and services which have historically mistreated them
- increased expansion of the Aboriginal health workforce and numbers of AHWs skilled in chronic care
- development of effective health services and programs in the context of socially disadvantaged communities where Aboriginal people frequently experience high rates of stress, poverty, unemployment, racism and abuse
- strengthening of the models of service delivery that are appropriate and effective for Aboriginal communities. The different characteristics and needs of Aboriginal communities mean that one model of service delivery is not necessarily appropriate or effective for all Aboriginal communities or all community members. This is especially relevant in urban communities where there is more limited research evidence.

Key factors specific to initiatives for the early detection and management of chronic conditions among Aboriginal people

There is evidence that Aboriginal health initiatives which ensure the early detection and appropriate management of chronic conditions are the most effective. These initiatives include the following key factors.

Accessible early detection and intervention programs

Many of the successful initiatives in the literature involved establishing programs for the early detection of chronic conditions, with systems to ensure referral and follow-up to appropriate services.^{21-24,30,31,38,41} Such programs have been successfully established in urban and rural settings, as well as correctional facilities.

Local (including outreach) multi-disciplinary teams or taskforces with clear roles and responsibilities

Multi-disciplinary teams which include Aboriginal Health Workers and others such as dieticians, registered nurses or general practitioners, are essential to provide the appropriate range of skills and services to the Aboriginal community.^{21-24,30,32} Close teamwork allows Aboriginal Health Workers the opportunity to maintain and improve the effectiveness of their clinical skills, and allows other health sector workers the opportunity to develop knowledge of Aboriginal cultural and community issues. Having access to medical supervision as required, in person or by phone, was an important feature of many of the teams described in the studies.

Locally agreed evidence-based clinical protocols

The development of locally agreed clinical protocols for the early detection and management of specified chronic conditions is another key factor.^{21-24,30,32} The protocols should specify referral paths to local services and follow-up care. Studies where staff understand and adhere closely to the protocols show the strongest benefits.^{30,32} The studies also clearly show that staff using the protocols should be supported by appropriate training and education. One study showed that the intensity of initial treatment and patient education was a factor in improving clinical outcomes because of early gains in well-being and improved likelihood of patient self-responsibility, responsiveness to recall and general motivation to continue with treatment.³⁰

Systems for follow-up care for example register and recall systems

Programs which utilise 'active intervention' systems – for example systems where clients are registered into a database and recalled when services are due by telephone contact, house visits or picking up clients in vehicles as appropriate – show more success than opportunistic delivery of services.^{21-24,30,32} Systems structured around acute 'reactive' care leave little room for adequate preventive monitoring and review. In particular, systems designed to monitor specific clinical parameters (blood pressure) in an ongoing fashion, set goals for these parameters and highlight clients at high risk are recommended.³⁰

Aboriginal Chronic Conditions Area Health Service Standards

Aim of the Standards

The aim of the *NSW Aboriginal Chronic Conditions Area Health Service Standards* is to facilitate improved Aboriginal health outcomes in NSW through Area Aboriginal Health Partnerships by optimising the accessibility and appropriateness of health services and programs for the prevention and management of chronic conditions in Aboriginal people. Local Aboriginal Area Health Partnerships are an integral component of this process.

The Standards augment the NSW Chronic Care Program Clinical Service Frameworks for heart failure, chronic respiratory disease and cancer. The Aboriginal standards take a broader approach to include the chronic conditions of cardiovascular disease, diabetes, kidney disease, chronic respiratory disease and cancer (see Appendix B).

A combined chronic conditions approach has been taken because of the common conditions that place Aboriginal people at greater risk for these diseases, and the common approaches needed for the prevention and management of these conditions in Aboriginal communities. Appendix B lists the range of diseases and risk factors relevant to the prevention and management of the related chronic conditions among Aboriginal people. Appendix C lists relevant local health and other services.

The *NSW Aboriginal Chronic Conditions Area Service Standards* provides a practical, evidence based and flexible approach to the prevention and management of chronic conditions in Aboriginal people, and is designed to assist Area Health Services in collaboration with ACCHS (through local Aboriginal Health Partnership arrangements), enhance their current services by:

- setting standards of practice for Area Health Services to optimise the accessibility and appropriateness of health services and programs for Aboriginal people with or at risk of chronic conditions
- establishing a set of indicators against which compliance by AHSs with the standards of practice can be monitored within specified timelines
- providing recommendations for implementation and evaluation

- providing case studies to illustrate implementation of the standards of practice.

The standards of practice are primarily organisational standards and are based on existing evidence of effectiveness or principles of best practice. They incorporate the following principles:

- promoting Aboriginal community participation
- placing people at the centre of care
- emphasising a primary health care approach
- fostering an integrated, coordinated approach across the continuum of care
- fostering multi-disciplinary care.

The four standards of practice outlined in this document are:

1. A coordinated local approach to the prevention and management of chronic conditions within the Aboriginal population.
2. Targeted Aboriginal chronic conditions health promotion initiatives across the life-course and the chronic conditions continuum, which includes prevention, treatment and palliative care.
3. Effective systems for the diagnosis and care of Aboriginal people with, or at risk of, chronic conditions.
4. Improved capacity of the Aboriginal health workforce to address chronic conditions prevention and management.

The standards of practice inter-relate and are consistent with those listed in the NSW Chronic Care Program Clinical Service Frameworks, and with the guiding principles of the NSW Aboriginal Vascular Health Program. They also seek to link with and reinforce other Aboriginal health initiatives such as:

