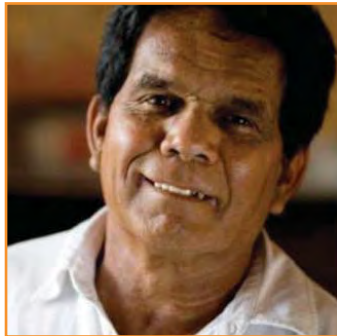


## *Clinical Services Redesign Program*



## Chronic Care for Aboriginal People Model of Care

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SHP: (HSP) 100071  
ISBN: 978-1-74187-565-2

The artwork on page 4 was created by Graeme Walker who is a Bundjalung man. The Bundjalung Nation encompasses an area bordered by Grafton, Baryulgil, Tabulam, Woodenbong, Tweed, Ballina, Evans Head and Yamba on the far North Coast of NSW, Australia.

Further copies of this document can be downloaded from the Australian Resource Centre for Healthcare Innovations (ARCHI) website:

<http://www.archi.net.au>

Design by Wattle Advertising

September 2010

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# Acknowledgment of Country

New South Wales Health acknowledges the traditional owners of country throughout Australia and their continuing connection to land and community. We pay our respect to them and their cultures, and to the elders both past and present. We would also like to acknowledge our Aboriginal people we have lost to chronic disease and pay respects to their families and loved ones.

The project team would like to say thank you to the local project representatives both current and those who have moved on, who have helped to coordinate workshops, meetings and data collection activities, to develop this Model of Care for Aboriginal people with or at risk of a chronic disease. This project would not have been possible without your support and enthusiasm.

New South Wales Area Health Services Aboriginal Nations Map



NSW HEALTH

Disclaimer: This map indicates only the general location of larger groupings of people, which may include smaller groups such as clans, dialects, or individual languages in a group. The boundaries are not intended to be exact. This map is not suitable for use in native title or other land claims.

(9/5/16) 090621

In line with NSW Health PD 2005\_319, the term “Aboriginal” is generally used in preference to “Aboriginal and Torres Strait Islander”, in recognition that Aboriginal people are the original inhabitants of NSW.

# Foreword

This document acknowledges the fact that chronic disease has devastating effects on Aboriginal communities across the state of New South Wales. The purpose of this paper is to highlight the significance in prevention and treatment of chronic disease in Aboriginal families. More importantly the aim is to bring to light the need to move from a traditional approach in health care to a model that considers Aboriginal people have very different needs to improve their health. For Aboriginal people, health is defined as, “not just the physical well being of an individual but refers to the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well being of their Community. It is a whole of life view and includes the cyclical concept of life - death - life” (National Aboriginal Health Strategy, 1989).

This requires a rethink about how the health system is responding to the challenge of managing chronic disease in Aboriginal families. All health professionals have a responsibility to contributing to addressing this issue. Some clinicians have offered to share their experience in successfully engaging with Aboriginal people to close the gap in health outcomes for Aboriginal people.

## Clinician Quotes

*“I learn a huge amount from my patients and working in an Aboriginal Medical Service, I also have access to experienced Aboriginal Health Workers. Sometimes the strategies I might plan, are just not going to work in the context of my patients and I need to carefully check back on what they think is going to work for them.”*

*Dr Jenny Reath, GP at AMS Western Sydney*

*“I find that one of the significant aspects of working with Aboriginal people is earning their respect and understanding their way of doing business and that it takes time to build relationships. When I first worked in the Aboriginal community I would go and visit elders/community members just to sit and chat, so that they got to know me, which made it easier when I provided health care to them”.*

*Marilyn Body, Clinical Nurse Consultant Chronic Care Aboriginal Health Coffs/Clarence Network NCAHS*

*“Have a deep respect for Aboriginal people and culture as everything you do, think or say has an effect.”*

*Liz McEntyre, Director Aboriginal Health, Justice Health*

*“I am sensitive to Aboriginal cultural issues of kinship to country, family, spiritual and culture. A key is always do what I say I am going to do for them”.*

*Kerry Irwin RN Aboriginal Chronic Care Program Nurse Justice Health*

*“Showing respect by making open ended suggestions, asking the person if there are any further problems, listening and repeating the answers to ensure you have understood them correctly. Use normal language, ask how they are coping or if they have other concerns, ask about their kids. Offer a cup of tea, just being a real person helps others know that you care.”*

*Jacqueline Woon, Clinical Nurse Consultant Chronic Care Aboriginal Health Hastings Macleay Network, NCAHS*

*“Don’t make a presumption that if someone “doesn’t look Aboriginal” then they aren’t Aboriginal.”*

*Natalie Green, RN ADE (UTS) Executive Officer - Aboriginal Health New England Division of General Practice*



## Shane's Story depicted in artwork by Graeme Walker





## Shane's Story (as told in the words of an Aboriginal Health Worker (AHW))

*“everybody knows  
him but no one  
wants to own him”*

I met Shane recently, a young man in his mid twenty's, from out west but been living down this way for about 4 years. He's married up a with a couple of kids, not working and living in the housing commission area of town.

Three years ago he lost his Mum to cancer, his Dad is not in the picture and early this year his younger brother was killed in a car accident. He has other brothers and sisters but they don't live here.

He's a mad footy player and his big goal is to get fit for the Knockout in October. This is how I met him at footy training, we started talking.....

I have since done some digging around and found that he's referred to in the system as a “frequent flyer” which means he's a regular at the local Emergency Department. He has been told he has a mental health condition and also has had undiagnosed diabetes for a long period of time.

From what I can make out Shane has slipped through the gaps many times, the staff in the Emergency Department know him well, they talk about him as being “difficult”.

Because most of his contact with the health system is when he is in crisis mode his care has been handled much the same.

His diabetes isn't being managed at all except when he is in hospital and then when he's discharged he is told to follow up with his GP. It was assumed he would..... he didn't.... he hasn't.

The days didn't get to him like the night time, this is when he would get sick and the Emergency Department was his only option. To fork out \$60.00 to see a doctor was not an option.

He believed they wanted to “send him away”, that's why he wouldn't go to any of his appointments. He said he didn't want to leave his woman and kids not even for a little while.

Some of his presentations to the Emergency Department were by Ambulance. His woman would panic and if they took too long then she would borrow her mobs car to get him to the Emergency Department to get him some medication because she knew it would be better for her and the kids.

His hospital stays were really short 1- 2 days, in and out. Sometimes he would sign himself out against medical advice.

He didn't want to go to the AMS for his mental health issues; he didn't want people to know he had a mental illness. He was reassured about confidentiality but he said if someone sees me with the mental health worker they will work it out.

I saw Karen (his woman) the other day her and kids were heading for the train station she said Shane went back home for a funeral. That was a week ago, he's not back so she was going out there.

# What is wrong with Shane's story?



Although Shane had a number of admissions he was not flagged as "at risk" and not screened or assessed comprehensively.



Shane was seen as difficult therefore no further testing for diabetes, kidney disease, COPD or heart disease was undertaken.



Shane had been labelled as "difficult". This meant that everyone avoided ever having a meaningful conversation about what was happening to him.



The link between Shane's mental illness and his diabetes went undiagnosed. If his diabetes was kept under control, his mental illness may be more stable.



Shane had no trust in the system. He thought they wanted to send him away so was very reluctant to share information about himself.



No information was given to Shane about how he could "get through the nights". His mental illness has never been explained to him. The side effects of his medication for diabetes and his mental illness and how the combination of these medications might affect him were never explained.



Short hospital stays with no referral to appropriate counselling, Aboriginal or community health services.



If Shane was followed up after his hospital stays to see if he had his medications, had made his doctors appointment and could actually get to the appointment, it may have stopped his next visit to the Emergency Department.



# The Way We Deliver Health Care for Aboriginal People Needs To Change

Aboriginal people living in New South Wales (NSW), represent approximately 2.2% of the total population and 29% of the total Australian Aboriginal population<sup>1</sup>. While many people living in NSW have experienced significant health gains in recent years, these improvements have not been equally shared by Aboriginal people who continue to experience greater health risks, poorer health and shorter life expectancies than non-Aboriginal people.

The disproportionately high burden of chronic diseases, such as diabetes, heart, kidney and lung disease, significantly contribute to the greater morbidity and premature mortality in Aboriginal populations. There are a range of factors which contribute to chronic health conditions in Aboriginal communities. These factors, although well-documented, are complex and often result in Aboriginal people presenting to health services late in the course of their disease, which in turn leads to significantly higher rates of complications and death.

The appalling statistics for every chronic condition in Aboriginal populations requires a rethink in the way we deliver health care. Chronic disease in Aboriginal people brings with it cultural and complex issues that challenge our current health care models. The NSW Department of Health (DoH) Chronic Care for Aboriginal People (CCAP) Program team engaged with key stakeholders from across the state including General Practice NSW (GP NSW), Aboriginal Medical Services (AMS), Aboriginal Health and Medical Research Council (AH&MRC), Area Health Service representatives, Aboriginal Workforce, the Centre for Aboriginal Health (CAH) and Aboriginal community members to consult and develop a model of care addressing the needs of Aboriginal people with or at risk of developing a chronic disease.

The development of a model of care (MoC) for Aboriginal people with a chronic disease is one of the state solutions resulting from the Walgan Tilly Redesign project which commenced in 2007. This was the first Aboriginal Redesign project facilitated by the NSW DoH with all Area Health Services including Justice Health and some Aboriginal Medical Services. Implementation concluded in July 2010 where local solutions will be embedded into their Aboriginal chronic care initiatives.

Eight fundamental elements were identified as being essential to the model of care for working with chronic disease in Aboriginal communities. They are Identification, Trust, Screening and Assessment, Clinical Indicators, Treatment, Education, Referral and Follow up.

A key literature scan was conducted by the Co-ordination and Policy Unit, Office of the Chief Health Officer<sup>2</sup>. The report found there are numerous chronic care models being used throughout the world, but not a lot of evidence of how well they work and nothing on effective chronic care models in Aboriginal communities. Much of the evidence that exists has been in relation to single chronic disease models and it is now known the

<sup>1</sup> Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Health Survey: New South Wales 2004-05*. ABS Cat. No. 4715.1.55.005. Canberra: ABS, 2006. Available at [www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4715.1.55.005](http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/4715.1.55.005)

<sup>2</sup> NSW Health. Internal report – Literature scan – Models of Care for Multiple Chronic Diseases, June 2010.

prevalence of multiple chronic diseases in people is much higher. The report found several pieces of evidence for each of our eight elements. As there is a lack of evidence surrounding effective chronic care models in Aboriginal communities, it is important to incorporate a comprehensive evaluation framework when implementing this model.

A number of factors have been found that are thought to contribute to the success of chronic disease programs in Aboriginal people. These key factors are<sup>2</sup>:

- Aboriginal community support and involvement;
- Effective local area partnerships and working groups;
- Participation and professional development of Aboriginal Health Workers;
- Adequate resources and coordination between existing human, financial and physical resources and initiatives.

Key factors specific to initiatives for early detection and management of chronic diseases among Aboriginal people are<sup>2</sup>:

- Accessible early detection and intervention programs;
- Local multidisciplinary teams or taskforces with clear roles and responsibilities;
- Locally agreed evidence-based clinical protocols;
- Systems for follow up care including register and recall systems.

These eight elements that make up the model have been evolving in Aboriginal Health since 2000 with the establishment of the Aboriginal Vascular Health Program (AVHP). In 2005 the Aboriginal Chronic Care Area Health Service Standards (ACCAHSS) were introduced to mainstream services to support this work as it was building capacity and strength that required the system to respond differently to cater for the needs of Aboriginal people with a chronic disease.

Walgan Tilly, through the Redesign process, identified the successful elements of this work that was happening in pockets of programs across the state. The model of care brings all the evidence of what works well for Aboriginal people into a package of how to deliver services to Aboriginal people with or at risk of developing a chronic disease.

This model complements and provides a practical approach for existing structures and initiatives that support improving health outcomes for Aboriginal people with or at risk of developing a chronic disease. It can be used by any health service providers as a framework to review and map this model to their existing programs or new strategies that is modelled from best practice across the state. This model also allows for the identification of gaps and opportunities at a local and state wide level to maximise existing resources or build business cases to provide new initiatives to address chronic diseases in Aboriginal communities. It also provides an ideal platform on which to establish committed engagement and partnerships with service providers within health and social networks to improve health outcomes for Aboriginal people.

It is important to note that the most significant difference of this model from other models of care is 'trust'. Historically Aboriginal people have suffered significant losses which include not only their family but also their land, identity, language and culture to name a few. As a result many Aboriginal people do not trust mainstream health services.

To effectively apply this model to suit an Aboriginal person or community, health care workers need to have a certain skill set to develop trust from the Aboriginal person or community. These skills are not always derived from a qualification gained from higher studies but in part by taking the time to meet on Aboriginal people's terms; listening and being respectful.



Chronic Care for Aboriginal People Model of Care





Gujaga Aboriginal Pre-school Kids.



Gujaga Aboriginal Pre-school Kids.

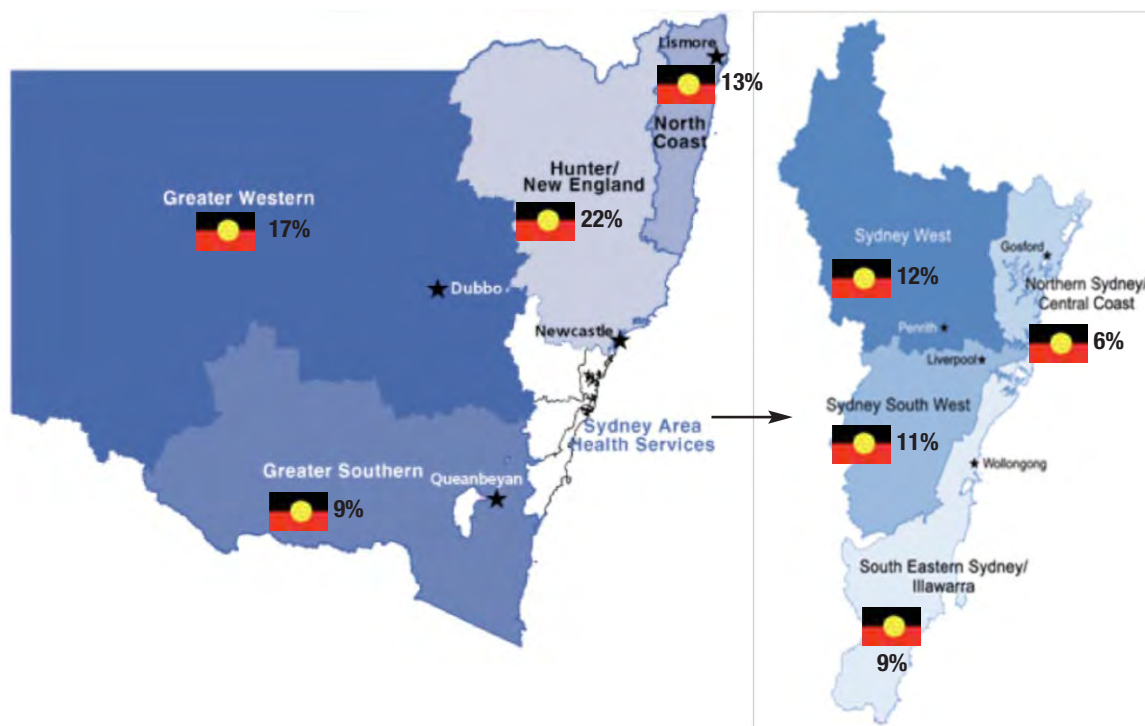
# The Need for Change

The Australian Bureau of Statistics is using a new methodology for estimating Aboriginal life expectancy from birth<sup>3</sup>. This methodology provides different estimates to the previously published 17 year gap in life expectancy between Aboriginal and non-Aboriginal Australians<sup>4</sup>. At a national level for 2005-2007, life expectancy for Aboriginal men is estimated to be 11.5 years less than life expectancy for non-Aboriginal men. For Aboriginal women, life expectancy is estimated to be 9.7 years less than for non-Aboriginal women. It is important to note that this new estimate does not represent an improvement of six years, but rather a different method of calculating life expectancy.