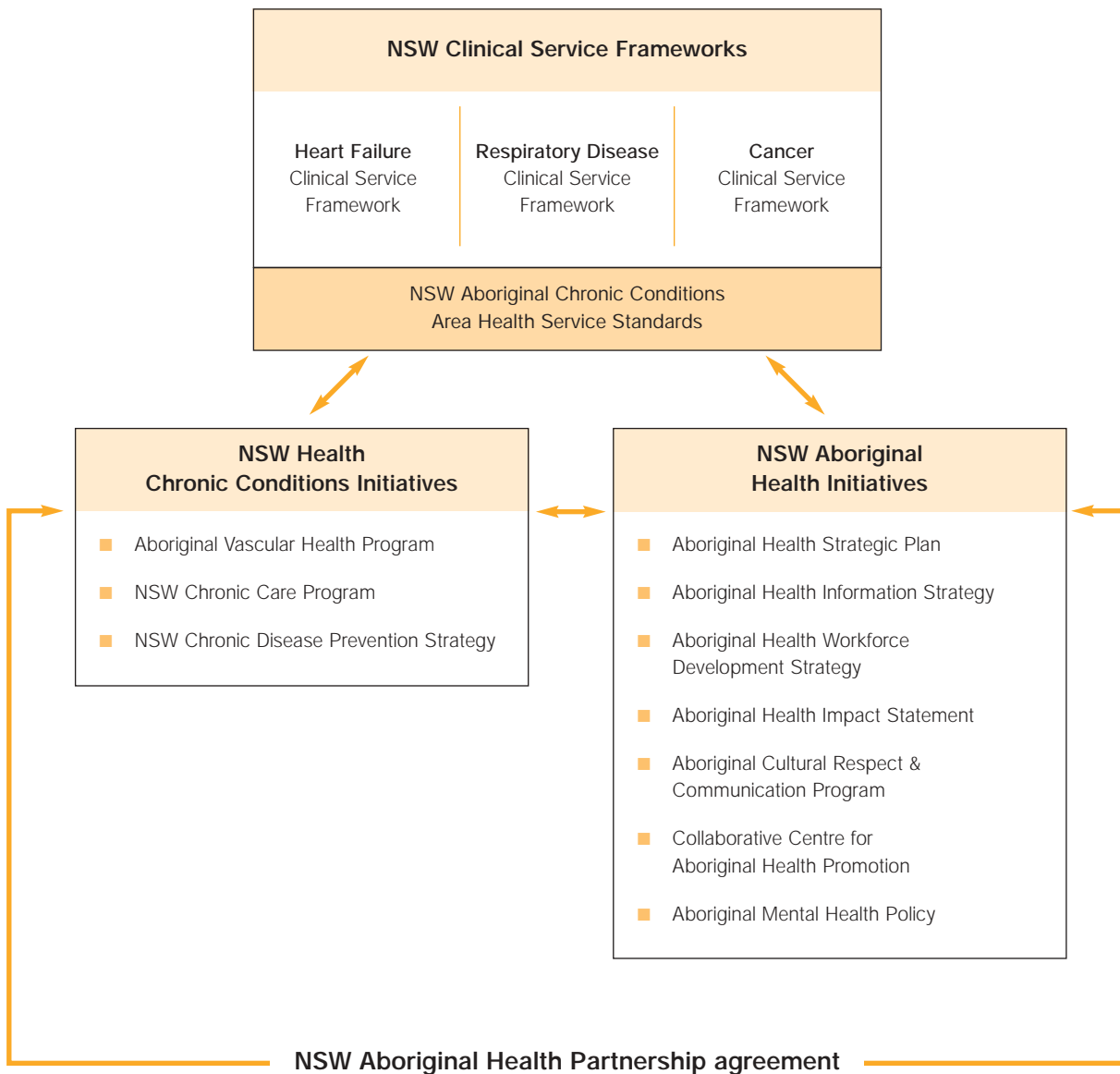
- *NSW Aboriginal Health Partnership Agreement (1999)*
- *NSW Aboriginal Health Strategic Plan (1999)*⁴⁷
- *Ensuring Progress in Aboriginal Health in NSW (2002)*²
- *NSW Aboriginal Health Information Strategy*
- *NSW Aboriginal Mental Health Policy (1997)*⁴⁸

The Aboriginal Chronic Care Area Health Service Standards

- *NSW Aboriginal Workforce Development Strategic Plan (2003)*⁴⁹
- NSW Aboriginal Cultural Respect and Communication Program
- *NSW Aboriginal Health Impact Statement (2003)*
- NSW Premier's Department *Partnerships: New Ways of Doing Business with Aboriginal people*
- *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013 (2004)*.¹

The *NSW Aboriginal Chronic Conditions Area Health Service Standards*, once implemented effectively, will enhance the capacity of NSW health services to prevent and manage Aboriginal chronic conditions and improve Aboriginal health outcomes. The process of implementation will be monitored and reviewed over time and the Standards will be revised as necessary.

Figure 3. Relationship between the *NSW Aboriginal Chronic Conditions Area Health Service Standards* and other NSW Health initiatives



Standard 1

A coordinated local approach to the prevention and management of chronic conditions within the Aboriginal population

Objective

To ensure integrated planning, effective support structures and local area partnerships for Aboriginal chronic conditions initiatives with responsibility clearly located at multiple levels within the Area Health Service.

Key points

- Successful initiatives in Aboriginal chronic conditions require leadership, commitment and support at multiple levels throughout the Area Health Service, from senior executives and clinicians through to middle managers and health workers.

- Effective local area Aboriginal health partnerships and working groups with involvement with other services is vital for sustainability of initiatives and improved Aboriginal health outcomes.
- The strength of local Aboriginal health partnerships vary between Area Health Services, and specific endeavours to develop, strengthen and maintain these may need to be undertaken.
- Planning for Aboriginal chronic conditions initiatives should take place in the context of local identification of Aboriginal community needs, priorities, resources and relevant initiatives.

Standard

Demonstration of compliance

1.1 Coordinated planning and integration

1.1a Executive level

All Area Health Services develop and implement Aboriginal chronic conditions initiatives through local area partnerships, with participation from senior level executives and clinicians.

1.1b Sector or local level

All Area Health Services establish or identify existing local working groups to actively progress Aboriginal chronic conditions initiatives.

Representation on the local level working group should include AHS Aboriginal health staff, Aboriginal community members and Aboriginal Community Controlled Health Service representatives, and others such as cardiac services, respiratory services, clinicians, community health services, diabetes educators, health promotion, Division of General Practice, Local Government Authority, mental health, palliative care and podiatry services (see Appendix C for a list of local relevant stakeholders).

By December 2005, all Area Health Services will include Aboriginal chronic conditions as a standing agenda item on local area partnership meetings, Area Chronic Care Program meetings and other relevant groups (eg Clinical Advisory Councils).

By June 2006, all Area Health Services to have identified areas where Aboriginal chronic conditions can be addressed.

By December 2006, all Area Health Services will incorporate Aboriginal chronic conditions into AHS strategic and service plans across relevant local services (eg diabetes services, health promotion).

By December 2005, all Area Health Services will establish or identify local working groups with terms of reference agreed to by the group members and the local area Aboriginal health partnership.

By December 2006, all AHS working groups will have demonstrated progress in addressing Aboriginal chronic conditions.

1.2 Aboriginal chronic conditions activity profile

All Area Health Services develop a local Aboriginal chronic conditions activity profile to inform planning and implementation.

The profile might include local stakeholders, a map of local services, relevant local initiatives, local issues and priorities for action.

By June 2006, all Area Health Services will have developed a local Aboriginal chronic conditions activity profile. The profile may exist within other AHS strategic plans (eg AHS Aboriginal Health or Chronic Care plans) or as a separate document.

A coordinated local approach to prevention and management of chronic conditions within Aboriginal populations

Illawarra Area Health Service

Illawarra Area Health Service (IAHS) has built support for Aboriginal vascular health initiatives at multiple levels within the AHS by strengthening the infrastructure required to deliver comprehensive and culturally appropriate services across the continuum of care.

An Aboriginal community needs assessment was undertaken to identify needs, issues and concerns in using current services. Local health service providers were also consulted to map service provision relevant to vascular health, discuss access issues for Aboriginal people, identify issues in providing services to the Aboriginal community, and to develop strategies to improve service provision and coordination. An expert advisory group was established including Aboriginal consumer representatives, Aboriginal Health Workers, Aboriginal Medical Services, cardiac rehabilitation, community health managers, diabetes unit, Divisions of General Practice, discharge planners, renal unit, specialist physicians and others. Findings from the consultation process have been presented to the senior executive and the AHS Board and a five-year Aboriginal Vascular Health Strategic Plan for the Area, with strategies, roles and responsibilities clearly defined.

New England Area Health Service

In 2002, the *New England Area Health Service Diabetes Service Plan* was developed, as an Area-wide initiative that recognises, among other things, Aboriginal people's poorer access to services within the New England Area Health Service. The plan aims to improve the coordination of Aboriginal Health Workers, clarify the roles of Aboriginal Health Workers and strategically focus on areas of vascular prevention, early detection and management of diabetes in Aboriginal people. The plan was developed in collaboration with Aboriginal health staff and emphasises collaborative responsibility and multiple partnerships in improving Aboriginal vascular health. It includes timelines, outcome measures and responsibilities for each strategy, including those specific to Aboriginal health.