## Aboriginal population in each Area Health Service based on 2006 Australian Bureau of Statistics Census.

Area Health Service	0-14 years	15-49 years	50-64 years	65+ years	Total
Greater Southern	5,467	6,574	1,286	493	13,821
Greater Western	9,874	11,913	2,355	921	25,064
Hunter New England	12,697	15,479	2,957	1,175	32,307
North Coast	7,262	8,653	1,702	622	18,239
Northern Sydney Central Coast	3,246	4,374	794	371	8,784
South Eastern Sydney Illawarra	4,820	6,759	1,307	578	13,464
Sydney South West	5,996	8,370	1,637	596	16,599
Sydney West	6,720	8,821	1,513	503	17,557

## Proportion of the whole NSW Aboriginal population in each AHS



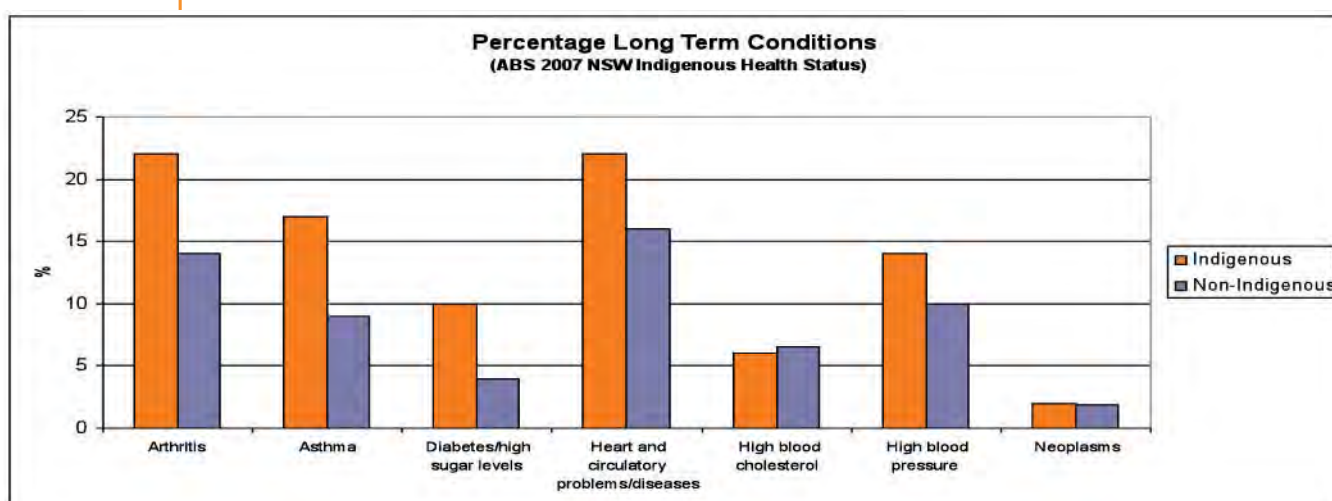
<sup>3</sup> Australian Bureau of Statistics 2010. Cat no 3302.0.55.003 - Experimental Life Tables for Aboriginal and Torres Strait Islander Australians 2005-2007.

<sup>4</sup> Population Health Division. The health of the people of New South Wales - Report of the Chief Health Officer. Sydney: NSW Department of Health. Available at [www.health.nsw.gov.au/publichealth/chorep/](http://www.health.nsw.gov.au/publichealth/chorep/)

## Chronic Care Discharges in-scope for 2008/2009

Below are the number of discharges for hospital patients who identified as Aboriginal and who were aged 15 years and older and admitted for a chronic disease as either their Principal Diagnosis or an additional diagnosis (based on an agreed set of ICD-10 codes\*, see appendix section).

Area Health Service	Total
Greater Southern	564
Greater Western	1,360
Hunter New England	1,245
North Coast	943
Northern Sydney Central Coast	311
South Eastern Sydney Illawarra	716
Sydney South West	608
Sydney West	567
<b>Total</b>	<b>6,314</b>



The poor health status and lower life expectancy of the Aboriginal population is evident in the following key health indicators<sup>5,6</sup>:

- The proportion of the Aboriginal population over the age of 65 years is just over 3%, compared with just over 13% in the non-Aboriginal population.
- People aged less than 25 years made up 10% of deaths of Aboriginal people compared with 2% of deaths among non-Aboriginal people. Aboriginal people are more likely to die at younger ages.

<sup>5</sup> Population Health Division 2008. The Health of the people of New South Wales - Report of the Chief Health Officer 2008. Summary Report. Sydney: NSW Department of Health

<sup>6</sup> Population Health Division. The health of the people of New South Wales - Report of the Chief Health Officer. Sydney: NSW Department of Health. Available at: [www.health.nsw.gov.au/publichealth/chorep/](http://www.health.nsw.gov.au/publichealth/chorep/). Accessed 28th July 2009.

\* The ICD-10 code system is based on a medical diagnosis of a global categorisation of diseases and is used by the World Health Organisation (WHO). Source: <http://www.who.int/classifications/icd/en/>



- 
- 40.3% of Aboriginal deaths occur among people aged 65 years and older compared with 81.2% of non-Aboriginal deaths, reflecting the relatively small proportion of the Aboriginal population that attains the age of 65 years.

The greater morbidity and premature mortality rates can be significantly attributable to the disproportionately high burden of chronic conditions in Aboriginal people, including heart disease, lung disease, kidney disease and diabetes.

The Aboriginal hospitalisation rates included in the NSW Chief Health Officer 2008 Summary Report<sup>7</sup> further highlights the poor health status of Aboriginal people in NSW. Compared to non-Aboriginals, hospitalisation rates for Aboriginal people in NSW are:

- 140% higher for conditions for which hospitalisations can be avoided through prevention and early management
- 40% higher for cardiovascular diseases
- 210% higher for diabetes
- 230% higher for chronic respiratory diseases

Many of the poor health outcomes are related to the continued socio-economic disadvantage experienced by Aboriginal people in NSW, such as<sup>8</sup>:

- diseases triggered by poverty
- poor access to education
- low incomes
- overcrowded housing
- poor nutrition

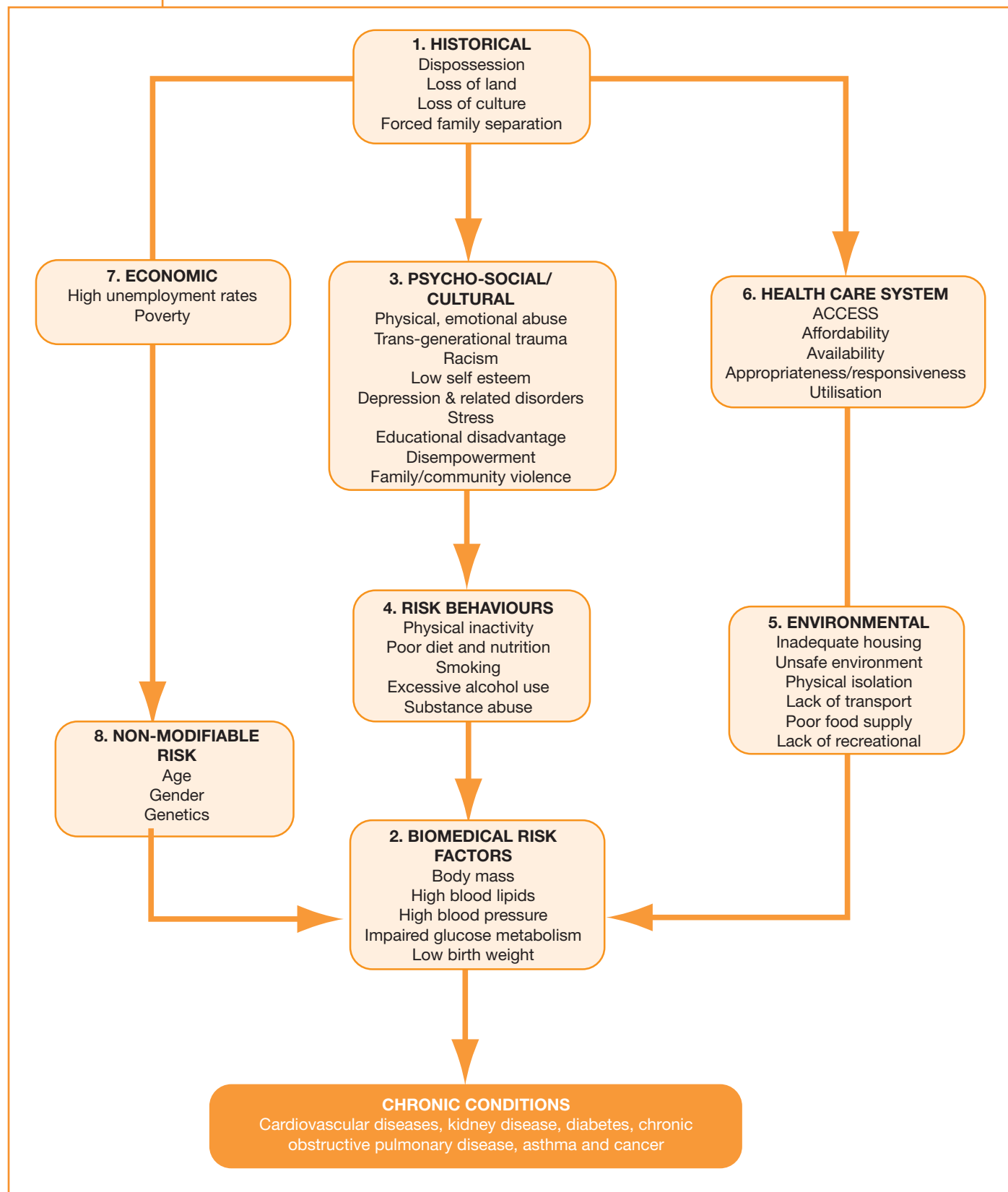
Socioeconomic disadvantage cannot however, fully explain the poor health status in Aboriginal communities. The high prevalence of chronic health conditions experienced by Aboriginal people can be influenced by a range of factors. These factors, although well-documented, are complex and often result in Aboriginal people presenting to health services late in the course of their disease. This in turn, leads to significantly higher rates of complications and death.

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<sup>7</sup> Population Health Division 2008. The Health of the people of New South Wales - Report of the Chief Health Officer 2008. Summary Report. Sydney: NSW Department of Health.

<sup>8</sup> Oxfam Australia. (2007). *Close the Gap: Solutions to the Indigenous Health Crisis facing Australia*. Victoria. Oxfam Australia

Factors contributing to chronic health conditions in Aboriginal communities are well summarised in this figure below.



Acknowledging that this is a complex issue, it was essential that a model of care for Aboriginal people be developed, to accommodate the Psycho-social/Cultural (3), Risk Behaviours (4), and Environmental (5) factors that have significant impacts on the ability of an Aboriginal person to engage with health care services (1) and ultimately monitor and reduce the biomedical risk factors (2) and improvements in their health outcomes.

By including clinical and non clinical elements into a model of care it is recognised that for Aboriginal people a combination of all these factors (1) - (8) will influence the impact a model of care will have on the health of an Aboriginal person. These influences cannot be underestimated and require an approach that is respectful of how difficult these factors are to overcome. In applying a model of care, a combination of health and social services will need to be involved to make improvements in health outcomes for Aboriginal people.



Gujaga Aboriginal Pre-school Kids.



# New Directions

This table outlines the initiatives that led to the development of a model of care for addressing chronic diseases in Aboriginal communities.

Date	Initiative
2000	Development of Aboriginal Vascular Health Program (AVHP)
2002	Development of the NSW Clinical Service Frameworks for heart failure, chronic respiratory disease and cancer
2003	An external evaluation of the NSW Aboriginal Vascular Health Program
2005	Implementation of the Aboriginal Chronic Care Area Health Service Standards
2007	Aboriginal Renal Health Enhancement Funding
2007	Walgan Tilly Redesign Project commenced
2008	Reporting of Aboriginal Chronic Care Area Health Service Standards complete December 2008
2008	Implementation of Walgan Tilly Local and State solutions
2008	Launch of new directions Chronic Care for Aboriginal People
2009	Model of Care for Aboriginal people with a Chronic Disease
2010	Walgan Tilly Redesign Project completion
2011	Implementation of the CCAP Model of Care
2012	Evaluation of the CCAP Model of Care

These initiatives have provided an evidence base for effective interventions in chronic disease for Aboriginal people.

The evaluation of these programs reaffirms:

- The importance of effective relationships at multiple levels of the health system
- The critical role of Aboriginal Health Workers providing the vital link between community and health services
- Need for flexibility in service delivery to ensure responsiveness to Aboriginal community needs.

These key drivers were instrumental in moving towards the development of a model of care for Aboriginal people with a chronic disease.

# Walgan Tilly

---

The Walgan Tilly project commenced in October 2007. It was the first Aboriginal Redesign\* project in NSW. It was developed from a number of established NSW Health initiatives in an attempt to address the gaps in health care and to improve access for Aboriginal people to chronic care services.

The Redesign project was named Walgan Tilly. Walgan is a Kamilaroi word meaning 'Aunty', a title of respect to Aboriginal women and 'Tilly' is short for the name Matilda. The reason behind naming the project was to ensure the focus was always on the people it was intended to be about. It was envisaged that as local projects commenced and progressed they would name them to give communities a sense of ownership to the solutions being driven in their areas.

As a result of the Walgan Tilly findings, six state wide solutions were identified. The six state solutions are;

- A Model of Care for Aboriginal People
- Greater Aboriginal cultural awareness and cultural sensitivity of services
- Integration of Aboriginal health and chronic disease mainstream services
- Justice Health Linkages
- Improved access to primary care
- Improved data quality

Implementation of these six solutions is coordinated by the NSW Department of Health in collaboration with NSW Area Health Services (AHS) and other key stakeholders including local Aboriginal Medical Services (AMS), General Practice NSW (GPNSW), Aboriginal Health & Medical Research Council (AH&MRC) and providers of services external to health. The Walgan Tilly project will be completed in July 2010. It is hoped the model of care will be operational within the State and localised to suit individual community needs shortly thereafter.

Implementation of both the state and local solutions will also be supported by Aboriginal Health Units, Chronic Care workers, Redesign teams and other key stakeholders.

---

\* Redesign will be explained in Section 3 of this document.

# The New Direction

The Walgan Tilly project resulted in moving from a vascular only model to that of a chronic disease approach, focussing on four major diseases; heart disease, diabetes, chronic lung disease and kidney disease.



Aboriginal Vascular Health Program logo



New CCAP logo

**Our new logo communicates the shift in program focus:**

**A holistic approach to health**

The focus is not just on the person but on the family



The colours represent the connection to country

**A new focus on treating the *people* who have the disease, and not just the disease itself**



---

The Chronic Care for Aboriginal People (CCAP) program's new direction is focussed on:

- Treating the person not just the disease
- Moving away from a “body parts” approach
- Facilitating local solutions to local problems in addressing access issues to mainstream chronic disease services
- Supporting the chronic disease work of Aboriginal Medical Services



Gujaga Aboriginal Pre-school Kid.

# Chronic Care for Aboriginal People

## Model of Care

### What is a Model of Care?

A model of care defines the way in which health care services are delivered. This model will describe eight core elements that will be the basis for service delivery across facilities and settings. The way in which the model is implemented and delivered will be determined at the local level. This could be achieved by case management, care navigation, care coordination, primary and community health care, multidisciplinary care or a combination of any of these health care modalities. Regardless of the model of delivery, all the elements are required in providing holistic and appropriate care to Aboriginal people and their communities.

### Context

This model needs to be specific and acceptable to Aboriginal people with or at risk of developing a chronic disease. For the purpose in this document, when referring to Aboriginal people the assumption is, that they have or are at risk (by genetic predisposition) of developing any of the four chronic diseases in scope, which are diabetes, heart, kidney and lung disease.

To effect change in health outcomes of this model, considerations of how to recognise and address “circumstantial co morbidities” that have a significant impact on the health and well being of Aboriginal people is required.

*Note: “Circumstantial co morbidities” describes the situations that may not be health related that are impacting a person’s health, these may include family violence, grief and loss, poverty and homelessness.*

A coordinated approach is required across a range of health and social services and consideration of implications to the individual, carer and family implications.

### Scope

The target group for implementation of this model are Aboriginal people who are 15 years and above with or at risk of developing diabetes, chronic heart, lung or kidney disease.

### Purpose

This model provides a practical framework for both health and non health care workers to effectively engage Aboriginal people in both rural and metropolitan areas across NSW into health or non health services to improve access and health outcomes. It describes the essential elements required for the delivery of appropriate chronic care services for Aboriginal people.

This means connecting social and clinical services to Aboriginal people with cultural and community needs being valued and respected.

---

## Aims

- To prevent or maintain chronic disease progression for an Aboriginal person.
- To improve access to affordable and available health services for Aboriginal people.
- To facilitate and support the social services involved in caring for an Aboriginal person.
- To address the cultural and environmental issues that influences an Aboriginal person's health.
- To reduce risk behaviours that are linked to the development and/or progression of chronic disease.
- To improve the clinical care of an Aboriginal person with a chronic disease.

## Performance Indicators

A performance indicator is a way of measuring how a service is performing against its objectives. Performance indicators for this project are collected locally and state-wide. It is anticipated that a combination of both local and state Key Performance Indicators (KPI) will be attached to the model of care.

The indicators below may be used as a guide in negotiating a measure of the effectiveness and sustainability of this model.

- A decrease in hospital admissions and readmissions for Aboriginal people with chronic disease.
- Increased use of care plans to reduce progression and complications of chronic disease.
- Improved patient experience for Aboriginal people.
- Increased uptake of Aboriginal specific Medicare chronic disease items.
- Decrease the escalation of chronic diseases amongst Aboriginal people
- Clinical indicators

This is consistent with the NSW Department of Health State Plan<sup>9</sup> priorities F5, S2 & F1, the Chronic Care for Aboriginal People Program Key Performance Indicators, Service Delivery Reporting Framework, Aboriginal Chronic Care Area Health Service Standards and the National Partnership Agreement.