Northern Rivers Area Health Service

A collaborative model was used to develop the Aboriginal Vascular Health project in the Casino Aboriginal Medical Service through partnerships with the AHS, Division of General Practice, Aboriginal Community Controlled Health Service and the Southern Cross University. The project has integrated with a local Area Primary Health Network project in Aboriginal diabetes also based at the Aboriginal Medical Service (AMS). The working group overseeing the project has representation from the Area and local sector service providers, AMS staff and community members and the Division of General Practice, which is enabling coordinated planning and implementation.

Note: The *NSW Health Aboriginal Health Impact Statement and Guidelines* have been developed to ensure that appropriate Aboriginal consultation/negotiation processes take place in the development of policies or programs by Area Health Services or the Department of Health, and that the health needs and interests of Aboriginal people have been properly considered.¹⁵

Note: In January 2005, NSW Health combined 17 existing Area Health Services to create eight larger Area Health Services. Case studies were drawn from AVHP project sites prior to January 2005. For the case studies, the former Area Health Service names have been retained.

Standard 2

Targeted Aboriginal chronic conditions health promotion initiatives across the life-course and the chronic conditions continuum

Objective

To ensure the establishment and implementation of coordinated Aboriginal health promotion initiatives to prevent chronic conditions and improve health outcomes across the life-course and the chronic conditions continuum.

Key points

- The poorer social, economic and environmental conditions which impact on Aboriginal people, from birth through to adulthood, as well as their reduced access to prevention and primary health services, leads to chronic conditions and exacerbates the effects of modifiable chronic conditions risk factors.

- Aboriginal people experience modifiable risk factors for chronic conditions at significantly higher rates than non-Aboriginal people.
- Health promotion encompasses a spectrum of approaches ranging from policy development, strategies to create supportive environments and/or reduce the impact of the social determinants of health through to strategies aimed at increasing knowledge, awareness and personal skills.
- Aboriginal staff, organisations and community members are vital in the planning, implementation and evaluation of Aboriginal health promotion initiatives.
- The expertise of health promotion specialists and the use of an evidence base for health promotion will help improve health promotion initiatives developed for Aboriginal communities.*

Standard

Demonstration of compliance

2.1 Aboriginal health promotion initiatives

All Area Health Services develop and implement collaborative Aboriginal health promotion initiatives to address the predisposing risk factors for chronic conditions and improve health outcomes for Aboriginal people with chronic conditions.

By December 2006, all Area Health Services will have collaboratively developed health promotion plans between AHS Aboriginal Health and AHS Health Promotion and others, cross-referenced to evidence or principles of best practice and its implementation.

2.2 Coordinated planning and evaluation

All Area Health Services ensure Aboriginal health promotion initiatives are coordinated, planned and effectively evaluated in collaboration with Aboriginal Health and AHS Health Promotion and other relevant stakeholders.

By December 2006, all Area Health Services will have documented the processes for planning, coordination and evaluation in the collaborative health promotion plans developed in 2.1.

2.3 Cultural sensitivity**

2.3a All Area Health Services ensure the involvement of Aboriginal Health Workers in the development, implementation and evaluation of Aboriginal chronic conditions health promotion initiatives (refer to standard 4).

Refer to standard 4.

2.3b All Area Health Services ensure culturally appropriate information and resources are available for Aboriginal people with, or at risk of, chronic conditions, with details of relevant local service providers.

By June 2006, NSW Health in partnership with the AH&MRC will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions.
By June 2007, all Area Health Services will have available in accessible locations culturally appropriate information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions.

*The Collaborative Centre for Aboriginal Health Promotion will be able to provide support and advice for Aboriginal health promotion initiatives, and distribute information of relevance via the clearinghouse. Relevant documents of interest include *Principles for Better Practice in Aboriginal Health Promotion: Sydney Consensus Statement*⁴⁶ and *NSW Aboriginal Health Promotion Program – Directions Paper*.⁵²

** Improving the cultural sensitivity of mainstream health promotion programs and non-Aboriginal staff is a critical component of this standard. The NSW Health, Aboriginal Health Workforce Development Unit is developing a Framework of Principles and Protocols for the Aboriginal Cultural Respect and Communication Program with the aim of improving the cultural sensitivity and competency of services within each AHS as well as ensuring a culturally safe and respectful workplace for Aboriginal staff.

Targeted Aboriginal chronic conditions health promotion initiatives across the disease continuum

South Western Sydney Area Health Service

Area wide multi-strategic Aboriginal health promotion plans

The South Western Sydney Area Health Service (SWSAHS) Aboriginal Health Promotion Working Group has representatives from AHS Aboriginal health, AHS Health Promotion Unit, AMS and the Gandangara Aboriginal Land Council. In 2002–2003 an audit of Aboriginal health promotion initiatives across SWSAHS highlighted a number of health promotion initiatives, however, most of these were small-scale and fragmented, reflecting the short-term funding provided for Aboriginal health promotion. More importantly, the audit highlighted the **strong support for Aboriginal health promotion** in SWSAHS. Subsequently, SWSAHS undertook development of a large-scale **multi-strategic Aboriginal health promotion plan** through planning days with the Director of Aboriginal Health, the Service Manager of the Aboriginal Health Unit, AHWs, Area Health Promotion staff and the Australian Centre for Health Promotion (Sydney University). The **evidence-based Aboriginal health promotion plan** will focus on identified priority areas and will specify outcomes along with long- and short-term strategies. The plan will be implemented over three to five years with **comprehensive evaluation** undertaken throughout, and will be closely linked with the Area Aboriginal Health Strategic Plan and Area Health Promotion Plans as appropriate.

New England Area Health Service/Pius X Aboriginal Medical Corporation

Creating a supportive healthy environment for Aboriginal preschool children

Pius X Aboriginal Corporation is an Aboriginal Community Controlled Health Service that offers a preschool service to Aboriginal children three to six years of age. During 2002, a one-day **kidney health promotion workshop** implemented by the Aboriginal Health Unit at NEAHS prompted the staff at Pius X to think about what they could do to make their preschool more health promoting – in particular by encouraging and educating young Aboriginal children about a healthy lifestyle and diet. Pius X successfully negotiated with the Aboriginal Health Unit for **health promotion funding** to develop two programs: a no-dig vegetable garden, and an exercise program for preschoolers. The staff at the Aboriginal Health Unit collaborated on the development of the plans and provided input throughout the programs as needed.

Central Coast Area Health Service

Collaborative 'Well Person's Health Check'

Central Coast Area Health Service has developed a strong commitment to appropriate Aboriginal participation in service planning through the adoption of the Aboriginal Health Impact Statement. The steering committee for the Aboriginal Vascular Health Program project includes representation from Nunyara Aboriginal Health Unit, Eleanora Duncan Aboriginal Medical Service, Area Public Health Unit, Diabetes Centre, Nutrition Department, Cardiac Rehabilitation, Cardiac Units, Podiatry, Renal Unit and the Central Coast Division of General Practice.

Successful **community-based health promotion and primary health screening** days have been conducted in two regional locations with more than 600 community members participating over two days. The initiative was based on the well-established Queensland model of the Well Person's Health Check. A local working group planned and coordinated the event and a wide range of service providers conducted health assessment clinics in heart health, podiatry, nutrition, oral health, diabetes, pathology, drugs and alcohol, sexual health, immunisation. Those with identified health risks were referred to either their GP or the AMS. The day was a fun family event with entertainment by Indigenous performers, and physical activities and games. Transport was available and local media provided extensive publicity. A **formal evaluation** was conducted.

Western Sydney Area Health Service/Daruk Aboriginal Medical Service

Community based health promotion

Daruk AMS in partnership with Western Sydney Area Health Service (WSAHS) has undertaken a number of health promotion initiatives to promote the vascular health of Aboriginal people in their community. In collaboration with Mt Drutt TAFE an 18-week healthy cooking program (one morning a week) for Aboriginal people with diabetes and their carers has been conducted at Daruk AMS. An Aboriginal person from TAFE delivers the program.

A physical activity health promotion activity the 'Pedometer Challenge Walking Program' was run in collaboration with the National Heart Foundation. Thirty high-risk Aboriginal clients were referred to the program, which began with a 'yarn-up' workshop at Daruk AMS. Pedometers were distributed for participants' personal use, and ideas to increase motivation to walk were also discussed. Most group members wanted to walk independently as well as join a walking group. The walking groups aim to facilitate self-sufficiency and will monitor the progress of individuals over time.

Daruk AMS and WSAHS have developed culturally appropriate health education pamphlets for Aboriginal people with high blood pressure and cholesterol. The pamphlets were developed by Aboriginal Health Workers in collaboration with others; they contain local contact information and photographs of local Aboriginal community members. The pamphlets have been well received by the community.

Standard 3

Effective systems for the diagnosis and care of Aboriginal people with, or at risk of, chronic conditions

Objective

To ensure the development and implementation, through local area partnerships, of local service arrangements to enable early detection, effective management and rehabilitation of chronic conditions experienced by Aboriginal people across the continuum of care.

Key points

- Aboriginal people generally present to health services late in the course of disease, and experience significantly higher rates of preventable complications and death.
- Aboriginal people with, or at risk of, chronic conditions require timely access to comprehensive clinical assessment, including appropriate diagnostic tests and investigations.
- Holistic assessment, including mental health assessment, is consistent with the Aboriginal view of health, and ensures the appropriate range of services are provided to Aboriginal people with chronic conditions.
- When culturally appropriate early detection services and systems of care are established which ensure follow-up and referral, risk markers for vascular diseases in Aboriginal people improve substantially.
- The involvement of Aboriginal staff in the delivery of health services, including clinical services, improves the likelihood that services will be utilised by Aboriginal people.
- Services should be provided and coordinated in collaboration with other local service providers such as Aboriginal Community Controlled Health Services and general practitioners (including Divisions of General Practice).
- Services should be made available in sites which are accessible to Aboriginal populations, including outreach services and programs in correctional centres.

Standard	Demonstration of compliance
3.1 Accessible early detection services	
All Area Health Services in partnership with AMSs collaboratively establish identifiable initiatives for the early detection of chronic conditions in Aboriginal people, in accessible locations (eg ACCHS community venues, correctional facilities). This may include local outreach teams, primary care teams and others.	By December 2007 , all Area Health Services will establish accessible early detection services for Aboriginal people with, or at risk of, the following chronic conditions (cancer, diabetes, renal, cardiac, respiratory).
3.2 Referral and follow up pathways*	
3.2a All Area Health Services develop agreed local/regional referral pathways for the diagnosis/ management and follow-up of Aboriginal people with, or at risk of, chronic conditions. The pathways should be developed and agreed by local relevant stakeholders, and include shared-care arrangements between AHS, ACCHS and others such as general practitioners, and improve the continuity of care (see Appendix C for a list of local relevant services).	By June 2007 , all Area Health Services will develop locally agreed referral pathways for Aboriginal people with, or at risk of, chronic conditions. By December 2006 , NSW Health will support implementation of assessment and management tools to assist AHS in monitoring referral and utilisation.
3.2b All Area Health Services establish mechanisms to monitor referral to and utilisation of relevant diagnostic and care services by Aboriginal people (eg angiograms, renal dialysis, cardiac rehabilitation, mental health services, palliative care).	By December 2007 , all Area Health Services will establish mechanisms to monitor referral and utilisation of services by Aboriginal people.
3.3 Local clinical protocols*	
3.3a All Area Health Services develop in collaboration with Aboriginal Health Workers and others local clinical protocols for the early detection and management of chronic conditions in Aboriginal people. These should be based on current Australian standards/guidelines, ensure holistic assessment and include shared care arrangements between ACCHS and GPs.	By June 2006 , NSW Health will develop prototypes for protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people.
3.3b All Area Health Services develop and provide appropriate training to support implementation of the protocols, in particular training for Aboriginal Health Workers.	By June 2007 , all Area Health Services will have collaboratively developed locally agreed clinical protocols for Aboriginal people with, or at risk of, chronic conditions (eg health assessment tools). By December 2007 , Area Health Services will develop and implement appropriate training to support the implementation of the protocols.
3.4 Chronic conditions self-management/support	
All Area Health Services develop identifiable initiatives to support Aboriginal people with or at risk of chronic conditions to self-manage their condition.	By December 2006 , NSW Health will develop and disseminate appropriate chronic conditions self-management models for Aboriginal people. All Area Health Services will establish Aboriginal chronic conditions self-management initiatives.
3.5 Cultural sensitivity	
3.5a All Area Health Services ensure the involvement of Aboriginal Health Workers in the above initiatives (refer to standard 4).	Refer to standard 4.
3.5b All Area Health Services ensure culturally respectful information and resources are available for Aboriginal people with, or at risk of, chronic conditions, with details of relevant local service providers.	By June 2006 , NSW Health in partnership with AH&MRC will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions. By June 2007 , all Area Health Services will have available in accessible locations culturally sensitive information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions.

* Note for 3.2 and 3.3: Legislation requires that the Department of Health collect certain information on clients/patients receiving treatment in the public health system and health care providers have an obligation to record details of services provided. Information is collected for purposes including: service delivery; continuity of care; clinical productivity; decision making and planning; quality measurement and management; funding and payment; and reporting requirements. Any person who has access to health information is bound by a duty of confidentiality. Information collected for these standards will enable AHS to: identify the extent of chronic conditions; provide appropriate access to chronic care services; and inform future planning decisions and the allocation of resources.

Effective systems for the diagnosis and care of Aboriginal people with, or at risk of, chronic conditions

New England Area Health Service

Comprehensive vascular risk assessment program

In NEAHS, a vascular health risk assessment has been offered to all Aboriginal adults aged more than 35 years. In addition, every Aboriginal family within the AHS has been offered family mapping to assist in identifying younger people who are potentially at high risk of vascular disease. Between 2000–2002 more than 1,000 Aboriginal people within NEAHS were identified with undiagnosed vascular disease or risk factors for vascular disease. Individuals with the greatest risk have been prioritised and referred to GPs, AMSs and local Chronic Care Programs. The three regional Divisions of General Practice have recently established diabetes or heart registers to which some of the **high-risk clients** are being referred. Clients are then **recalled** to attend **multi-disciplinary appointments** as required (dietician, podiatry, pathology, eye check, GP, hearing).

AHWs from the AHS and the AMSs are extensively involved in the planning and delivery of the program. They have been **trained** to undertake screening including blood pressure checks, pulse, and blood glucose levels. A **local risk assessment algorithm** was collaboratively developed to standardise testing and referral processes for AHWs. Follow-up home visits are conducted to monitor blood pressure and blood glucose levels, specifically during medication changes, to provide basic foot care assessment, as well as education and information. Clients are **referred** to walking groups, healthy cooking classes and exercise programs that have been developed in conjunction with the local gym. Two towns have been selected for concerted effort to increase the number of Aboriginal people participating in cardiac rehabilitation.