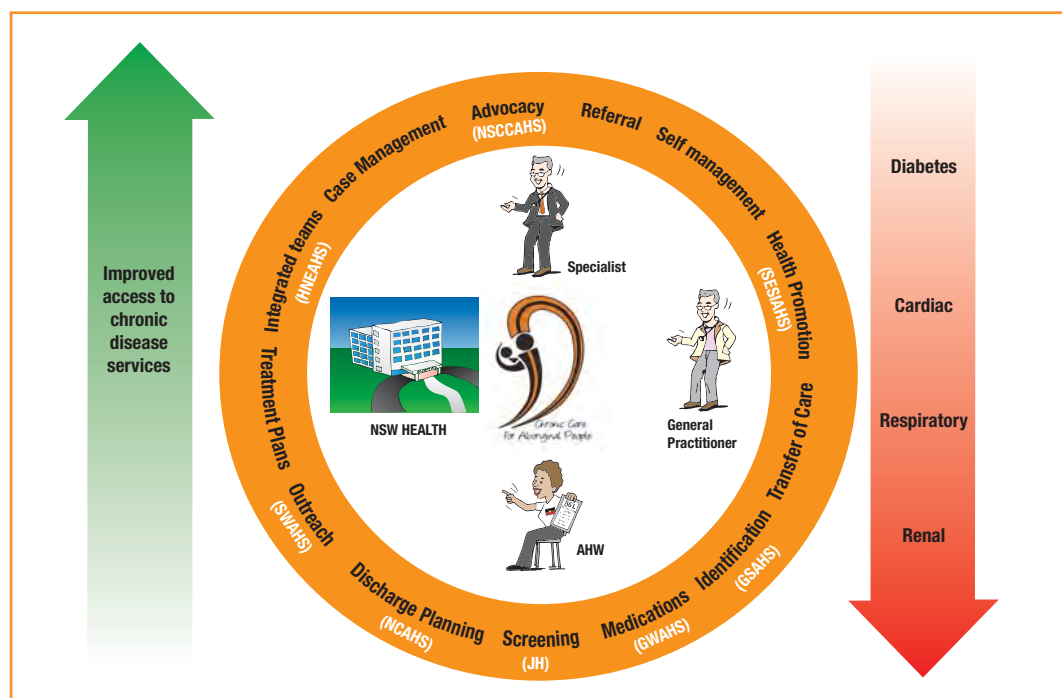
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<sup>9</sup> NSW Government State Plan - a new direction for NSW, 2006

## Background to the CCAP Model of Care

The development of the model of care resulted from a combination of the Walgan Tilly state solutions and a number of local initiatives. The following framework was developed in October 2008 in consultation with AHS and AMS.

## Framework for the Model of Care



The depiction of this framework was derived by identifying key aspects of the care provided by a large range of health care providers. These included health workers from AHS, AMS, General Practice, other government and non government organisations. All these initiatives were documented as they were what was being delivered in local communities by various health care professionals and support workers to Aboriginal people with or at risk of developing a chronic disease.

The challenge at hand was to identify the key elements from these initiatives that would contribute to appropriate care for Aboriginal people. The analysis of these initiatives resulted in some commonalities which developed into the core elements of the model of care. These elements were further explored and consulted on by Aboriginal Health Workers, clinicians, hospital executives and community members until the final eight elements were agreed upon.

The eight fundamental elements that were identified as being essential to the model of care for working with chronic disease in Aboriginal communities are Identification, Trust, Screening & Assessment, Clinical Indicators, Treatment, Education, Referral and Follow up.



These elements have been developed from extensive consultation, literature research of best practice and fact finding site visits to explore how communities are responding to the challenge of managing chronic disease in Aboriginal people. The framework has provided a very clear and practical approach to working in Aboriginal health and more importantly, the psycho-social/cultural factors\* contributing to chronic disease.

### The Elements of the Chronic Care for Aboriginal People Model

There are eight essential elements identified in this model. These are:

- |                             |              |
|-----------------------------|--------------|
| 1. Identification           | 5. Treatment |
| 2. Trust                    | 6. Education |
| 3. Screening and Assessment | 7. Referral  |
| 4. Clinical Indicators      | 8. Follow up |

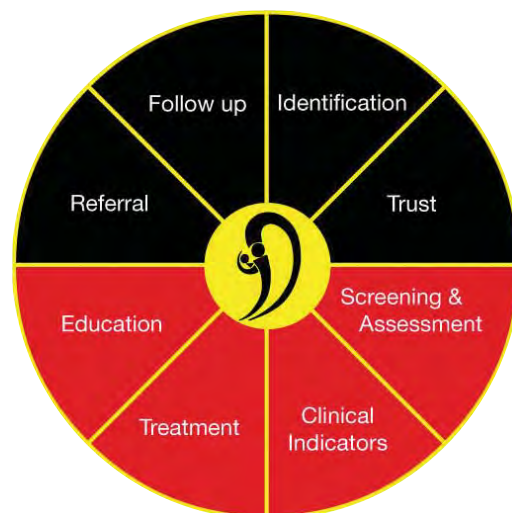


Once all the elements have been identified, a simple yet easily identifiable diagram was developed to depict both the elements and the relationship with the Aboriginal person and their family. The diagram above was the start of the development towards our new CCAP Model of Care.

The blank structure of the pie formation quickly evolved into incorporating the black, red and yellow colours of the Aboriginal flag.

\* Refer to figure on page 14 on the factors contributing chronic health conditions in Aboriginal communities.

## The Chronic Care for Aboriginal People Model of Care



The use of the colours from the Aboriginal flag is symbolic as many Aboriginal people identify with these colours. The colours are bold and are easily recognisable to both Aboriginal and non Aboriginal people. Incorporating these colours into a model of care signifies the specific aim of addressing the needs of the Aboriginal community.

For the purpose of this document we have aligned the colours in the model exactly to that of the flag. In reality this would look very different. The colours can be used to indicate which service providers have responsibility for the eight elements. The elements coloured black could represent the contribution of Aboriginal Health in applying this model. The elements in red may describe the responsibility of other health professionals. The yellow section represents the Aboriginal person, their family and their community, who are always at the centre of our work. It is important that Aboriginal people recognise and feel they have a contribution to make to this model.

It is important to note that the eight elements can be black, red or interchangeable depending on the setting in which it's being implemented and the way in which it being described.

- Black elements = Aboriginal Health contribution to the model
- Red elements = elements performed by non Aboriginal providers e.g. community health setting, GP's, Allied Health

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\* The Aboriginal flag was designed by Harold Thomas in 1971. It is divided into two equal halves. The top is black, the bottom is red and there is a yellow circle in the centre. The black half symbolises Aboriginal people past, present and future. The yellow circle is the sun, the giver and renewer of life. The red half of the flag is the earth. It also represents red ochre symbolising spiritual attachment to the land.

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The way in which these elements are performed is dependant on:

- The type of service delivery and available resources
- Needs of the individual, family & community
- Workforce, both Aboriginal and non Aboriginal (skill-set, vacancies and recruitment strategies)
- Context in which the model is being used, programming, service delivery, evaluation, planning

## Workforce

To ensure there is an integrated approach in implementing the roles and responsibilities of the elements associated with this model, two positions have been identified and developed. It is essential to note that there is strong support to ideally encourage Aboriginal people into both of these positions in line with the Aboriginal Employment Strategy.\*

This model is an example of a team approach to providing care which includes an Aboriginal Health Worker in an identified position (a position in which only Aboriginal people may apply) with the other position open to both an Aboriginal and non-Aboriginal health worker.

An AHW is:

- An Aboriginal or Torres Strait Islander person,
- Employed in an identified position in the NSW Public Health system and provides health services or health programs directly to Aboriginal people regardless of whether the person is employed in a generalist or specialist position. It encompasses all or any areas of health irrespective of the award that covers employment of the worker (IB2005\_001 NSW Health).

Draft position descriptions for these two positions are in the resources section of the document.

### Community Chronic Care Coordinator

This position has been developed as a non clinical role however they may perform clinical tasks depending on the skill, qualifications and experience of the worker. This position will predominately perform all the non clinical aspects of the elements, which could include assisting the clinician with health assessments, basic treatment such as first aid, assist to develop or refer to educational needs and the follow up of clients.

### Community Chronic Care Clinician

This position is responsible for the clinical care delivered from this model. The role (nurse, allied health etc) and skills (qualification and experience) of the clinician will be determined at the local level.

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\* PD2005\_120 \_ This policy directive is mandatory and provides the necessary leadership and direction as well as the infrastructure necessary to achieve the desired employment outcomes for Aboriginal and Torres Strait Islander people in NSW Health

In such cases where the knowledge or skill level is beyond their scope of practice then a referral to the most appropriate treatment options available should be made. This is not to say they will relinquish care of the client to another health care provider but the follow up element will come into play. The clinician will navigate the client to the best treatment options and continue to follow up on any treatment or referrals to other service providers that they are unable to provide themselves.

These positions are the foundations of the model and are responsible for the facilitation of other key players including Specialist, General Practice, Allied Health and Non Government Organisation staff whose services will be required at different times throughout a client's journey. Both of these positions will constitute a team that is responsible for the care of the Aboriginal person with a chronic disease.

The point of care for the positions to identify the client/patient could start in any type of setting or situation such as; an inpatient or discharge from hospital; Aboriginal Medical Service; General Practitioner; Community Health; Outpatient Clinic; Justice Health; or opportunistic e.g. community events. It is essential that relationships/partnerships with other services, both in health and non health areas are formed to support integration of services, timeliness of referrals, follow ups, and clinical and non clinical handover of clients.

The positions will maintain a connection with the Aboriginal clients they enrol to ensure linkages and follow up regarding their health requirements and associated non health requirements such as housing, transport and domestic issues that may impact on access to health services.

Records should be kept and maintained to support identification, follow up, recall, screening, assessments, clinical indicators, referrals and treatment to report health outcomes.

Client data should be extractable and measurable against set key performance indicators from a State and local perspective and form one section of the evaluation.

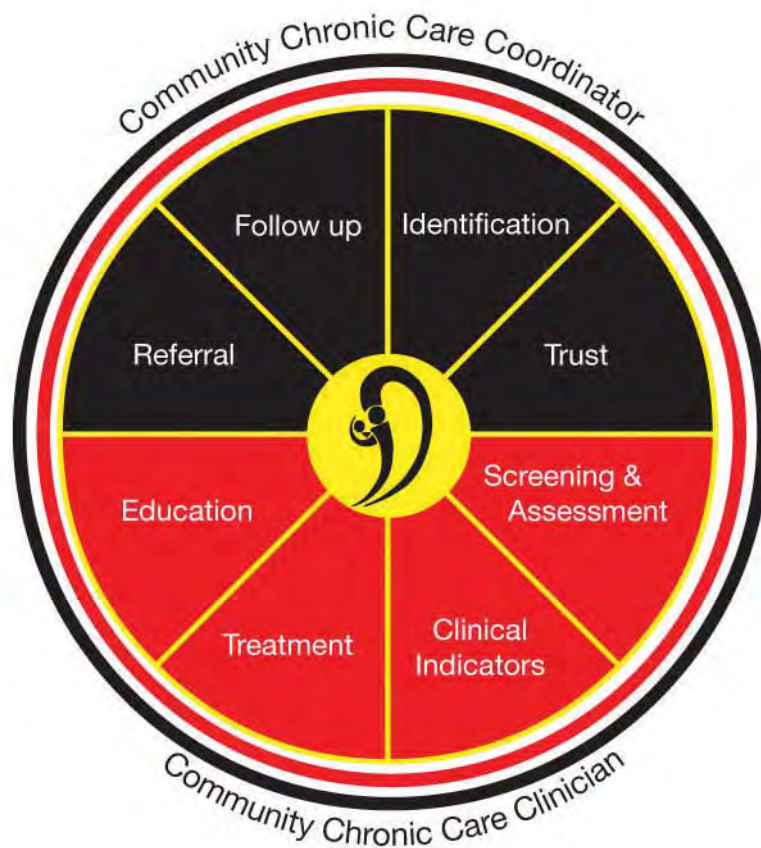
The positions attached to the model of care should be actively promoted within the Aboriginal community to encourage self referral of clients and family members. It should also be communicated to other providers about how their services may support the client in meeting their health and non-health needs.

With the possibility of many staff being responsible for a person's care, the implementation of the model will require a "Shared Care" agreement regarding:

- Shared responsibility between Aboriginal Health and mainstream chronic disease services
- Shared between health and social services or clinical and non clinical roles
- Shared with the individual/family in managing and making decision about their care



- Shared across health care teams and settings including Aboriginal Medical Services
- Shared roles between Aboriginal Health staff and clinicians
- Shared respect of Aboriginal culture and communities and how to conduct business appropriately.



## How to use the Model

The model can be used as a guiding framework for the planning, monitoring and evaluation of service delivery initiatives and programs.

Below are a number of examples of how the model can be applied in practice. The diagrams as depicted below may be used as examples of how or what you are trying to achieve in describing the model.

### Using the Model

#### 1 Establishing new programs and services



- Conduct an Aboriginal Health Impact Statement
  - How to accommodate Men's and Women's business if necessary
  - What will be the governance and reporting structures of the program
  - How will services be delivered eg Case Management, Care Coordination etc and identification of resources required to deliver
  - Who will be responsible for delivery of the elements
  - OH&S for staff
  - How will the program address psycho-social and cultural risk factors
- Evaluation and assessment of existing programs (email CCAP for more information)

#### 2 Evaluation of existing programs



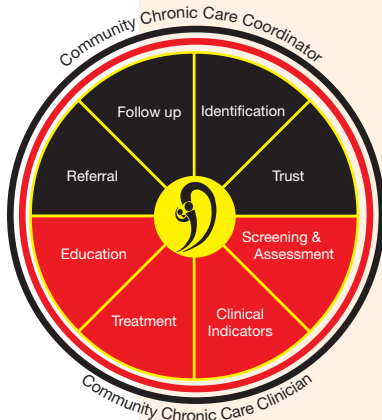
- Adhering to clinical guidelines, standards and policy directives
- Assess the capacity to link with Health Promotion and Preventative initiatives
  - Documentation, collation and analysis of data and reporting
  - Use of quality of life tools for existing programs
  - Incorporate Self Management Support to existing programs
  - Inclusion of the clinical indicators
- Developing partnership programs with Aboriginal Medical Services, GP Divisions, mainstream services and other providers

#### 3 Identifying Partnership projects



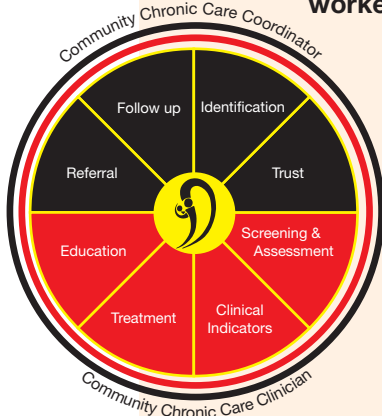
- Support the uptake of the Aboriginal specific chronic disease MBS items
- How and who can make referrals between services
- Identification of Aboriginal clients and recording across all services
- Who is responsible for the delivery of each of the elements in the model
- Identify non health service providers, eg Centrelink, Medicare, Community Options or Legal Aid who may be applicable to the model

#### 4 Recruiting to new/vacant positions



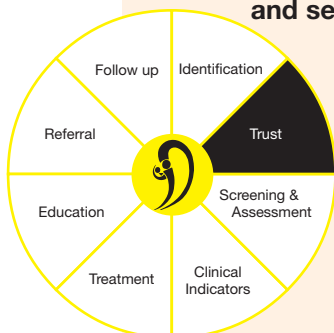
- Matching job descriptions with Clinical Guidelines
- Line Management of positions
- Clinical and Non Clinical mix of positions
- Matching positions to community needs
- Define grade and essential criteria for positions

#### 5 Defining roles and responsibilities of staff including Aboriginal Health workers, Community Health staff and management positions



- Training for staff appropriate to responsibilities
- What is the role of the positions attached to the model and how can management support this work