South Western Sydney Area Health Service

An urban multi-disciplinary team in action

In SWSAHS, two Aboriginal Health Workers, a primary health nurse (PHN) and dietician work in collaboration with the diabetes clinical nurse consultant and endocrinologist to deliver **comprehensive vascular health screening, assessment and follow-up** services to Aboriginal people living in the Liverpool and Fairfield areas. Clients are recruited through word of mouth, promotional days or outreach clinics (eg Miller Community Health Centre, Local Aboriginal Lands Council).

A **flow chart and comprehensive culturally appropriate local screening tool** have been developed and implemented to improve service coordination and the standardisation of procedures. Each client has been registered on a database, which will enable **monitoring of outcomes and follow-up**. Referral and regular follow-up is provided through telephone calls, home visiting and outreach by the multi-disciplinary team to: monitor symptoms; provide one-to-one support for clients to implement lifestyle change; provide information and education; accompany clients to appointments where requested; liaise and communicate with GPs and transport clients where necessary. Advocacy on behalf of clients for other services, such as social services and Department of Housing has also been undertaken.

The team meets weekly for **case management, review and planning** for patient care. A lot of time and effort has been taken to build relationships and trust with Aboriginal clients. This has been critical to the success of the project and is paying off over the longer term by building a sense of **sustainability**.

Western Sydney Area Health Service/Daruk Aboriginal Medical Service

Chronic conditions self-management system

The Western Sydney Indigenous Vascular Risk Assessment and Management Project (IVRAMP) is a collaborative initiative between WSAHS and Daruk AMS. One strategy of this project has been the trial of **chronic conditions self-management strategies** developed by Flinders Coordinated Care Trial Unit, with modifications to improve appropriateness for Aboriginal clients and the AHWs who administer it. AHWs are trained and supported to gather information about their clients' health, lifestyle, knowledge of their illness and their own health goals in order to develop care plans between the client and the GP based on their identified problems and goals. **Follow-up case management** is provided by AHWs which includes monitoring symptoms, referral, assistance making appointments, transport to appointments where necessary and attendance with client on request, and ongoing education and support. The program is targeted for patients who have poor self-management skills, are newly diagnosed or have complicated health issues.

The model is working well for the AHWs, particularly in identifying the full range of health and lifestyle issues affecting the client and the health goals of the client. Currently processes are being reviewed to enhance the capacity of GPs within the AMS to complete their section of the plan.

Illawarra Area Health Service

Culturally appropriate Chronic Care Program for Aboriginal people

The IAHS Chronic and Complex Care Program developed a **broad chronic conditions program specifically** for local Aboriginal community members in an appropriate culturally safe setting. A weekly program was established for a 12-week period at the Wollongong Aboriginal Cultural Centre. A group of local Elders with a spectrum of chronic conditions has been prioritised as the first group to participate to actively assist in shaping the program and **engaging** the broader Aboriginal community. **Strong partnerships** between a range of different service providers from the Area and AMS oversee the program and AHWs (including AHW students from TAFE) have been integral to developing and delivering the program.

The program has been developed with a football team motif ('players and coaches') with an emphasis on fun and sharing. Health workers provide **holistic health assessments** to participants and a letter is sent to their general practitioners or specialists informing them that their patient is participating in the program and if they have any concerns to contact the program. Participants develop **personal goals** and an individualised physical activity program is tailored for each participant to gradually build fitness. Hands-on **participatory education** across a range of **chronic conditions self-management** aspects is provided with particular attention to addressing stress and psychosocial issues in a safe environment.

Initial evaluation of the program shows promising indicators of **improved health outcomes**, including increased markers of physical fitness. There has been very high enthusiasm of participants and workers alike and other community members have expressed interest to join. Consideration is now being given to program **sustainability** and expansion to more community members.

Justice Health

Vascular health inreach services to Aboriginal people in NSW Correctional Centres

A vascular health project in Justice Health Service provides **health assessment/health promotion** and referral to Aboriginal offenders in eight correctional centres throughout NSW (Grafton, Tamworth, Parklea, Emu Plains, Cessnock, Broken Hill, Ivanhoe, Lithgow). Through the Aboriginal Health Partnerships between Justice Health and local ACCHS, arrangements have been made for small teams of Justice Health primary health staff and AHWs from local ACCHS to conduct monthly visits to correctional centres. **Comprehensive health assessments** identify those with, or at risk of, vascular diseases who are then referred to the **primary health clinics** as necessary.

Evidence-based health assessment tools and referral pathways have been developed. Information and **health education** is provided for all participating offenders and specific efforts are being directed at ensuring continuing care following release through referral to local ACCHS. Interventions to support chronic condition **self-management and healthy lifestyles** whilst in custody are also being developed.

The Aboriginal offenders, many of who had not previously had the opportunity to focus on health issues, have very enthusiastically received the program. Justice Health and the ACCHSs workers involved are very committed to the project. A state co-ordinator has recently been appointed to improve co-ordination, support and consistency of **data collection** across the eight sites.

Standard 4

Enhanced capacity of the Aboriginal health workforce to address prevention and management of chronic conditions

Objective

To increase the employment, education, career pathway development and retention of Aboriginal Health Workers in the NSW Health workforce to address chronic conditions prevention and management.

Key points

- The involvement of Aboriginal Health Workers and Aboriginal community members in the planning, delivery and evaluation of health services and programs, improves the chances that these will be utilised by Aboriginal people.
- Meeting the health needs of Aboriginal people requires, among other things, the employment of Aboriginal Health Workers in clearly defined and/or expanded roles with appropriate support and training.
- The development of individualised training development plans and career pathways for Aboriginal Health Workers, combined with an appropriate level and quality of support and mentoring, will enhance the capacities and retention of Aboriginal Health Workers.
- Extensive work is currently being undertaken at a national level to develop agreed competency based Aboriginal Health Worker training programs.

Standard

Demonstration of compliance

4.1 Aboriginal chronic conditions positions

All Area Health Services support local Aboriginal Health Workers to work in chronic conditions positions/roles. This may include positions in cardiovascular disease, diabetes, kidney disease, chronic respiratory disease, cancer and/or health promotion.

By June 2006, all Area Health Services will ensure that AHWs who have roles in chronic conditions management are working in partnership with Area chronic care initiatives and relevant service providers.

By December 2007, all Area Health Services will establish working relationships with AHWs to have clearly articulated roles and competency-based position descriptions in order to form part of a multi-disciplinary team to work in chronic condition management.

4.2 Training and education opportunities

All local area Aboriginal Health Partnerships develop and implement professional training plans for Aboriginal Health Workers, which facilitate development in chronic conditions management.

By December 2005, NSW Health in partnership with the AH&MRC will develop a proforma to identify the current skills, knowledge and experience of AHWs as a basis for ongoing training and career development plans.

By June 2007, all Area Health Services in partnership with the AH&MRC will establish ongoing training plans for AHWs working in chronic conditions management.

By June 2008, all Area Health Services in partnership with the AH&MRC to ensure that ongoing training and support of AHWs in chronic conditions management has occurred.

Enhanced capacity of the Aboriginal health workforce to address prevention and management of chronic conditions

New England Area Health Service

In NEAHS, following an extensive survey of local Aboriginal communities, the *NEAHS Aboriginal Health Strategic Plan* was developed. Initially the plan focused on diabetes then later extended to vascular disease. The plan aims to **improve coordination** of AHWs, **clarify the roles** of AHWs and strategically focus AHWs in the areas of vascular disease prevention, early detection and management in Aboriginal people.

The Area Manager of Aboriginal Health (AMAH), who has responsibility for the NEAHS Aboriginal Health Strategic Plan, successfully negotiated an **expansion of the Aboriginal Health Worker (AHWs) role** to include clinical skills in relation to the early detection and monitoring of vascular health conditions. The New England Aboriginal Vascular Health Program involves 22 AHWs delivering vascular health services to 19 communities, the majority as part of their **generic health worker role** with two employed to work solely in the area of vascular health. Over the course of this program the role of AHWs has been expanded, in particular their clinical role, which has been supported with extensive **training and education**. Training has ranged from introductory courses through to **competency-based programs** and all AHWs (from both AMSs and the AHS) have participated. The training has been developed and delivered by local service providers in collaboration with other organisations such as New England TAFE, NSW Podiatry Association, NSW Health and others.

The AHS has contributed substantial funds for the implementation of the training, with some enhancement funds provided through the Aboriginal Vascular Health Program project funds. The training has included, among other things:

- accredited basic training in the collection and recording of blood pressure and blood sugar levels
- diabetes education training (60-hour accredited course over nine weeks)
- basic footcare assessment
- infection control
- blood glucose screening training
- kidney workshop (one-day introductory course)
- cardiovascular workshop (one-day introductory course)
- cardiac health training program for AHWs (60 hours over nine weeks).

Illawarra Area Health Service

Peer support for Aboriginal Health Workers

Illawarra Area Health Service has established an Aboriginal Vascular Health Working Group comprising all AHWs from the AHS and AMSs who work with Aboriginal people with vascular diseases. The group has looked at clarifying the role of AHWs, increasing their involvement in a broad range of services as well as the development of a long-term plan to improve referral processes to AHWs. A range of **capacity building strategies** has been undertaken to increase skills and confidence of AHWs, and build consistency of practice in relation to managing clients with vascular health conditions.

The group provides support for AHWs and a forum for issues to be formally raised and addressed. It has strengthened the Area Aboriginal Health Partnership at the grassroots level by **facilitating professional relationships** between AHWs in the AMS and AHS. The establishment of this group has increased the trust of AHWs in services providers, created an avenue for AHWs to have input into service improvement and assisted in the development of a local *Aboriginal Vascular Health Strategic Plan*.

Greater Murray Area Health Service

Network of vascular health workers

As part of the Greater Murray Area Health Service (GMAHS) Chronic and Complex Care Program, a network of three Aboriginal diabetes/vascular health workers has been established across the Area. They are based in Community Health and an Aboriginal Medical Service. The vascular workers are linked into, and receive support from, the Area Aboriginal Health team via second monthly meetings and each worker having a self-selected clinical and cultural mentor. During the early establishment phase of the project a dedicated part-time project officer provided support, mentoring and co-ordination of the project workers.

Diabetes related skills, including clinical skills, have been developed through delivery of an accredited AHW training program adapted by the Area Diabetes Clinical Nurse Consultant (CNC) and delivered through and in partnership with the local TAFE. Ongoing clinical support, back-up and advice are provided by the CNC. The team has recently collaborated with the Riverina Institute of TAFE to develop a 2-day diabetes education program for community members. The team members are also supported in statewide networking and education through NSW Aboriginal Vascular Health Program initiatives including the Network and six monthly Forums.

Timelines

Standard 1 A coordinated local approach to the prevention and management of chronic conditions within the Aboriginal population

Standard 2 Targeted Aboriginal chronic conditions health promotion initiatives across the life course and chronic disease continuum

December 2005

1.1a Area Health Services will include Aboriginal chronic conditions as a standing agenda item on Local Area Aboriginal Health Partnership meetings, Area Chronic Care Program meetings and other relevant groups.

1.1b Area Health Services will establish or identify local working groups with terms of reference agreed to by the group members and the Local Area Aboriginal Health Partnership.

First six-monthly AHS report on standards implementation.

June 2006

1.2 Area Health Services will have developed a local Aboriginal chronic conditions activity profile.

2.3a NSW Health in partnership with Aboriginal Health & Medical Research Council will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions.

Second six-monthly AHS report on standards implementation.

December 2006

1.1b Area Health Services will incorporate Aboriginal chronic conditions into AHS strategic and service plans across relevant local services (eg Diabetes Services, Health Promotion).

Area Health Services working groups will have demonstrated progress in addressing Aboriginal chronic conditions.

2.1 Area Health Services will have collaboratively developed health promotion plans between Area Health Services, Aboriginal Health including Local Area Aboriginal Health Partnership and Health Promotion Units. These will be cross-referenced to evidence or principles of best practice and its implementation.

2.2 Area Health Services will have documented the processes for planning, coordination and evaluation in the collaborative health promotion plans developed in 2.1.

Third six-monthly AHS report on standards implementation.

June 2007

2.3b Area Health Services will have available in accessible locations culturally appropriate information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions

Fourth six-monthly AHS report on standards implementation.

December 2007

Fifth six-monthly AHS report on standards implementation.

June 2008

Sixth six-monthly AHS report on standards implementation.

Standard 3
Effective systems for the diagnosis and care of
Aboriginal people with, or at risk of, chronic conditions

Standard 4
Enhanced capacity of the Aboriginal health
workforce to address chronic conditions prevention
and management

December 2005

4.2 NSW Health will develop a proforma to identify the current skills, knowledge and experience of Aboriginal Health Workers as a basis for ongoing training and career development plans.

First six-monthly AHS report on standards implementation.

June 2006

3.3a NSW Health will develop prototypes for protocols and health assessment tools for the early detection and management of chronic conditions in Aboriginal people.

3.5a NSW Health in partnership with Aboriginal Health & Medical Research Council will develop culturally sensitive information for Aboriginal people with, or at risk of, chronic conditions.

4.1 Area Health Services will ensure that Aboriginal Health Workers who have roles in chronic conditions management are working in partnership with area chronic care initiatives and relevant service providers.

Second six-monthly AHS report on standards implementation.

December 2006

3.2b NSW Health will support implementation of assessment and management tools to assist Area Health Services in monitoring referral and utilisation.

3.4 NSW Health will develop and disseminate appropriate chronic conditions self-management models for Aboriginal people. Area Health Services will establish Aboriginal chronic conditions self-management initiatives.

Third six-monthly AHS report on standards implementation.

June 2007

3.2a Area Health Services will develop locally agreed referral pathways for Aboriginal people with or at risk of chronic conditions.

3.3a Area Health Services will have collaboratively developed locally agreed clinical protocols for Aboriginal people with, or at risk of, chronic conditions eg health assessment tools.

3.5b Area Health Services will have available in accessible locations culturally sensitive information and resources with details of relevant local service providers for Aboriginal people with, or at risk of, chronic conditions.

4.2 Area Health Services will establish ongoing training plans for Aboriginal Health Workers working in chronic conditions management.

Fourth six-monthly AHS report on standards implementation.

December 2007

3.1 Area Health Services will establish accessible early detection services for Aboriginal people with or at risk of chronic conditions.

3.2b Area Health Services will establish mechanisms to monitor referral and utilisation of services by Aboriginal people.

3.3b Area Health Services will develop and implement appropriate training to support the implementation of the protocols.