#### 6 Engaging the Aboriginal community in the development of programs and services



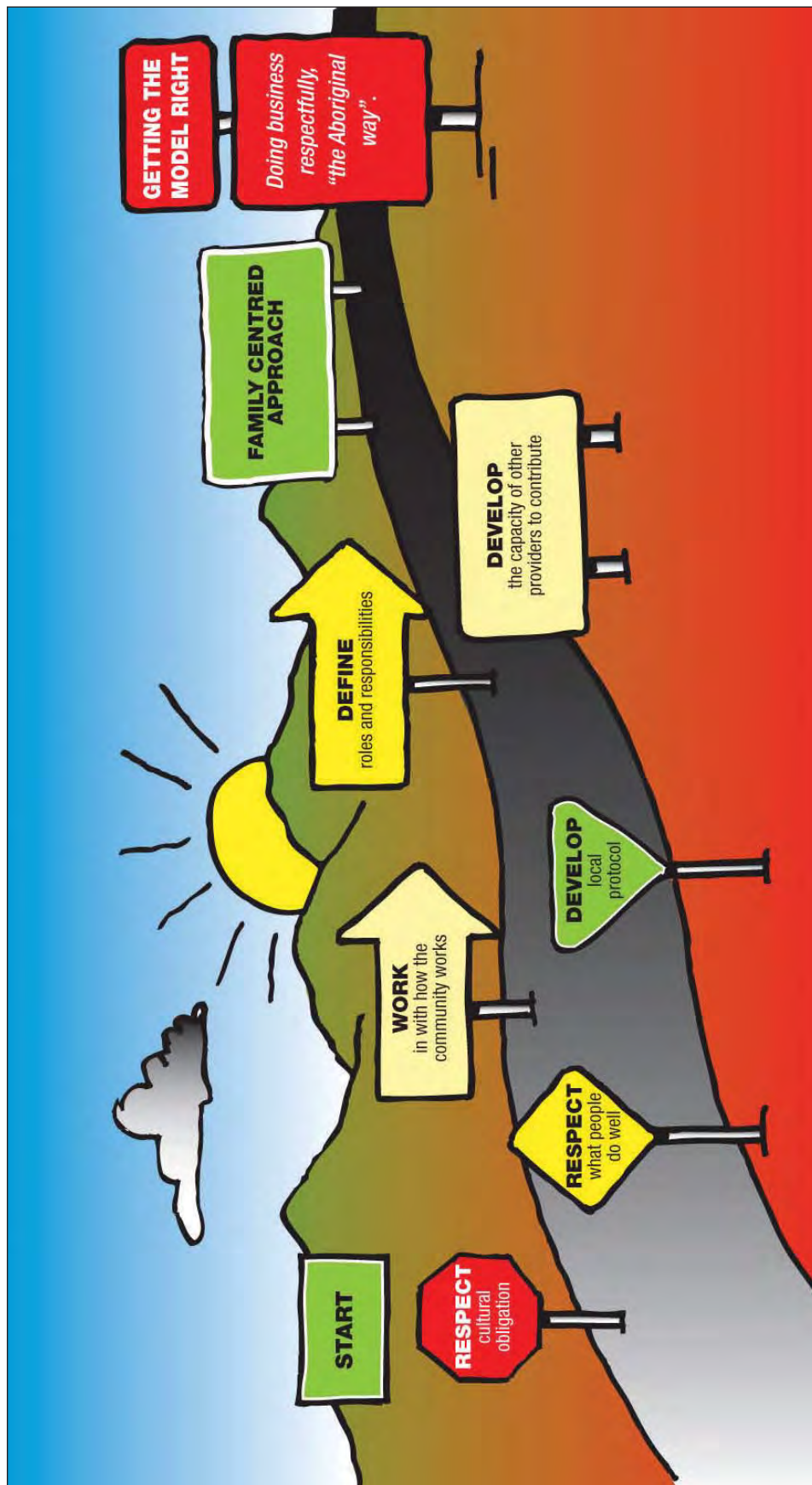
- Community engagement and consultation in line with Aboriginal Health Impact Statement

#### 7 Looking at the patient journey and identifying gaps in service delivery



- Entry and exit points for clients (active and inactive clients)
- What is the system for frequency of recall of clients
- What will constitute follow up of clients
- Is identification occurring across all services and facilities
- Is this a chronic care approach not a disease specific approach

# Getting the Model Right



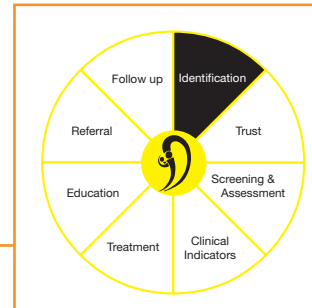


# Key Elements Required to Make the Model Work

## Identification

*"Don't be embarrassed to ask a client if they identify as being of Aboriginal and/or Torres Strait Islander descent. People are proud of their culture. It shouldn't be any different than asking their date of birth, address or phone number"*

(Natalie Green, RN ADE (UTS) Executive Officer - Aboriginal Health New England Division of General Practice).



Identification of an Aboriginal person is the starting point for the delivery of appropriate care. Identification involves three main areas for implementation

### 1. Asking the question, "Are you of Aboriginal or Torres Strait Islander Origin?"

Standard responses are:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin
- Aboriginal and Torres Strait Islander origin
- Not Aboriginal or Torres Strait Islander origin

### 2. Recording of Aboriginal status

As per NSW Health Policy Directive PD2005\_547 Aboriginality must be populated in a mandatory field in Patient Administration Systems and forms. This should follow the client across services and settings.

### 3. Establishing a local process for clients who identify as Aboriginal.

Frontline staff will need to be involved in this process as they will be responsible for delivery at the local level. This process may involve access to Aboriginal specific services and staff, comprehensive screening and extended family issues.

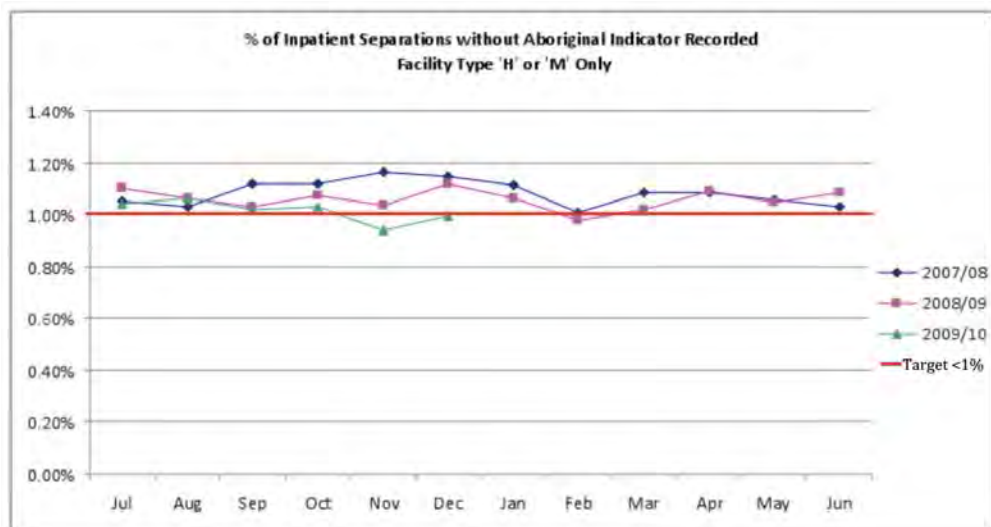
Data on Aboriginal status of admitted NSW public hospital patients is captured through the Health Information Exchange. Data for ED presentations, community and hospital outpatient attendances would like to be captured in the future. Data is categorised into those separations (discharges) with an Aboriginal status of:

- Aboriginal and/or Torres Strait Islander
- Not Aboriginal and/or Torres Strait Islander
- Unknown/not indicated response

Area Health Services are able to extract this data through their Information Management Units.

In the Performance Management Framework, the target for unknown/not indicated separations is less than 1%. As per the graph on the following page, early indications for 2009/2010 show a dramatic reduction in the number of unknown records. The CCAP team have been working with AHS to train staff to ensure the question is asked and the appropriate fields completed. Further work is required to ensure the target is reached consistently over time.

Further work is required to ensure the accuracy of responses collected is high, and assumptions are not made based on people's appearances.



Source: Health Information Exchange, NSW 2010

### Implementation:

- Mandatory training in “identification” for all frontline staff of Area Health Services.
- Include identification in staff orientation and in the broader context of Cultural Respect Training for all staff including Executive and Management positions.
- Frontline staff need to be involved in this process as they will be responsible for developing local protocol around the process once an Aboriginal person is identified and enters the system.
- A systems approach is required for this element as identification will need to follow the Aboriginal client across services and settings.
- Promotion of self identification by Aboriginal people when presenting at health services.

It is important to be aware that Aboriginal people may be suspicious of staff asking the question regarding Aboriginality as many Aboriginal people have had negative experiences with health services.

Useful resources are:

- The Identification process is described in Aboriginal & Torres Strait Islander Origin - Recording of information of patients and clients (PD2005\_547).
- NSW DoH has developed an Identification training package which is available by contacting the CCAP team via email [CCAP@doh.health.nsw.gov.au](mailto:CCAP@doh.health.nsw.gov.au)
- Another useful resource is the Aboriginal Chronic Conditions Activity Profile (ACCAHSS) that was undertaken by AHS in the period from 2005 to 2009.
- The Aboriginal Chronic Conditions AHS Standards (PD2005\_588) is also a good resource.
- The Australian Bureau of Statistics has posters and pamphlets promoting self-identification.  
<http://www.abs.gov.au/websitedbs/c311215.nsf/20564c23f3183fdaca25672100813ef1/0179c2b24398e077ca2570a8000945d2!OpenDocument>
- Awarbukarl Cultural Resource Association also has posters promoting self-identification. [www.acra.org.au](http://www.acra.org.au)
- National Best Practice Guidelines for collecting Indigenous Status in health data sets, released by Australian Institute of Health and Welfare - [www.aihw.gov.au/publications/index.cfm/title/11052](http://www.aihw.gov.au/publications/index.cfm/title/11052)

Improving Identification could mean ensuring that clinicians and staff have easy access to a patient's Aboriginal status and access to reports that list Aboriginal inpatients or identify patients who have an unknown Aboriginal status. Northern Sydney & Central Coast Area Health Service have recently been through the process of changing the placement of Aboriginal status on their Patient Administration System (PAS) and documents.



### ***How did it get started and who was involved?***



From process mapping sessions with staff it was found that Aboriginal status was not on the admitted patient's front sheet (with other demographic and clinical information) which was often checked and referred to by clinicians when making referrals or writing correspondence. Staff had to check several screens of their PAS before finding the patient's Aboriginal status. Inpatient and discharged patients reports weren't able to be run for identified Aboriginal patients. Aboriginal Health met with the Information Management & Technology (IM&T) staff to discuss the required changes. Aboriginal Health was also represented on the Area Forms Committee.

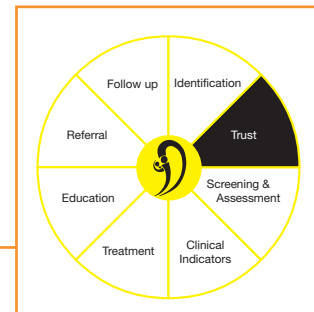


### ***Who was this project targeted at?***



It's important that our information systems and records adhere to policy directives and that our systems support staff in easily accessing information about patients. Working together with IM&T, NSCCAHS over many months have been able to achieve the required changes in their PAS. Aboriginality is now on the admitted patient front sheet and finding Aboriginality in the patient details section of PAS is much easier. NSCCAHS staff can now run reports on Aboriginal inpatients and recently discharged patients which has been very important for their 48 hour follow up processes. These reports are also sent electronically to the Nunyara Aboriginal Health Unit who follow up with frequent presenters and ensure that these patients are referred to appropriate services. This has seen a reduction in the number of readmissions for these particular patients.

For more information please contact LaVerne Belleair, Area Director Aboriginal Health, NSCCAHS Ph: 0414 192 872 or email: [lbelleair@nscchahs.health.nsw.gov.au](mailto:lbelleair@nscchahs.health.nsw.gov.au)



## Trust

*"I find that one of the significant aspects of working with Aboriginal people is earning their respect and understanding their way of doing business and that it takes time to build relationships. When I first worked in the Aboriginal community I would go and visit elders/community members just to sit and chat, so that they got to know me, which made it easier when I provided health care to them"*

(Marilyn Body, Clinical Nurse Consultant Chronic Care for Aboriginal People, Coffs/Clarence Network NCAHS)



Lynette Mieni (SWAHS)  
with clients



Kay Stewart (SESIAHS)  
with client

Gaining trust with an Aboriginal person underpins the relationship required to engage the person and their family in this process. Trust means you will be accepted and invited to contribute in the experiences of an Aboriginal person. This should be treated as a sign of respect and a privilege as trust is very difficult for some Aboriginal people to give. If you haven't got the time or expertise to build trust, make sure you bring someone who is "trusted" into your care team.

Trust refers to the relationships and informal processes that are crucial to this model having a real impact on Aboriginal people, their families and communities. Building trust will facilitate true engagement and improved health outcomes for Aboriginal people with or at risk of a chronic disease.

Trust needs to start at the individual level and slowly build to the community level. Most Aboriginal people will be reluctant to share their personal information in the first instance. This process of establishing trust and credibility needs to be led by an Aboriginal person who may have an established presence in the community. It can not be underestimated the impact this element has in making this model work. Taking the time to develop a rapport and understanding of Aboriginal people will have significant impacts on approach, delivery and assessment of the patients needs.

### Implementation:

Some strategies to developing this trust are;

- Keeping strict confidentiality and patient consent
- Building networks with Aboriginal staff from health and non health agencies

- Taking time for “cups of tea and yarnin”. This may not always be specific to what is happening from a health perspective but is important in demonstrating an interest in the whole person and not just their disease
- Staying neutral to community and family politics and not seen as being aligned to any one side
- Attending community events which are seen as important by Aboriginal people
- Doing business respectfully, this can mean many things. Some examples are:
  - Acknowledging Men’s and Women’s business when necessary.
  - Respecting the role elders have in the community.
  - Respecting the huge implications grief and loss has in communities.

Useful resources are:

- Communicating positively with Aboriginal people - A guide to appropriate terminology. Copies can be downloaded from [www.health.nsw.gov.au](http://www.health.nsw.gov.au)
- Aboriginal Health Impact Statement and Guidelines (PD2007\_082)
- Aboriginal & Torres Strait Islander Peoples - Preferred Terminology to be used (PD2005\_319).

***Many thanks to these Aboriginal and non-Aboriginal workers for sharing their experiences on the importance of trust:***

**“I have found that if a clinician is prepared to provide truly holistic culturally sensitive care and be patient they are more likely to gain trust and actually be useful.”** *Bronia Kandl, Clinical Nurse Consultant Cardiac Rehabilitation Service Shoalhaven Region, South Eastern Sydney Illawarra Area Health Service*

**“It takes time to make a friend, it takes time to earn their trust and it takes time to know a client. I take time to shake their hand and to listen, take time to understand. It is important for them to know me, where I come from, who I am and that I care. The client and I are both on the same mission. We both aim to improve their life outcomes, reduce the impact of complications and to facilitate a better quality of life, one that has purpose and meaning. It is important to remember it is their health journey and I am a privileged supporter.”** *Sue Wilson RN, Chronic Conditions Coordinator Dharah Gibinj AMS Casino NSW*

**“I think trust of non- Indigenous health professionals is an issue for many Aboriginal people. Working in an Aboriginal Medical Service provides an obvious statement of my willingness to work with the community and gives me a head start. From there I find it is usually about giving people the time they need, maintaining a non-judgemental and interested, affirming approach. Sometimes we doctors can be very reprimanding - I try to celebrate small gains with my patients and then work together on agreeing next steps in management.”** *Dr Jenny Reath, GP at AMS Western Sydney, Associate Professor, Bullana - The Poche Centre for Indigenous Health, University of Sydney & GP Manager Aboriginal and Torres Strait Islander Health Unit Royal Australian College of General Practitioners*



**“Some of the things I've done to build a rapport and trust with the community are; Return to provide a sustainable service as promised, same people same days, have a cook up, invite the community to chat about what they wanted to improve health for their children and involve the community - Aboriginal Asthma Awareness was all about the community and what they perceived about asthma and management.”**

*Judy Murrells, Pulmonary Rehab Coordinator Tweed Heads, Community Health North Coast Area Health Service*

**“It wasn't until I saw Aboriginal people in their own community clinic that I was able to understand just how uncomfortable many of them feel when attending larger medical institutions such as the tertiary referral centre I work from. I'm sure this feeling of community ownership and identity with each AMS translates to better clinic attendance, and better communication between doctor and patient, and hopefully better medical outcomes.”** *Pat Oakley, Senior Staff Specialist in General Medicine, Hunter and New England Health*

**“I have found that the most important issue with Aboriginal Elders is establishing trust. Everything else flows on as a result of this. This process generally takes time, patience and understanding. If you do not have the genuine desire to want to help Aboriginal Elders, they will see right through you and stop the process. As a coordinator I have found that you must be very honest and up-front with Aboriginal Elders in what you can genuinely provide. If you cannot do something as part of the service you provide be honest about it straight away to avoid any potential problems. Also, communication is a big issue. You must listen to Aboriginal people to find out what assistance they really need. They are only interested in what you can really do for them. Aboriginal Elders have generally had a very tough life in one way or another. Respect is of utmost importance. Do not ever betray any trust that is bestowed upon you by any Aboriginal Elder. Family is the most important thing in most Aboriginal Elders lives. Most Aboriginal Elders will go without to ensure their children and grandchildren do not go without.”** *Andrew Moran, Acting Care Coordinator Moonee Community Care*

**“I let people get comfortable with me before making approaches socially. Getting used to the way Aboriginal people do business means sitting back and waiting to be asked, and not jumping in and being too pushy. Part of gaining legitimacy within the community has been working in partnership with other Aboriginal people, gaining trust over years, being able to talk about medical stuff in a way that people understand, and also taking the time to talk about family and social stuff too and just being an okay person. I think the big thing is taking it slow and making time for people to adjust.”** *Trudie Duiveman, Chronic Care Co-ordinator, Northern Sydney & Central Coast Area Health Service*

**“Working with and through any Aboriginal Health Workers is vital as they know the 'country' and can help you in acknowledging the traditional owners and identifying who the Elders are. It's important to include the Elders in the planning, ask their opinion and gain their acceptance. Show respect and be interested in people's story. 'Yarning' to gain their respect is important - they have a lot of knowledge also. We should not be the 'expert' but have information that may be helpful. Try to see things through their eyes.”** *Maureen Klinberg, Respiratory Care Coordinator, Greater Southern Area Health Service*

**“Key words around building a rapport and trust with your community are Patience, Consistency, Never making assumptions and do not be judgemental.”** *Debbie Beahan, Aboriginal Health Education Officer, Chronic Care, Betty Orth Diabetes Unit, Dubbo Base Hospital*

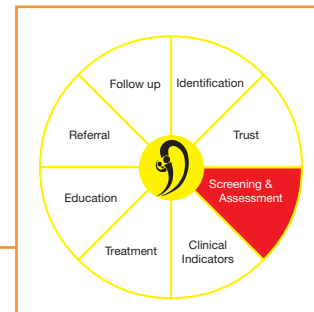
## **MENINDEE STORY**

Bill is now in his 70's. He's not a well man with his diabetes, high blood pressure and many complications. He's lived in Menindee all his life. In 1995 when the Aboriginal Health Workers (AHW) started at Menindee Health Service, they knew of Bill as they lived in the community. They knew how unwell he was and visited him at home to let him know who they were and how they could help him. They visited him several times just let remind him they were around to help.