4.1 All Area Health Services will establish working relationships with Aboriginal Health Workers to have clearly articulated roles and competency-based position descriptions in order to form part of a multi-disciplinary team to work in chronic condition management.

Fifth six-monthly AHS report on standards implementation.

June 2008

4.2 Area Health Services to ensure that ongoing training and support of Aboriginal Health Workers in chronic conditions management has occurred.

Sixth six-monthly AHS report on standards implementation.

Implementation

The *NSW Aboriginal Chronic Conditions Area Health Service Standards* establishes standards of practice for Area Health Services for the prevention and management of chronic conditions in Aboriginal people. It is expected that Areas will develop plans to meet the Standards through local partnerships, in particular, Area Aboriginal Health Partnerships, to ensure the input of the Aboriginal community and ACCHS. The NSW Aboriginal Health Partnership has endorsed the Standards.

It is intended that there is allowance for some variation in the strategies employed by Areas in achieving the Standards depending on their different circumstances and requirements. Many Areas have undertaken significant progress towards meeting aspects of the standards through existing initiatives and programs. Potential approaches to implementation of various aspects of the Standards are outlined throughout the document.

The standards of practice are considered to be sufficiently important to recommend overall compliance by December 2008.

Statewide support for implementation of the Standards will be provided from the Chronic Care Unit for specific issues as they arise and the development of generic prototypes and proformas. A NSW Aboriginal Chronic Conditions Advisory Committee, with representation from the Department of Health, AHSs, AH&MRC and ACCHS will be established to provide leadership and oversee the development of statewide implementation strategies. Support for development of the Aboriginal health workforce will be provided through the strategies of the NSW Health Aboriginal Workforce Development Unit and Aboriginal Vascular Health Workforce and Resource Development Advisory Group.

It is not anticipated that implementation of the Standards will require specific additional financial resources. The standards reflect best practice in preventing and managing chronic conditions in Aboriginal populations and are designed to reorientate and strengthen the capacity of health services to address the greater needs of Aboriginal people.

The success of this policy in meeting its key objectives depends on the strong and demonstrated commitment of the NSW Department of Health and each AHS in supporting its implementation. It also relies upon active local area Aboriginal health partnerships and participation between clinicians and health care providers in the AHS and community sector, particularly ACCHSs.

At the Area level key steps in effective implementation include:

- identifying key stakeholders involved in Aboriginal chronic conditions – including those within the AHS and community setting (ACCHS and other Aboriginal community organisations and members) (refer to Standard 1.2)
- establishing a local implementation team for the *NSW Aboriginal Chronic Conditions Area Health Service Standards* with appropriate Aboriginal representation (including ACCHSs) and explicit accountability arrangements (refer to standard 1.1). In addition, links should be established between this team and the implementation teams for the Area Chronic Care Program initiatives
- developing specific strategies and policies to establish, strengthen and/or maintain local Aboriginal Health Partnerships
- establishing effective ongoing collaboration between local ACCHSs, Divisions of General Practice and other relevant organisations and community groups
- identifying local priorities for Aboriginal chronic conditions (refer to Standard 1.2)
- developing locally agreed protocols and implementation strategies for the *NSW Aboriginal Chronic Conditions Area Health Service Standards*
- taking an evidence-based approach to improving Aboriginal chronic conditions
- establishing multi-disciplinary networks with Aboriginal representation, and effective communication, between acute care, primary care and community health sectors (including ACCHS)

- establishing monitoring and evaluation strategies for the Standards at the Area level
- developing collaborative links with training and education organisations such as AH&MRC – Aboriginal Health College, TAFE, Universities, or the newly established NSW Institute of Rural Clinical Services and Teaching
- supporting professional up-skilling and education programs for AHWs and others, including Aboriginal Cultural Respect and Communication programs to improve the cultural competency of AHS staff
- supporting the implementation of related strategies and programs within the Area such as the *NSW Aboriginal Employment Strategy*, the *NSW Aboriginal Workforce Development Strategy* and the *NSW Aboriginal Health Information Strategy*.

For specific advice or consultation on the implementation of the Standards in your Area contact:

Chronic Care Unit
NSW Department of Health
Locked Mail Bag 961
North Sydney NSW 2059
Tel. (02) 9391 9921
Fax. (02) 9424 5816.

Monitoring and evaluation

A multi-level approach is proposed for the monitoring and evaluation of the *NSW Aboriginal Chronic Conditions Area Health Service Standards*, occurring at three levels:

1. Program, service or initiative level
2. Area Health Service level
3. State level.

Evaluation activities at the program or initiative level will support the Area Health Service evaluation that will in turn support the state-level evaluation activities.

Level 1: Program, service or initiative

Evaluation at this level will be used to monitor local programs, services or initiatives relevant to the *NSW Aboriginal Chronic Conditions Area Health Service Standards*, against program aims and objectives. The aim of this level of evaluation is to provide information about:

- What is happening within the program initiative or service?
- How and why it is happening?
- Ways in which the program initiative or service can be modified by the managers and staff involved improving its effectiveness.

Primary responsibility for evaluation at the program level will rest with the key program managers and staff. The main areas for suggested local evaluation are:

- processes involved with the program, service or initiative
- appropriateness of the program, service or initiative for Aboriginal people
- impact of the program, for example utilisation of the program, service or initiative by Aboriginal people
- Aboriginal health outcomes for participants of the program (where feasible and appropriate)
- resource allocation and key outputs.

The strategies for this level of evaluation are to be incorporated into the planning of the initiative, with input from Aboriginal people and others. Where feasible and appropriate the Department of Health will assist with standardisation of data collection tools and

associated mechanisms to enable aggregation of the data within and across Areas.

Level 2: Area Health Service

Evaluation at this level will be used to monitor overall compliance with the *NSW Aboriginal Chronic Conditions Area Health Service Standards* at the Area level. The aim of this level of evaluation is to provide information about the initiatives and processes within the Area that demonstrate compliance with the standards of practice. It will be undertaken in conjunction with monitoring progress in the Chronic Care Program initiatives.

Primary responsibility for this level of evaluation will rest with AHSs, however the Department of Health will develop a standardised reporting proforma for six-monthly reporting to assist with this process. The implementation of the *NSW Aboriginal Chronic Conditions Area Health Service Standards* will be incorporated into Performance Agreements between the NSW Department of Health and AHSs.

Level 3: State

Evaluation at this level will be used to monitor progress in addressing Aboriginal chronic conditions across NSW. Progress will be measured over time in relation to three main domains:

Domain	What will be monitored
Local capacity and infrastructure	Aggregated information about the development and delivery of quality health programs, services or initiatives consistent with the <i>NSW Aboriginal Chronic Conditions Area Health Service Standards</i>
Risk factors for chronic conditions	Prevalence of key risk factors determining chronic conditions in Aboriginal people
Chronic conditions health status and outcomes	Health of Aboriginal people in relation to chronic conditions

Primary responsibility for this level of evaluation will rest with the NSW Department of Health. Evaluation activities at the program and Area Health Service level will feed into the state-level evaluation of capacity and infrastructure. Routine data collections will be the main data source used to monitor the risk factors for chronic conditions and health outcomes.

Acronyms and abbreviations

Acronym	Definition
Aboriginal	The term Aboriginal is used throughout the document to represent both Aboriginal and Torres Strait Islander people
ACCHC	Aboriginal Community Controlled Health Committees
ACCHS	Aboriginal Community Controlled Health Services
ACCERS	Aboriginal Community Controlled Health Related Services
AHEO	Aboriginal Health Education Officer. For ease of reading throughout the document the term Aboriginal Health Worker will encompass both Aboriginal Health Education Officers and Aboriginal Health Workers.
AHISU	Aboriginal Health Information Strategy Unit
AH&MRC	Aboriginal Health & Medical Research Council of NSW
AHS	Area Health Service
AHW	Aboriginal Health Worker. For ease of reading throughout the document the term Aboriginal Health Worker will encompass both Aboriginal Health Education Officers and Aboriginal Health Workers.
AMAH	Area Manager of Aboriginal Health
AMS	Aboriginal Medical Service
ATSIC	Aboriginal and Torres Strait Islander Commission
AVHP	Aboriginal Vascular Health Program
CCP	Chronic Care Program
CNC	Clinical Nurse Consultant
PHN	Primary Health Nurse
TAFE	Technical and Further Education

Appendix A

Summary of relevant Aboriginal health organisations and agreements

National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013. Framework for action by Governments

The framework builds on the *National Aboriginal Health Strategy 1989* and addresses approaches to primary health care and population health within contemporary policy environments and planning structures. The goal of the framework is to ensure that Aboriginal and Torres Strait Islander people enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.

Aboriginal Health & Medical Research Council of NSW

Aboriginal Health & Medical Research Council of NSW is the peak body for Aboriginal Community Controlled Health Services in NSW representing – in June 2004 – 50 member organisations, comprised of Aboriginal Community Controlled Health Committees (ACCHC), Aboriginal Community Controlled Health Services also known as Aboriginal Medical Services and Aboriginal Community Controlled Health Related Services.

NSW Aboriginal Health Partnership Agreement

The NSW Aboriginal Health Partnership was formed through an agreement between the Aboriginal Health & Medical Research Council of NSW, the peak body for Aboriginal Community Controlled Health Services in NSW, and the NSW Government through its Health portfolio. The Partnership was originally formed in 1995, and a revised Partnership Agreement signed in 1997. Following a review of the Agreement in 2000, a strengthened Partnership Agreement was signed in May 2001 by the NSW Minister for Health, the Hon. Craig Knowles MP, the Chief Executive Officer of the AH&MRC, Ms Sandra Bailey and the Deputy Chairperson of the AH&MRC, Ms Christine Thorne. The partnership was once again resigned in September 2003.

This historic partnership aims to ensure that the expertise of Aboriginal communities is brought to the health care process through the development of agreed positions on health policy, strategic planning and broad resource allocation issues for Aboriginal health.

Local Area Aboriginal Health Partnership Agreements

Under the terms of the NSW Aboriginal Health Partnership Agreement, each Area Health Service is required to establish a Local area partnership Agreement with Aboriginal Community Controlled Health Services in the Area, to put into practice the strategic directions established by the state level Partnership and the *NSW Aboriginal Health Strategic Plan*. This requirement is reflected in the Performance Agreements of Area Health Services and the Director-General of NSW Health.

Local Area Aboriginal Health Partnership Forums

A number of local area Aboriginal health partnerships have also established local Partnership Forums, which are working arrangements to formalise the input of a range of other agencies involved in Aboriginal health into the business of the local Partnership. Those involved could include, for example, the Division of General Practice, specialist health service providers, and other local and state government agencies.

NSW Aboriginal Health Forum

NSW Agreement on the Health of Aboriginal and Torres Strait Islander People – *The Framework Agreement*. The Agreement on Aboriginal and Torres Strait Health 1996–2000, was signed in August 1996, by the following signatories:

- NSW Department of Health
- Australian Government Department of Health and Ageing
- Aboriginal Health & Medical Research Council of NSW
- Aboriginal and Torres Strait Islander Commission.

The Agreement was resigned in 2004. The Agreement establishes an Aboriginal Health Forum which meets quarterly to facilitate the process of joint planning for Aboriginal health across NSW, and to monitor progress in implementing the NSW Aboriginal Health Strategic Plan.

Appendix A: Summary of relevant Aboriginal health organisations and agreements

The aim of the Agreement is to improve the health of Aboriginal and Torres Strait Islander people through joint planning and intersectoral collaboration to achieve:

- improved access to both mainstream and Aboriginal community controlled health services
- adequate resourcing based on need
- coordinated planning
- transparent and regular reporting for all services and programs

- provision of culturally sensitive and ethically sound privacy and confidentiality protocols for the routine collection of standardised data on Aboriginal health
- health outcomes for Aboriginal and Torres Strait Islander people which are comparable with those for the broader community.

The information in Appendix A is extracted from *Ensuring Progress in Aboriginal Health in New South Wales: A reader friendly information kit.*²

Appendix B

Diseases, risk factors and health services/practitioners relevant to the prevention and management of chronic conditions among Aboriginal people

The *NSW Aboriginal Chronic Conditions Area Health Service Standards* takes a broad chronic conditions approach because of the common conditions that place Aboriginal people at greater risk for these diseases, and the common approaches needed for the prevention and management of these conditions in Aboriginal communities. The broad approach is consistent with the cluster concept as exemplified by the World Health Organisation, and other national and state strategies and policies.⁵⁰⁻⁵²

In terms of this framework 'chronic conditions' encompasses:

- cardiovascular diseases, including ischaemic heart disease and stroke
- kidney disease
- diabetes
- chronic obstructive pulmonary disease
- asthma
- cancers.

It is frequently the case that Aboriginal people concurrently experience several of these conditions and other co-morbidities. In addition, people with chronic and complex conditions often present with depression, anxiety or other related mental health disorders as a clinical component.

Modifiable risk factors/behaviours

- Physical inactivity
- Tobacco smoking
- Poor nutrition/unhealthy eating
- Excessive alcohol use
- Stress – psychosocial risk factors.

Biomedical risk factors

- Obesity
- High blood lipids
- High blood pressure
- Impaired glucose metabolism (impaired fasting glucose (IFG) and impaired glucose tolerance (IGT))
- Low birth weight.

Socio-environmental factors

- Socio-economic status
- Education
- Place of residence
- Poverty
- Occupation
- Social exclusion
- Racism
- Unemployment.

Appendix C

Local health and other services and individuals relevant to the prevention and management of chronic conditions among Aboriginal people

- Aboriginal Community Controlled Health Services
- Aboriginal Health & Medical Research Council of NSW
- Aboriginal Health Units in Area Health Services
- Aboriginal Health Workers, including for example mental health and vascular health workers
- Aboriginal Lands Councils
- Asthma educators
- Cancer screening services (eg Breast Screen)
- Cancer services
- Cardiac rehabilitation
- Cardiac services
- Clinical Nurse Consultants in related areas
- Clinical Nurse Specialists
- Clinicians in related areas
- Community Health
- Diabetes educators
- Diabetes services
- Division of General Practice/General Practitioners
- Health promotion
- Home and Community Care (HACC)
- Local Government Authority
- Mental health services
- Non-Government Organisations (NGOs)
- Nurse Practitioners
- Palliative care services
- Physiotherapy units
- Podiatry
- Population health services
- Primary Health Care Network (PHCN)
- Pulmonary rehabilitation services
- Renal services
- Thoracic/respiratory services
- Training and education organisations such as TAFE or universities.

Appendix D

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Margaret Scott	NSW Department of Health
Pauline Slater	NSW Department of Health
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Jean Turner	South Eastern Sydney/Illawarra Area Health Service
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