In 1996, Bill started to come to the Health Service but would wait for the AHWs at the back door. They would bring him in and yarn with him and try to convince him to see the RN. Sometimes he would, but only with the AHWs present. Gradually Bill became more comfortable at the service and in 2001 he started coming through the front door and asking for the AHWs. They would see him and organise for the RN to come in if needed. They were happy to see him coming through the front door and be transported to Broken Hill if necessary.

In 2007, Bill started coming to the service when he was unwell, rather than waiting until his next appointment or he saw the AHWs. Bill is happy to see anyone in the service without the presence of a AHW. Bill still needs reminders for his appointments and checks on his sugar levels. The AHWs believe the Aboriginal faces at the health service and their patience with Bill have greatly contributed to his trust of their service.

# Screening & Assessment



*“Don't look at Aboriginal health problems as singular, boxed problems. Aboriginal health has to be viewed as a holistic issue, and you have to understand that health issues affect and are affected by, so many other areas of a person's life”*

(Natalie Green RN ADE (UTS) Executive Officer - Aboriginal Health New England Division of General Practice)



Natalie Richards (SSWAHS) with client

Screening and Assessment relates specifically to targeted screening for Aboriginal people at risk of chronic disease. The indicators are aligned to the four major diseases affecting Aboriginal communities:

- Diabetes
- Kidney Disease
- Heart Disease
- Lung Disease

The clinical indicators associated with these diseases are described in the 'clinical indicators' section of this paper.

Screening and Assessment is important for a number of reasons, one being the known high burden of chronic disease in Aboriginal communities. The other is the high levels of at risk behaviour linked to the onset and progression of these chronic diseases in Aboriginal people. This is evident in the high rates of smoking, excessive alcohol and substance abuse, poor diet and nutrition in many Aboriginal communities.

It is well documented that the high tobacco use is widespread among the Aboriginal and Torres Strait Islander populations<sup>10</sup>. Half of the combined total Aboriginal populations are current daily smokers, which is more than double the prevalence among the Australian population as a whole. There has been little change in the rate of smoking amongst Aboriginal people since the early nineties up until the present<sup>11</sup>.

Smoking is a significant risk factor in the development of a chronic disease such as hypertension, coronary heart disease, and diabetes. The use of screening methods and implementing robust initiatives that aim to reduce smoking rates among Aboriginal communities is important in the prevention of developing or exacerbation of chronic diseases.

<sup>10</sup> National Aboriginal and Torres Strait Islander Health Survey, 2004-05

<sup>11</sup> Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and Issues. Third Edition. Melbourne

The historical, psycho-social/cultural and economic context in which Aboriginal people live is a major cause of this participation in “at risk” behaviours. The impact of these behaviours can be described as circumstantial co morbidities. They are factors that impact on the chronic disease and the capacity of the individual to deal with reducing the impact of living with a chronic disease.

In assessing the impact this has on an Aboriginal person it is recommended that an Aboriginal staff member is involved as this may require some cultural awareness and explanation for the clinician. The assessment of the non medical factors impacting on the Aboriginal client needs careful consideration as this will provide an indication of how much support that client will need to address their medical situation.

Although the CCAP program does not collect AHS data on screening for chronic disease, below is a snapshot of what some of the AHS screen for. The list below indicates responses from AHS on the types of screening activities undertaken by a combination of Aboriginal Health Workers and Registered Nurses as part of a comprehensive health assessment. Adverse results are referred to appropriate services such as GPs, AMS, Allied Health and clinics.

- |                        |                               |
|------------------------|-------------------------------|
| • Blood Glucose Level  | • Albumin to Creatinine Ratio |
| • HbA1c (if indicated) | • Spirometry (not routinely)  |
| • Cholesterol          | • Body Mass Index             |
| • Blood Pressure       | • Girth                       |
| • Weight               | • Smoking status              |

Through state wide consultations it was identified that there are a number of screening tools being used across the state specifically designed for Aboriginal people. It is important to maintain the use of these local screening tools to not only capture vital information that may inform your programs but also to identify risks for chronic diseases. It is highly recommended that the use of screening tools not only be utilised in all programs but also modified and adapted to capture chronic disease data. When reviewing current tools and modifying for best practice incorporate the clinical indicators attached to this Model of Care and share best practice with other Areas or services.

Screening should be consistent with the Medicare items relating to Aboriginal people, chronic disease and allied health staff. For providers who this may not be applicable to, it is strongly recommended to support the work of the Primary Health providers in increasing access to these items.

The analysis of Medicare data indicates that the uptake of these Medicare items is quite low. This suggests a need to educate patients and GPs about health checks and claimable items. Refer to resource section for information on these items. Medicare has a program for Aboriginal people and service providers. The Indigenous Access Program phone number is 1800 556 955.

Opportunistic screening for Aboriginal people and their families is also an important feature of this model. With established trust and access to an Aboriginal family, this can allow the provision of Primary and Secondary Care in the one service.

A recent Policy Directive was released regarding kidney disease screening. The Kidney Health Check: Promoting the early detection and management of chronic kidney disease, NSW Health Policy Directive (PD2010\_023) was released in April 2010. The aim of this policy is to optimise existing contacts with at risk patients in hospital settings to detect early signs of chronic kidney disease. All hospitals in NSW will develop processes to ensure that patients with abnormal results following a Kidney Health Check will receive appropriate follow up advice. The high prevalence of chronic kidney disease in Aboriginal communities is well known and this screening initiative and links back to Primary Health providers should assist in the prevention of progression to end stage kidney disease.

### Implementation:

- There are also a number of tools to assess quality of life and initiate self management support strategies.
- It's important these tools are localised to meet the needs of Aboriginal people.
- Staff need to be supported and trained to effectively use these tools.
- An assessment taking account of both the health and social factors contributing to the Aboriginal person's health is a key element of this model.

***The Mootang Tarimi Service at SWAHS has focussed on screening and assessing Aboriginal people in an outreach setting.***



***Who is your program targeted at?***



Mootang Tarimi - Living Longer is an outreach service of SWAHS for Aboriginal people aged 16 years and older. The service is staffed by a Clinical Nurse Specialist and an Aboriginal Health Worker.

The service involves screening clients and undertaking a comprehensive assessment form. Screening undertaken includes; height, weight, girth, blood pressure, HbA1c, blood glucose, lipid profiles, urinalysis, albumin to creatinine ratio, EUC (electrolytes, urine & creatinine) and haemoglobin. The assessment form covers a wide range of topics including; family medical history, dental care, nutrition, physical activity, immunisation status, alcohol use and smoking history.

Based on the results of the screening and assessment, there are several pathways that could be offered to clients, for example, referrals to GPs, Specialist clinics, Diabetes Education, Aboriginal specific exercise programs, smoking cessation and the Get Healthy program. A specialist clinic (with a Cardiologist, Nephrologist and Endocrinologist) is held at Mt Druitt Community Health and is bulk billed. Depending on the client's needs, other referrals are made, for example grief counselling and home care services. Clients receive a follow up phone call one month after their visit to see how they are going.





### ***How did it get started?***



The outreach service was one of the Walgan Tilly solutions for SWAHS. There was a steering committee involved in the implementation of the service. The committee had representatives from SWAHS Aboriginal Health, Area Director Aboriginal Health, Health Promotion & Population Health, Renal Team, Clinical Nurse Consultants in Cardiology, Diabetes and Renal, Network Managers, Community Health and the local Aboriginal community.

Since starting in July 2009, the service has seen over 250 clients. Over 30 referrals have been made to the specialist clinic, with only one client being unable to attend their appointment



### ***How did you get the Aboriginal Community involved?***



There were community representatives on the steering committee. The AHW has spoken to local Aboriginal organisations about regular bookings for the service. Regular bookings have been made with Parole & Probation Board, Drug & Alcohol Centre, Men's Shed and Muru Mittigar Aboriginal Cultural & Education Centre.



### ***What advice would you give a newcomer working in Aboriginal Health?***

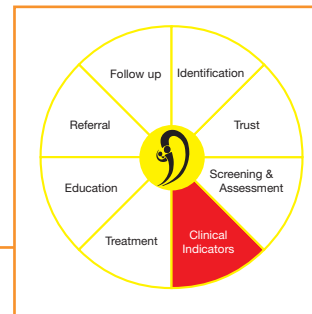


To be open minded and respectful of people's choices.



For more information please contact: Yvonne Snowdon, Clinical Nurse Specialist Aboriginal Chronic Care Program (Outreach) Ph: 0409 391 999 or email: Yvonne.Snowdon@swahs.nsw.gov.au or Tim Agius Area Director Aboriginal Health, SWAHS Ph: 9881 1670 or email: tim.agius@swahs.health.nsw.gov.au

# Clinical Indicators



*"Know the morbidity and mortality statistics. Know the risk factors. Know the history and cultural expectations of your local community. But treat every Aboriginal patient as an individual. Don't stereotype. Listen to their needs, their concerns, their unique story."*

(Tim Usherwood Professor of General Practice, University of Sydney, & General Practitioner, AMS Western Sydney)



Athol Lester (SESAHS) screening.



Lynette Mieni (SWAHS) screening.

An outcome of this model is an improvement in Aboriginal people's clinical outcomes as they relate to chronic disease. Four clinical indicators have been chosen to provide this outcome measure.

The indicators are:

- HbA1c - for diabetes
- Albumin to Creatinine ratio - for kidney disease
- Spirometry - for lung disease/chronic obstructive pulmonary disease
- Blood pressure - for heart disease

The chosen clinical indicators are useful in detecting disease and showing a pattern of management over a period of time. The four diseases they target are: chronic obstructive pulmonary disease (COPD), diabetes, heart disease and renal disease. All of these diseases share the end point of significant vascular pathology leading to damage of the heart, brain, lungs and kidneys.

The indicators are not meant to be taken in isolation in assessing a population's health status but should form one part of an overall plan to monitor a health service's approach to Aboriginal health. This plan should complement and consider local needs, current programs and resources.

The disease processes of diabetes, heart disease, kidney disease and lung disease are acknowledged as having commonalities in their risk factors, biomedically measurable markers and modifiable behaviours. The inter-related nature of the pathological processes involved in the four diseases presents an opportunity to impact on all four diseases.

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## HbA1c

Glycated haemoglobin (HbA1c) measures diabetes management, and is used to determine whether the quality of clinical management for Aboriginal people with diagnosed diabetes is improving. Poorly managed diabetes increases the risk of cardiovascular disease and other associated complications.

HbA1c is the only measure of glycaemic control that has been shown to be associated with long-term complications of diabetes<sup>12</sup>.

## Spirometry

Although there is no cure for COPD, symptoms can be controlled to improve quality of life. The lung and airway damage cannot be repaired, but all of the symptoms of COPD can be reduced. Quality of life can be improved and the length of life can be extended.

Spirometry is useful in detecting COPD lung disease and is an objective measure of any response to treatment. The overall lung volume (forced vital capacity = FVC) and the amount released in a one second interval (forced expiratory volume in 1 second = FEV1) is measured. Normally 80% of the patient's air should be released within the one second period. FEV1/FVC of >70% = COPD.

Indications for spirometry include<sup>13</sup>:

- Breathlessness that seems inappropriate;
- Chronic (daily for two months) or intermittent, unusual cough;
- Frequent or unusual sputum production;
- Relapsing acute infective bronchitis; and
- Risk factors such as exposure to tobacco smoke, occupational dusts and chemicals

## Albumin to Creatinine Ratio (ACR)

An early diagnosis of Chronic Kidney Disease (CKD) allows preventive measures to be put in place that may favourably affect clinical outcomes and in those people with progressive kidney failure facilitate a smooth, orderly and less morbid transition on to dialysis and transplant programs.

The detection of CKD early in its course relies on the performance of tests on urine (albumin or protein) and blood (serum creatinine), and these together with a blood pressure measurement have been popularly called a 'kidney health check'.

It is important to recognise at the outset, that screening can occur in two ways - population-based screening where a test is offered to all individuals in a targeted group and opportunistic screening when a test is offered to an individual without symptoms of the disease when they present to the health-care system for other reasons.

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<sup>12</sup> Australian Institute of Health and Welfare: Key indicators of progress for chronic disease and associated determinants

<sup>13</sup> McKenzie, D.K. et al. The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease 2008.

Proteinuria has emerged as the most important determinant of likely progression to kidney failure and has been shown to be a strong independent predictor of kidney failure in a mass screening setting. Screening for ACR from age 15 years with follow up annually if normal, three monthly if abnormal<sup>14</sup>.

### Blood pressure (BP)<sup>15</sup>

This indicator provides a measure of one of the most significant risk factors for many chronic diseases in Aboriginal communities. High blood pressure is a risk factor for a range of chronic disease, as well as a separate chronic disease itself. It is associated with coronary heart disease, stroke, heart failure, peripheral vascular disease and kidney failure.

The World Health Organisation defines high blood pressure as:

- Systolic blood pressure of 140 mmHg or more; and/or
- Diastolic blood pressure of 90 mmHg; and/ or
- Receiving medication for high blood pressure.

### Implementation:

National Guidelines for these chronic diseases in our model of care can be found at:

- Diabetes Australia - [www.diabetesaustralia.com.au](http://www.diabetesaustralia.com.au)
- Kidney Health Australia - [www.kidney.org.au](http://www.kidney.org.au)
- Caring for Australians with Renal Impairment - [www.cari.org.au](http://www.cari.org.au)
- The Australian Lung Foundation - [www.copdx.org.au](http://www.copdx.org.au)
- Heart Foundation - [www.heartfoundation.org.au](http://www.heartfoundation.org.au)

***An important part of the Murr-roo-ma Dhun-barn Program in Justice Health is the collection of clinical indicators.***



### *Who is your program targeted at?*

The Justice Health Aboriginal Chronic Care Program 'Murr-roo-ma Dhun-barn' - To Make Strong, is a positive and culturally effective approach to close the gap in chronic conditions for Aboriginal peoples in contact with the criminal justice system in NSW. The primary focus of the Program is on the early detection, intervention and prevention of chronic conditions in Aboriginal people, through systematic screening and health promotion activities. Aboriginal peoples in custody are even more disadvantaged with regard to their health and wellbeing, with socio economic circumstances being more complex. The percentage of incarcerated Aboriginal peoples in NSW has increased at alarmingly disproportionate rates to 22% and the recent Justice 2009 NSW

<sup>14</sup> Mathew, T & Corso, O.: Review article: Early detection of chronic kidney disease in Australia: Which way to go?

<sup>15</sup> Australian Institute of Health and Welfare: Key indicators of progress for chronic disease and associated determinants

Inmate Health Survey has determined a significantly higher morbidity related to chronic conditions within the Aboriginal population. Justice Health is putting serious effort into addressing the rights of health equity for Aboriginal patients through a health intervention that thrives on Aboriginal self determination and culturally informed leadership.



### ***How did it get started?***



The Aboriginal Chronic Care Program has a long history of demonstrated momentum. Commencing in 2001 as a pilot project for the NSW Aboriginal Vascular Health Program, it was initially trialled in 3 adult correctional sites. In the next 12 months it was expanded to 8 sites as the Program was seen to be culturally effective with addressing the access barriers faced by Aboriginal patients. To oversee the operations of this growing Program, enhancement funding was sought for and received from the NSW Department of Health to recruit for a full time Aboriginal Coordinator. In 2008, through the pooling funding sources, the Program was rolled out to 16 sites, with 2 sites being juvenile detention centres. As a result of this reform, more than 50% of Aboriginal adults (Males; 48%; Females 89%) and 31% of Aboriginal young people (males) have increased access to targeted chronic care services.



### ***How do you know if it works?***



The Program's Clinical Indicators that are used for capturing evidence of chronic conditions were first developed from the NSW Health Aboriginal Vascular Health Program State-wide Key Performance Indicators. They have been reworked over time to firstly, better understand the health needs of Aboriginal patients affected by incarceration and detention and secondly, to improve Program design for the delivery of enhanced chronic health interventions to more than half of the Aboriginal patient population. For example, 350 patients were screened by nursing professionals and Aboriginal Health Workers in a six month period, resulting in 29% of patients having an undiagnosed chronic disease. The results of the Clinical Indicators are also collated and reviewed bi-annually to provide ongoing insight into the health and well-being of Aboriginal patients, with both asthma and mental illness presently being highly prevalent with both adults and young people.





### *What advice would you give a newcomer working in Aboriginal Health?*



It is imperative to know the health inequities between Aboriginal and non-Aboriginal Australians and the risk factors that attribute to the health crisis. A comprehensive approach to chronic disease and care is likely to be more effective for Aboriginal patients than a single disease or 'body part' approach, with knowledge that the social determinants for health such as adequate schooling, stable housing and employment also impact on Aboriginal people living longer and more fulfilled lives. Meeting the complex health needs of the Aboriginal population in custody is a significant challenge. However, the unique environment also provides an opportunity to improve the health status for a group of people who suffer poorer health. Working in Aboriginal health takes courage, boldness and commitment. However, having real commitment to Aboriginal people, families and communities living longer lives means working 'even when no one is looking'.



### *How do you get the Aboriginal community involved?*



Each adult correctional centre has an Aboriginal 'delegate' who is an elected Aboriginal leader and advocate for the community in the facility. The Health Centre Nursing Unit Manager, nursing professionals engaged in the Program and Aboriginal Health Workers consult with the Aboriginal delegate to have input into health services and health promotion programs. The importance of adequate consultation with Aboriginal patients and having a process for 'discussion' rather than 'telling' is fundamental for Justice Health to continue to deliver improved chronic health outcomes for Aboriginal patients in NSW. Justice Health's partnering agencies including the Aboriginal Health & Medical Research Council of NSW, Corrective Services NSW and Juvenile Justice NSW, are key stakeholders for meeting the health needs of Aboriginal people incarcerated and detained in NSW.



Justice Health Team accepting their award at 2009 NSW Aboriginal Health Awards.

For more information please contact Elizabeth McEntyre, Area Manager Aboriginal Health on Ph: 499 32337 or email [Elizabeth.McEntyre@justicehealth.nsw.gov.au](mailto:Elizabeth.McEntyre@justicehealth.nsw.gov.au) or Libby Johns, Coordinator Aboriginal Chronic Care Program on Ph: 499 32354 or email [elizabeth.johns@justicehealth.nsw.gov.au](mailto:elizabeth.johns@justicehealth.nsw.gov.au)

# Treatment

*“What I try to do is explain in very simple terms what the process is, what dialysis is and I often show pictures or demonstrate the equipment. I stay friendly and quiet and encourage the person to ask any questions.”*

(Gail O'Brien, Renal Outreach/Haemodialysis Unit GWAHS)



Client receiving treatment Dialysis Unit (SESAHS)

Timely treatment is the key for Aboriginal people. Evidence shows that Aboriginal people often present late in their stage of disease and have many issues relating to access of health services. This affects the treatment and options available to the Aboriginal client.

The treatment provided with this model will very much depend on the skill level of the positions attached to the model. When treatment cannot be provided by these positions, referral to the appropriate provider is required. Treatment will be on a case by case basis and will be in consultation with the client, the carer and where appropriate the family.

Effectiveness of treatment will need regular monitoring, review and modification to achieve the best outcome for the client and their family. For most Aboriginal people, treatment will need to be explained without jargon and technical terms. This also relates to medications. Simple straight forward information needs to be provided:

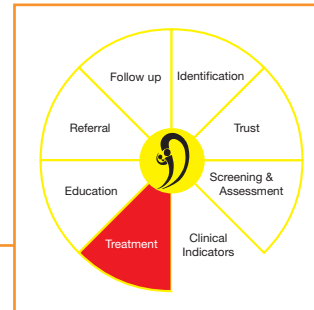
- on the side effects of medications
- on priority of medications if cost is an issue (the clinician should be advised that cost is an issue)
- on medication initiatives such as the S100 program<sup>16</sup>
- on consequences of sharing of medications and
- on the consequences of not taking medications

It is important that when treating Aboriginal people you are not just treating the **disease** but treating **the people** who have the disease.

## Implementation:

Treatment will be evidence based in accordance with the relevant clinical guidelines such as:

- Heart Foundation
- Kidney Health Australia
- The Australian Lung Foundation
- Diabetes Australia
- NSW Health policies



<sup>16</sup> Australian Government Department of Health and Ageing, Aboriginal Health Services and the Pharmaceutical Benefits Scheme

***The chronic care program at Miller Community Health Centre in SSWAHS has a multi-disciplinary approach to treatment.***



***Who is your program/project targeted at?***



This program is targeted at Aboriginal persons aged 15 years and older. A person does not need to have an existing chronic condition. The program has a strong preventative focus, so anyone is welcome to have screening done, and join some of the program components such as the exercise group, nutrition groups, or smoking cessation.



***How did it get started and who was or needs to be involved?***



The program was piloted in 2000, and secured recurrent funding in 2002 from NSW Health. The original team consisted of 2 Aboriginal Health Education Officers (AHEOs), a Nurse Practitioner in Diabetes, a Community Nurse and a Dietitian. In 2010, the team consists of 2 AHEOs fulltime, and part time Clinical Nurse Specialist (CNS) and Dietitian. The program is managed by Community Health.



***How do you know it works?***



The multi-disciplinary team holds a drop-in-clinic every Tuesday, and home visits/outreach on Wednesdays. Once a month, a clinic with an Endocrinologist is held, along with a podiatry clinic for clients on the Aboriginal Chronic Care Program. AHEOs provide self management education with the CNS and Dietitian. Most clinical treatment (excluding medical treatment) is done by the multi-disciplinary team.



### ***What advice would you give a newcomer working in Aboriginal Health?***



Ensure that you get to know the Area Health Service, including the Aboriginal Health Unit and Aboriginal Health Workforce. There are plenty of training opportunities provided by the health service which should be utilised by newcomers in the area in which they are working. For a newcomer, it would benefit them if they 'buddy' with someone in their field of work for the first couple of months, Aboriginal or mainstream, to assist them with orientation and familiarisation of new tasks.



### ***How do you get the Aboriginal community involved or how do you let them know what's happening in your service?***



The local community is engaged and consulted whenever new programs/initiatives are developed for the Aboriginal Chronic Care Program (ACCP). For example, the development of recipe cards involved community members providing their own favourite recipes, and clients then acknowledged on the recipe cards.

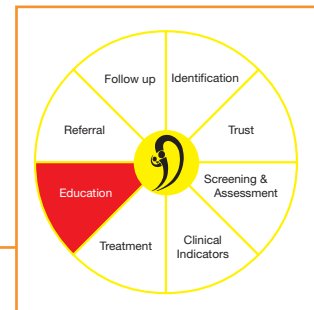
The ACCP team utilise the manager of the Miller Community Health Centre to ensure that the community is informed of necessary events. However, as the ACCP sees a large number of clients, and have easy access to local Elders, it is very easy to transfer relevant information from the program into the community.



Tony Phiskie, Natalie Richards and George Long from SSWAHS

*For more information* please contact Natalie Richards, Project Officer- Walgan Tilly/Dietitian- Aboriginal Chronic Care Program, Ph: 9612 0707 (M/Th/F) 98286773 (Tue/Wed) or email: [natalie.richards@sswahs.nsw.gov.au](mailto:natalie.richards@sswahs.nsw.gov.au)

# Education



*“I believe that Aboriginal people want the full depth of information down to a cellular level and then they feel they can relate it to things they know about. Protected time and environment is really important for information exchange. Somewhere people feel comfortable to talk, that might mean around the campfire or in a clinic room with someone they trust. Most importantly much information can be exchanged over a cup of tea! That is really where the relationships are built”.*

(Rebecca Davey, Clinical Nurse Consultant Chronic Care for Aboriginal People, Tweed/ Richmond Networks, NCAHS)

*“I hope to promote self management. It must be their journey, their decisions and we need to be ready for the opportunity to provide the education, encouragement, support and help they may ask for”.*

(Sue Wilson RN Chronic Conditions Coordinator Dharah Gibinj Aboriginal Medical Service - Casino, NSW)



Cardiac education

Clinical information about disease progression, stages of disease and use of medications is an area that has been identified as a gap in the health care system for Aboriginal people. Health Literacy for Aboriginal people is an area that requires delivery of key messages on what is a chronic disease, how you get it, how you look after it and what can go wrong.

This information needs to be delivered in a meaningful way and at multiple stages throughout the Aboriginal client’s journey. It needs to be practical, reinforced and related to everyday experiences.

The link between “at risk” behaviour and chronic diseases needs to be described in a way that has relevance to the Aboriginal person in their family context. The connection of Aboriginal people to family and extended family is strong and in influencing behaviour change this needs to be acknowledged and accommodated. For many Aboriginal people the reality of premature death has become part of everyday life, and almost acceptable.

Health promotion can also be incorporated into this element as there are a number of existing initiatives on which to build capacity for staff to deliver the appropriate information to Aboriginal people and communities.

Support for self management strategies should also be considered as part of education. Self management support is defined as the care and encouragement provided to people with chronic conditions to help them understand their role in managing their illness, make informed decisions about their care and engage in healthy behaviours<sup>17</sup>. This will require expertise in dealing with Aboriginal people on a very sophisticated level. An in-depth knowledge of

<sup>17</sup> <http://www/ihi.org/IHI/Topics/PatientCenteredCare/SelfManagementSupport/>



Aboriginal history and culture along with the technical training in self management strategies and how they may be applied in the Aboriginal context is essential. This is a very unique skill mix.

### ***Education is a large component of the Aunty Jean's Good Health Program in SESIAHS***



#### ***Who is your program targeted at?***



The Aunty Jean's Good Health Program is targeted at all Aboriginal people living with a chronic condition.



#### ***How did it get started?***



A need for services to improve health outcomes for Aboriginal People with a Chronic Disease was identified. A Steering Committee was formed with relevant Stakeholders (e.g. doctors, relevant clinical staff, AHW, Community, AMS & Division of General Practice).

Staff involved in running the program includes: Exercise Physiologist, Cardiac Rehab Clinical Nurse Consultant, Aboriginal Health Workers and other clinical staff who assist with education sessions. Allied Health and Clinical Nurse Consultants are used to provide a wide range of education on chronic disease, for example, dialysis information, nutrition, foot checks etc.



#### ***How do you know if it works?***



We can measure the success of the program by the following:

- Positive feedback and comments from the participants and the Aboriginal community in general
- Persistent good numbers of participants involved in the program on a weekly basis
- Program has been running successfully for over 6 years
- Program has been adapted and implemented in a number of sites across GSAHS and GWAHS with keen interest from other Area Health Services across NSW, and health services across Australia.



### ***What advice would you give a newcomer working in Aboriginal Health?***



- To have an understanding of the underpinning issues that contribute to disparity in health for Aboriginal people and an understanding on what the Aunty Jeans Program is, and why it is being used
- Not to only be familiar with the material, but also to have an understanding of the content;
- Deliver the content, keeping in mind that your target audience is at community level. Jargon needs to be avoided.
- The importance of maintaining cultural safety within the program



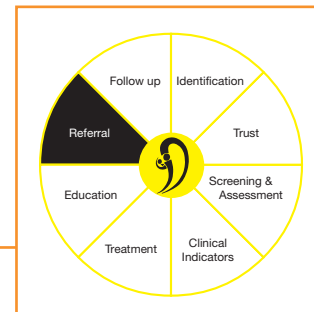
### ***How do you get the Aboriginal community involved?***



- The Aboriginal Community has been a partner, and it is important they are involved from the start. They have also input into continuing evolution of the program.
- Having a relationship with key people and/or organisations across the community allows information about the serviced to filter down
- Development of promotional material (Pamphlets, DVD's, Posters etc)
- Koori Grapvine!! (Word of Mouth)

*For more information please contact Gail Daylight, Area Manager Aboriginal Health on Ph: 9947 9840 or email [gail.daylight@sesiahs.health.nsw.gov.au](mailto:gail.daylight@sesiahs.health.nsw.gov.au)*

# Referral



*“ .....In other words don't just assess and manage the disease but be prepared to take the time to listen and provide respectful guidance when clients do disclose a Pandora's Box' of difficulties and health issues .It is very important to facilitate referral and linkage to health care and other service providers”.*

(Bronia Kandl Clinical Nurse Consultant Cardiac Rehabilitation Service, Shoalhaven Region, SESIAHS)



(SESAHS)  
Wollongong's Aunty Jean's Program



(GWAHS)  
Condobolin Womens Active Act Program

Referrals will be to a number of providers both internal and external to the NSW Health system. Considerations of referral to services include:

- Affordability and providers who bulk bill or have no out of pocket expenses
- Access to transport
- Availability of Aboriginal specific programs where appropriate
- Consultation with the client
- Timeliness of the referral to a provider

The key in this referral process is not to just make the referral but to assist the client to navigate the different services including General Practice and AMS. Referrals may be made to:

- Specialists (affordable)
- Diagnostics
- Allied health services
- Aboriginal Health Workers

It has also been noted in consultations across the state that a priority referral system for Aboriginal clients based on clinical need should be explored, especially for specialists services and specialist outreach services.

As part of the referral process it is also good practice to have linkages with a number of services that may be required at different times, these may include:

- Aboriginal Medical Services
- Primary and/or Community Care

- Social and emotional well being programs
- Rehabilitation programs
- Advance Care Planning
- Palliative Care
- Drug and Alcohol services
- Mental Health
- Aboriginal Maternal Infant Health Service
- ComPacks
- CAPAC

***Referral pathways have been developed in NCAHS for Aboriginal people.***



### ***Who is your project targeted at?***



The referral pathways are targeted at Aboriginal people who present to Casino Hospital Emergency or who are admitted to Casino Hospital and have one of these diseases; kidney disease, heart disease, lung disease or diabetes. There are also pathways for support services, mental health and drug and alcohol issues.



### ***How did it get started?***



The referral pathways are just one part of our Walgan Tilly Dullgu Gummurr local solutions. There was a working party at Casino working on the Walgan Tilly Dullgu Gummurr solutions. There were representatives from Casino Hospital's Emergency Department, Ward Staff and Community Health, as well Dharah Gibinj (Casino) Aboriginal Medical Service and members from the local Aboriginal community. This working group thought the pathways would be a good idea to inform Aboriginal people as to what local services were available to assist them after they were discharged from Hospital. It also fostered good partnerships between Casino Hospital and Dharah Gibinj.



### ***How did you get the Aboriginal community involved?***



Having a community representative on our working party was very important. We had a local Aboriginal artist assist with the artwork for the pathways. Once the pathways were finalised, we attended local Aboriginal groups, organisations and community centres to talk about the pathways and let them know how the pathways could help them.



## How do you know if works?



We are looking to work with Dharah Gibinj on the sustainability of the pathways and to ensure they are kept up to date and relevant for the local community.



## What advice would you give a newcomer working in Aboriginal Health?



Ensure you consult the local Aboriginal community, build a rapport and liaise with other Aboriginal health worker/s within your organisation also with Aboriginal workers in other organisations in the same geographical location.



Anthony Franks,  
Project Officer  
NCAHS

For more information please contact Anthony Franks, Project Officer, Aboriginal Health, NCAHS, Ph: 6620 2225 or email: [anthony.franks@ncahs.health.nsw.gov.au](mailto:anthony.franks@ncahs.health.nsw.gov.au)

### Kidney Disease

Learn about Kidney Disease and how to ...

- Understand functions of the kidney
- Understand treatment of kidney disease, medications and lifestyle interventions

**Casino Hospital Community Health**  
Ph: 66 602 669  
**Charmie Turner**  
Chronic Kidney Disease Nurse Practitioner  

- Need to book in
- Initial one hour (one on one) appointment
- Follow up 2 - 12 monthly
- Not Aboriginal specific
- Current 1-2 month wait
- Free service

**Dharah Gibinj Chronic Kidney Disease Clinic**  
Ph: 66 62 304 (Book through NMS)  
**6 Clinic dates per year**  
**One hour initial consultation with:**

- Charmie Turner - Chronic Kidney Disease Nurse Practitioner
- Medication and management plan developed with GP at NMS
- One on one Chronic Kidney Disease Lifestyle and medication education
- Follow up as required
- Free service

**My Doctor**  
Ph: \_\_\_\_\_  

- Book in appointment
- Medication education
- Medication management
- Care plan
- Follow up as required
- May be bulk billed
- May need to pay \$

Need further assistance contact \_\_\_\_\_ Phone \_\_\_\_\_

### Heart (Cardiac) Disease

Learn about Heart Disease and how to ...

- Understand your heart and tablets
- Prevent problems or know how to treat them
- Know what to do when you have heart pain
- Help you get fit, lose weight, stop smoking, sleep better and feel better

**Casino Community Health Cardiac Rehabilitation**  

- Free service
- Not Aboriginal specific

**Group Cardiac Program**

- Need to book in
- Ph: 66 62 304 (ask for physio)
- Once a week for 6 weeks
- Group exercise
- Heart disease education
- Heart disease self management

**Home Cardiac program**

- Ph: 66 62 304
- Home visits with individual assessment and program

**Dharah Gibinj Aboriginal Medical Service**  
Ph: 66 62 304  
**GPs - male and female**

- Follow up
- Referrals
- Medications
- Medicine bulk bill

**Chronic disease program**

- Aboriginal specific
- Care Plan

**Healthy Lifestyle Group**

- Healthy lifestyle education
- Help with managing your disease
- Medication support
- Exercise
- Stop smoking support
- Action plan

**My Doctor**  
Ph: \_\_\_\_\_  

- Follow up
- Referrals
- Medications
- Education
- Stop smoking support
- Care plan
- May be bulk billed

Need further assistance contact \_\_\_\_\_ Phone \_\_\_\_\_

### Lung (Respiratory) Disease

Asthma, Bronchitis, COPD, Bronchiectasis

- Understand your lung disease and lung medications
- Help you to manage your cough and breathlessness
- Know when an acute attack is coming on
- What to do, where and when to go for help
- Improve your fitness, help to lose weight, stop smoking, sleep better, feel better

**Casino Hospital Pulmonary Rehab**  
Ph: 66 602 304 (Physio)  

- Need to book in
- Adults
- At Casino Hospital Physio Department
- Two times per week for 8 weeks
- Group exercise
- Lung disease education
- Lung disease self management
- Not Aboriginal specific

**Respiratory Educator**

- One on one education
- Need to book in
- Ph: 66 602 304
- Adults or Kids
- Lung disease education
- Understanding lung medication
- Check your puffers
- Free service

**Aboriginal Medical Service**  
Ph: 66 62 304 (you can just turn up)  
**Adult Respiratory Clinic**

- Dr. Luard (once per month)
- Care Plan
- Medication free

**Paediatric (Kids) Clinic**

- Dr. Jackie Andrews
- Medication free

**Healthy Lifestyle Group**

- Disease education
- Medications
- Exercise
- Stop smoking support
- Get on action plan
- Aboriginal specific
- Bulk billed
- Free service

**My Doctor**  
Ph: \_\_\_\_\_  

- Need to book in
- Check up, follow up
- Medications
- Disease education
- Stop smoking support
- Care Plan
- May be bulk billed

Need further assistance contact \_\_\_\_\_ Phone \_\_\_\_\_

### Sugar Diabetes

Learn about diabetes and how to

- Stop diabetes making you feel sick
- Take your medicine properly
- Know what to do if you have problems
- Improve your fitness, eat well and lose weight
- Stop smoking, sleep better, feel better and be healthy
- Recognise problems and how to get help early

If you are pregnant and have diabetes, this can be managed through the Diabetes Clinic at Casino Community Health

**Casino Community Health**  
Ph: 66 62 304  

- Free
- Not Aboriginal specific

**Diabetes Clinic**

- Diabetes and Diabetes Educator
- Not weekly

**Casino Community Health Goorie Diabetes Complications and Assessment Clinics (DCAC)**  
Ph: 66 62 304 (Dharah Gibinj)  
**66 62 304 (Co-ordinator)**

- Free Medicare bulk bill
- Aboriginal specific
- Clinic held at several communities

**Or Refer**

- Through GP

**Dharah Gibinj Aboriginal Medical Service**  
Ph: 66 62 304  

- Aboriginal specific
- Medicine bulk bill

**NMS GPs**

- Diabetes (larger) medications
- Clinical management
- Care plan
- Refer to DCAC
- May refer to Diabetes Clinic at Casino Community Health

**Healthy Lifestyle Group**

- Education on disease and lifestyle
- Medicine support and education
- Smoking cessation support
- Exercise program

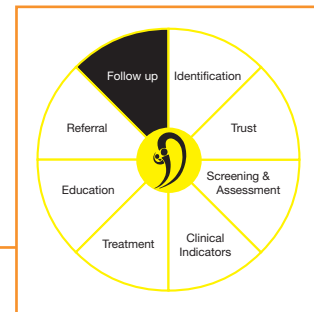
**My Doctor**  
Ph: \_\_\_\_\_  
**Diabetes check up, follow up**

- Not Aboriginal specific
- May be bulk billed
- Diabetes/Sugar medications
- Education
- Smoking cessation support
- Care plan
- May refer to Goorie Diabetes Complications and Assessment Clinic
- May refer to Diabetes Clinic at Casino Community Health

Need further assistance contact \_\_\_\_\_ Phone \_\_\_\_\_



# Follow Up



*“Making contact with Aboriginal clients at least every 3 months to keep abreast of how they are going is also vital but doesn't need to be intrusive”.*

(Sue Wilson, RN Chronic Conditions Coordinator Dharah Gibinj AMS, Casino, NSW)



Aboriginal Health Workers (SWAHS)

Literature review suggests that the follow up of client's results in improved health outcomes. A systematic, local approach for follow up of Aboriginal people is essential.

Both formal and informal follow up should be included in service delivery. Each point of contact with the Aboriginal person and their family should involve some aspect of their health and general well being.

The positions attached to this model are the basis of a team approach responsible for following up with the Aboriginal person. Having systems to recall clients to review and update screening, care plans and post appointments will assist in making this core business for providers of health or social services.

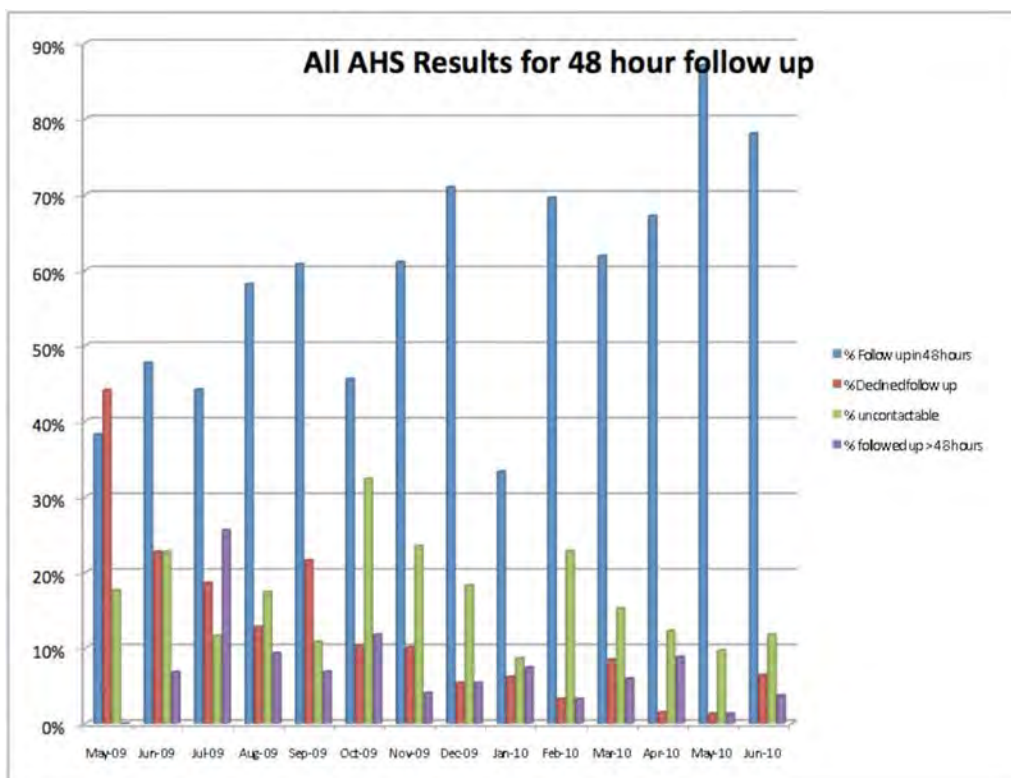
Communication across settings is important as many Aboriginal people will have more than one health provider. This is because more often than not contact with health services is usually in crisis or emergency situations, rather than planned visits or check ups. In order to prevent this, follow up should be planned, systematic and consistent according to need. Information sharing between providers about individual clients will need to be negotiated at a local level with consent of the client.

48 hour follow up is a State initiative. It was designed for Aboriginal people, 15 years and older who are discharged from hospital with a chronic disease. This follow up addresses general well being, medications and appointments with GPs or AMS.

All AHS have commenced 48 hour follow up in some or all of their facilities, with over 45 facilities currently performing 48 hour follow up as of July 2010. AHS have adopted different models for 48 hour follow up that best fits with their resources and community needs. AHS continue to implement 48 hour follow up across their sites. Data on 48 hour follow up is reported monthly to the CCAP team.

As per the graph below, the difference between patients identified for follow up and those patients actually followed up is decreasing. AHS are fine tuning their processes to improve the number of patients being followed up within 48 hours.

In the first 12 months of follow up, an average of 44 Aboriginal chronic disease patients were identified by all AHS for follow up each month and 24 patients were followed up each month. Of the average 44 patients identified each month, 11 patients declined follow up and on average 9 patients were 'un-contactable'. AHS are identifying ways to reduce the number of patients declining follow up and those who cannot be contacted.



### Implementation:

48 Follow Up toolkit

Refer to Resources section.

***SWAHS have undertaken a different approach to 48 hour follow up using their Care Navigation Team.***



### ***Who is your program/project targeted at?***

The Sydney West Area Health Service (SWAHS) Navigation of Care and 48 hour follow-up program aims to target all Aboriginal patients over the age of 15 with a chronic disease presenting or admitted to a SWAHS Facility.

Sydney West covers an area of almost 9,000 square kilometres, spanning nine LGA's - Lithgow, Blue Mountains, Penrith, Hawkesbury, Blacktown, Baulkham Hills, Holroyd, Parramatta and Auburn. The area is home to a substantial Aboriginal community of approximately 18,112 representing 31.5% of the total Aboriginal population in urban NSW. The largest Aboriginal communities in SWAHS reside in the LGAs of Blacktown (7,502) and Penrith (4,203). SWAHS acknowledges the Darug, Gundungarra and Wiradjuri people as the traditional owners of the land within the SWAHS boundaries.



### ***How did it get started and who was or needs to be involved?***

The Aboriginal Care Navigation role is being piloted at Blacktown & Mt Druitt at this stage with the intention of expanding across the other clusters within the Area Health Service in the future. The Navigation of care provides a model of care to Aboriginal people with chronic disease through SWAHS Navigation Care system, which includes the identification, flagging, self-management care planning and a 48hr follow up telephone call system post discharge ensuring their health needs are met.

Key stakeholders were identified and we have fostered & developed close linkages with the following;

- Hospital Aboriginal Liaison Officers (ALO's)
- Aboriginal Health Workers
- Aboriginal Community Workers
- Aboriginal Community Members
- Hospital acute facility staff members & Patient Flow Unit
- Care Navigators within SWAHS
- The local Aboriginal Medical Service (AMS)
- Both mainstream and Aboriginal Community Controlled Organisations

- Primary & Community Health
- Established outreach services and groups within the area which are Aboriginal specific
- Division of General Practice / Wentwest
- NSW Health, Chronic Care for Aboriginal People (CCAP) Program



### *How do you know it works?*

The main indicators emerging as influences on positive outcomes on the whole patient journey process/experience is highlighted as follows;

- Having an identified position in place (Aboriginal Care Navigation Officer)
- Increased access & utilisation of/to mainstream services
- Increased referral pathways to both mainstream and Aboriginal Community Controlled Organisations
- Referral to Mobile Outreach Service (Mootang Tarimi Van Outreach) for screening & assessment overcoming the impediment of the lack of access to transport
- Increased awareness of services available to patients (especially post discharge)
- Increased identification of Aboriginal & Torres Strait Islander patients upon presentation (due to education re; asking the question/recording)
- Increased patient understanding post discharge about their medications, condition & future planning of their health care
- Relationship building - increased close links & enhanced communication channels have been created prompting greater dialogue with all key stakeholders
- Positive/negative patient journey experiences voiced during 48hr follow-up phone calls
- 48hr follow-up phone calls are welcomed
- Improvement in data collation/collection
- Greater understanding with mainstream staff re' cultural awareness/sensitivity

The 48hr follow-up process is a state-wide initiative, NSW Health's CCAP program are developing and conducting an evaluation framework on the whole process on what is/has been achieved.



### *What advice would you give a newcomer working in Aboriginal Health?*



Being able to work and be involved in Aboriginal Health is quite challenging. Being an Aboriginal Health Worker is invaluable to our Aboriginal & Torres Strait Islander community members.

Being a part of the decision-making process can make a genuine difference in their lives by turning someone's disadvantage into an advantage is very rewarding.

I would advise newcomers to be confident, professional in their approach, be an extremely good listener/communicator, ask questions, be honest, have a mentor, build up your networks, be passionate about what they believe in, be true to yourself, stand up for what you believe in, be a team player, know your community well and if you really like what you do, the positives will outweigh the negatives.

- Primary & Community Health
- Established outreach services and groups within the area which are Aboriginal specific
- Division of General Practice / Wentwest
- NSW Health, Chronic Care for Aboriginal People (CCAP) Program



Lynette Mieni,  
Aboriginal Care  
Navigator

*For more information please contact Lynette Mieni, Aboriginal Care Navigator Blacktown Hospital 0410 017 642 or email: [lynette.mieni@swahs.health.nsw.gov.au](mailto:lynette.mieni@swahs.health.nsw.gov.au)*



# Aunty Tilly's Story



Aunty Tilly and her friend were asked if they would take some health checks.



The health worker had a catch up with Aunty Tilly and the kids about her health checks results and how the family is.



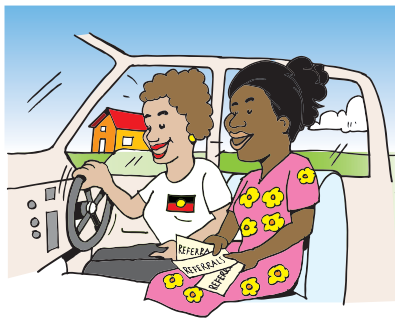
After a week, the health worker rang Aunty Tilly to make sure she'd made her doctor's appointments.



The doctor asked Aunty Tilly a lot of questions about her family and her health. He told her she had diabetes.



The doctor also did a number of tests including blood pressure, spirometry, blood sugar and a urine test.



The doctor gave Aunty Tilly a number of referrals and the health worker drove Aunty Tilly to her appointments.



The health worker also gave Aunty Tilly a lot of information about managing diabetes and taught her how to use the blood glucose test machine.



Aunty Tilly goes back to the clinic for her planned treatments.

# Aunty Tilly's Story

**A good story - This is an example of how all the elements of the model of care are incorporated in the patient journey. Each element is identified throughout the story.**

*It's been about a year since I was told I had sugar I'm not even that old. I remember it because it was NAIDOC week and I took the grand kids in for a look at the do in the park.*

*I was there catchin up with everyone when this young one asked if they could do some health checks on me, I didn't really wanna but they had good little bags and drink bottles for the kids so I said "alright then, It won't take long will it?" She was real friendly with a big smile and I could see some other people I knew in the tent so I thought it couldn't be that bad, so in I go.*

*The young one weighed me, measured my belly, took me blood pressure and took a bit of blood from my finger (**Screening**). She wrote it all down for me and said I should come to the AMS for a check up, I said "yeah I will next week aye", grabbed my bags for the kids and took off real quick, I saw my cousin and needed to get a lift home.*

*About a week later that young one, she rang me and asked if I'd made my doctor's appointment she said she'd do it for me and ring me to remind me in case I forgot. She rung me back like she said she would and tried getting me to the doctors. I dodged her a few times until she finally tracked me down and got me to the doctor (**Follow up**).*

*Dunno what I was worried about, the doctor was alright he gave me a good lookin over and asked me a lot questions, where I'm from, who's my mob and all that. I reckon I was there about an hour before he told me I had diabetes, I told the doctor "but I'm not sick, I'm right". I heard about diabetes cause I think it runs in my family (**Assessment**). While I was in there, he made sure I had more tests for other stuff, not sure what they were for, I didn't ask I just wanted to get outta there (**Clinical Indicators**).*



*The doctor got that young one to talk to me about what diabetes means, what it does to ya, what you can eat and all that. She gave me this little machine for my sugars and told me how to use it. **(Education)**. She's got big plans for me about goin' for walks and other stuff but I'm right I got other stuff to do. She's ain't gunna leave me alone so I tell her "yeah one day..."*

*That young one's got these papers for me to help me stay out of hospital and keep me out of trouble with the doctor. If I want to know anything I can ring or go in and see her, she'll even come out and see me at home if I want, she writes stuff about what's happening to me **(Care Planning)**.*

*She's cluey too, she told me she'd come out and take me to them appointments I reckon she'd have a feeling I wouldn't go on my own. She said she'd stay with me too and explain anything I didn't know. She's good this one, she don't tell lies she does what she says she's gunna do **(Trust)**.*

*She rings me every now and then to see how I'm goin, she even came and seen me when I ended up in the hospital, dunno how she tracked me down, I think she was makin sure that lot from the hospital was lookin after me cause she knows my stuff. That's good cause I don't know those fullas, I feel shame telling them my business, they might wanna keep me in the hospital. She told me she was gunna come back and get me when they send me home, she reckons they've got her number, musta been when I gave it to 'em when I first come in. Old mate who works at the hospital was good to me too. He made sure I had clothes and money and that my mob was right when they come to see me **(Follow-up)**.*

*Last time she came to my place she asked if she could check some of the family, we said "Nah, not now, might next time". I think she put that in her book so she'll be back, you can bet on it.*

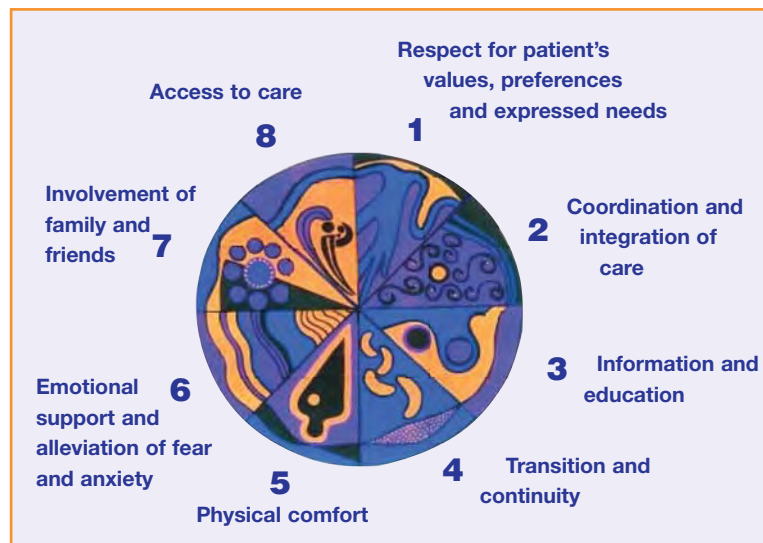
# Project Planning and Implementation

**A distinct difference of this process is the methodology used for planning and implementation. This acknowledges that the model will look different in each area and has the capacity to respond to local community needs.**

## Redesign

Redesign is a methodology used for Project Planning and Implementation. Redesign is changing the way we do things to improve processes to deliver better patient journeys. The Redesign methodology enables the Area Health Services, local facilities and other health service providers to identify when there is something affecting patient care and how best we change the way we do things to result in a better experience for patients, carers and staff. For further Redesign resources please go to <http://www.archi.net.au>.

Improving patient journeys is the core driver for Redesign and it involves measuring progress by using patient and carer experience surveys as part of business-as-usual. Using a person's experience of being cared for by the health service providers is called a patient journey. The NRC + Picker diagram below has been adapted to be more meaningful to Aboriginal people.



*NRC+ Picker's Description of Positive Aspects of Your Health Care Experience. Artwork by Bronwyn Bancroft*

## Accelerated Implementation Methodology (AIM)<sup>18</sup>

Despite Redesign teams undertaking very successful projects, implementation is still one of the biggest challenges. AIM is the method of choice to use for implementation and is designed to improve the success rate of projects by effectively managing the change. AIM is about how to address or remove obstacles that might prevent projects from being delivered on time, on budget and in scope.

Training on this methodology is provided by NSW Department of Health and at various AHS. For more information please contact [CHR@doh.health.nsw.gov.au](mailto:CHR@doh.health.nsw.gov.au) or via the "GEM" website <https://gem.workstar.com.au>

For more information on patient carer interviews please refer to Section Four on resources.

<sup>18</sup> Accelerating Implementation Methodology (AIM). IMA 2007. [www.imaworldwide.com](http://www.imaworldwide.com)

# Resources and Acknowledgements

## Resources:

### Walgan Tilly Final Report

<http://www.archi.net.au/e-library/delivery/indigenous/ccap>

### Area Health Services Aboriginal Nations Maps

<http://www.archi.net.au/e-library/delivery/indigenous/ccap>

### 48 hour follow up toolkit (on the HSNet website, you need to join the Walgan Tilly Chronic Care for Aboriginal People Group)

[http://www.hsnet.nsw.gov.au/Group\\_Home.aspx?grpID=432](http://www.hsnet.nsw.gov.au/Group_Home.aspx?grpID=432)

### Patient & Carer Interviews (on the HSNet website, you need to join the Walgan Tilly Chronic Care for Aboriginal People Group and ARCHI website)

[http://www.hsnet.nsw.gov.au/Group\\_Home.aspx?grpID=432](http://www.hsnet.nsw.gov.au/Group_Home.aspx?grpID=432)

<http://www.archi.net.au/e-library/patientexperience>

### Aboriginal Chronic Conditions Activity Profile (ACCAHSS) - each Area Health Service should have their own activity profile.

### The Aboriginal Chronic Conditions AHS Standards (PD2005\_588)

[www.health.nsw.gov.au/policies/pd/2005/pdf/pd2005\\_588.pdf](http://www.health.nsw.gov.au/policies/pd/2005/pdf/pd2005_588.pdf)

### Communicating positively with Aboriginal people.

<http://www.health.nsw.gov.au/pubs/2004/abterminology.html>

### Aboriginal Health Impact Statement and Guidelines (PD2007\_082)

[http://www.health.nsw.gov.au/PublicHealth/Aboriginal/impact\\_sment.asp](http://www.health.nsw.gov.au/PublicHealth/Aboriginal/impact_sment.asp)

### Aboriginal & Torres Strait Islander Peoples - Preferred Terminology to be used (PD2005\_319)

[www.health.nsw.gov.au/policies/PD/2005/PD2005\\_319.html](http://www.health.nsw.gov.au/policies/PD/2005/PD2005_319.html)

### My Health Record (MHR)

[www.health.nsw.gov.au/consumer/](http://www.health.nsw.gov.au/consumer/) or email [HSPIB@doh.health.nsw.gov.au](mailto:HSPIB@doh.health.nsw.gov.au)

<http://www.health.nsw.gov.au/initiatives/myhealthrecord/index.asp>

### Medicare Health Checks and MBS Items - Indigenous Access Program ph 1800 556 955

<http://www.medicareaustralia.gov.au/public/services/indigenous/index.jsp>

<http://www.aodgp.gov.au/internet/main/publishing.nsf/Content/pacd-medicare-healthchecks-factsheet.htm>

### Working with Aboriginal People and Communities - NSW DoCS resource

[http://www.community.nsw.gov.au/DOCSWR/\\_assets/main/documents/WORKING\\_WITH\\_ABORIGINAL.PDF](http://www.community.nsw.gov.au/DOCSWR/_assets/main/documents/WORKING_WITH_ABORIGINAL.PDF)

### Chronic Disease Management Office

<http://www.health.nsw.gov.au/cdm/index.asp>



## **Aboriginal Health Contacts:**

Aboriginal Health & Medical Research Council (for Aboriginal Medical Services details)  
[www.ahmrc.org.au](http://www.ahmrc.org.au)  
Ph: 9212 4777

General Practice NSW  
[www.gpnswh.com.au/programs/aboriginal-health](http://www.gpnswh.com.au/programs/aboriginal-health)  
Ph: 9239 2900

Greater Southern AHS  
Ph: 6938 6174

Greater Western AHS  
Ph: 6363 8063

Hunter New England AHS  
[www.aboriginalhealthinfo.com.au/contact.htm](http://www.aboriginalhealthinfo.com.au/contact.htm)  
Ph: 4924 6499

Justice Health  
[www.justicehealth.nsw.gov.au/our-services/aboriginal-health.html](http://www.justicehealth.nsw.gov.au/our-services/aboriginal-health.html)  
Ph: 4993 2354

North Coast AHS  
[www.ncahs.nsw.gov.au/services/results\\_brief.php?servicetype=13&locality=0](http://www.ncahs.nsw.gov.au/services/results_brief.php?servicetype=13&locality=0)  
Ph: 6620 2225

Northern Sydney & Central Coast AHS  
Ph: 4320 2694

South Eastern Sydney & Illawarra AHS  
Ph: 9947 9806

Sydney South West AHS  
[www.sswahs.nsw.gov.au/SSWAHS/ACRS/default.htm](http://www.sswahs.nsw.gov.au/SSWAHS/ACRS/default.htm)  
Ph: 9828 6093

Sydney West AHS  
Ph: 9881 1670

Chronic Care for Aboriginal People Program  
[www.health.nsw.gov.au/initiatives/Chronic\\_care/aboriginal/index/asp](http://www.health.nsw.gov.au/initiatives/Chronic_care/aboriginal/index/asp)  
Ph: 9391 9351 or 9391 9571  
Email: [CCAP@doh.health.nsw.gov.au](mailto:CCAP@doh.health.nsw.gov.au)

# Aboriginal Health Impact Statement Checklist

# Aboriginal Health Impact Statement Checklist

This Checklist should be used when preparing an Aboriginal Health Impact Statement for new health policies, as well as major health strategies and programs. To complete the checklist and to fully understand the meaning of each checklist item, it is essential to refer to *How to Use the checklist* in Part 3 of the Aboriginal Health Impact Statement.

## Development of the policy, program or strategy

1. Has there been appropriate representation of Aboriginal stakeholders in the development of the policy, program or strategy? ☒ Yes ☐ No

2. Have Aboriginal stakeholders been involved from the early stages of policy, program or strategy development? ☒ Yes ☐ No

*Please provide a brief description*

Consultations have been extensive with key Aboriginal Health stakeholders as well as mainstream chronic care health workers acknowledged in this document.  
This strategy is the result of a number of Aboriginal Chronic Care Initiatives developed since 2000. Consultations with staff, managers and patients of these initiatives have shaped the CCAP model of care as it now exists. Many of these initiatives are overseen by steering committees with Aboriginal stakeholder representation.

3. Have consultation/negotiation processes occurred with Aboriginal stakeholders? ☒ Yes ☐ No ☐ N/A

4. Have these processes been effective? ☒ Yes ☐ No

*Explain*

Regular stakeholder meetings have been held as a platform for open discussion and suggested content. Many presentations on the model of care have been organised to get feedback on the appropriateness of the elements of the model of care.  
Site visits to a mix of metropolitan and rural sites have been conducted to build an evidence base for activities attached to the model of care.  
Clinicians have also shared their experience in working in Aboriginal Health.

5. Have links been made with relevant existing mainstream and/or Aboriginal-specific policies, programs and/or strategies? ☒ Yes ☐ No ☐ N/A

*Explain*

PD2005\_547 Aboriginal and Torres Strait Islander Origin - Recording of Information of Patients and Clients  
PD2005\_319 Aboriginal and Torres Strait Islander Peoples - Preferred Terminology to be Used  
NSW Aboriginal Chronic Conditions Area Health Service Standards  
Closing the Gap

## Contents of the policy, program or strategy

6. Does the policy, program or strategy clearly identify the effects it will have on Aboriginal health outcomes and health services? ☒ Yes ☐ No

*Comments*

Model of Care for Aboriginal people with or at risk of a chronic disease.  
Outlines the importance of Identification of Aboriginal patients  
Proposes clinical indicators to measure health outcomes  
Proposes a number of process indicators to measure effectiveness of the implementation of the model of care

7. Have these effects been adequately addressed in the policy, program or strategy? ☒ Yes ☐ No

*Explain*

This is an Aboriginal specific strategy addressing Chronic Care for Aboriginal People. All indicators are addressing effectiveness and management of chronic disease

8. Are the identified effects on Aboriginal health outcomes and health services sufficiently different for Aboriginal people (compared to the general population) to warrant the development of a separate policy, program or strategy? ☒ Yes ☐ No ☐ N/A

*Explain*

This is an Aboriginal specific model that will address the disparity of health outcomes for Aboriginal people. In particular the devastating impact that Diabetes, Respiratory, Cardiovascular and Chronic Kidney Disease have on Aboriginal families and communities.

## Implementation and evaluation of the policy, program or strategy

9. Will implementation of the policy, program or strategy be supported by an adequate allocation of resources specifically for its Aboriginal health aspects? ☒ Yes ☐ No ☐ N/A  
☐ To be advised

*Describe*

Area Health Services and selected Aboriginal Medical Services currently receive a funding allocation to support Chronic Care for Aboriginal People.

10. Will the initiative build the capacity of Aboriginal people/organisations through participation? ☒ Yes ☐ No ☐ N/A

*In what way will capacity be built?*

The capacity of each service implementing this model will be enhanced as it combines the clinical and non clinical skill base of the organisation. This will increase the access to patients who have or who are at risk of developing a chronic disease. It also integrates Primary and Secondary health care initiatives and capacity of mainstream health workers to work with Aboriginal health workers ensuring Aboriginal Health is everyone's business.

11. Will the policy, program or strategy be implemented in partnership with Aboriginal stakeholders? ☒ Yes ☐ No ☐ N/A

*Briefly describe the intended implementation process*

Implementation will be in partnership with Area Health Services, Aboriginal Community Controlled Health and NSW Department of Health.

12. Does an evaluation plan exist for this policy, program or strategy? ☒ Yes ☐ No ☐ N/A

13. Has it been developed in conjunction with Aboriginal stakeholders? ☒ Yes ☐ No ☐ N/A

*Briefly describe Aboriginal stakeholder involvement in the evaluation plan*

The Centre for Aboriginal Health (NSW DoH), through an implementation committee, will contract an external consultant to develop a plan to evaluate the strategy.



# Appendix

ICD 10 Codes used for Chronic Care for Aboriginal People Program ICD 10  
Codes used for Chronic Care for Aboriginal People Program

Chronic disease category	ICD code	ICD code description
Asthma	J45	Asthma
Asthma	J46	Status asthmaticus
Cardiac	I05	Rheumatic mitral valve diseases
Cardiac	I06	Rheumatic aortic valve diseases
Cardiac	I07	Rheumatic tricuspid valve diseases
Cardiac	I08	Multiple valve diseases
Cardiac	I09	Other rheumatic heart diseases
Cardiac	I20	Angina pectoris
Cardiac	I21	Acute myocardial infarction
Cardiac	I22	Subsequent myocardial infarction
Cardiac	I23	Certain current comp following acute MI
Cardiac	I24	Other acute ischaemic heart diseases
Cardiac	I25	Chronic ischaemic heart disease
Cardiac	I30	Acute pericarditis
Cardiac	I31	Other diseases of pericardium
Cardiac	I32	Pericarditis in dis classified elsewhere
Cardiac	I33	Acute and subacute endocarditis
Cardiac	I34	Nonrheumatic mitral valve disorders
Cardiac	I35	Nonrheumatic aortic valve disorders
Cardiac	I36	Nonrheumatic tricuspid valve disorders
Cardiac	I37	Pulmonary valve disorders
Cardiac	I38	Endocarditis valve unspecified
Cardiac	I39	Endocarditis heart valve disrd dis cl/e
Cardiac	I40	Acute myocarditis
Cardiac	I41	Myocarditis in diseases class elsewhere
Cardiac	I42	Cardiomyopathy
Cardiac	I43	Cardiomyopathy in diseases cl/e
Cardiac	I44	Atrioventricular & L bundle branch block
Cardiac	I45	Other conduction disorders
Cardiac	I46	Cardiac arrest
Cardiac	I47	Paroxysmal tachycardia
Cardiac	I48	Atrial fibrillation and flutter
Cardiac	I49	Other cardiac arrhythmias
Cardiac	I50	Heart failure
Cardiac	I51	Comp & ill-def description heart disease
Cardiac	I52	Other heart disrd in dis class elsewhere
Cardiac	I60	Subarachnoid haemorrhage
Cardiac	I61	Intracerebral haemorrhage
Cardiac	I62	Oth nontraumatic intracranial haem
Cardiac	I63	Cerebral infarction
Cardiac	I64	Stroke not spec haemorrhage or infrc
Cardiac	I65	Occlus precereb art no cereb infrc
Cardiac	I66	Occlus stenosis cereb art no cereb infrc
Cardiac	I67	Other cerebrovascular diseases
Cardiac	I68	Cerebrovascular disorders in dis cl/e
Cardiac	I69	Sequelae of cerebrovascular disease
COPD	J43	Emphysema
COPD	J44	Other chronic obstructive pulmonary disease
Diabetes	E09	Impaired glucose regulation



Diabetes	E10	Type 1 diabetes mellitus
Diabetes	E11	Type 2 diabetes mellitus
Diabetes	E13	Other specified diabetes mellitus
Diabetes	E14	Unspecified diabetes mellitus
Renal	N00	Acute nephritic syndrome
Renal	N01	Rapidly progressive nephritic syndrome
Renal	N02	Recurrent and persistent haematuria
Renal	N03	Chronic nephritic syndrome
Renal	N04	Nephrotic syndrome
Renal	N05	Unspecified nephritic syndrome
Renal	N06	Isolated proteinuria with specified morphological lesion
Renal	N07	Hereditary nephropathy, not elsewhere classified
Renal	N08	Glomerular disorders in diseases classified elsewhere
Renal	N10	Acute tubulo-interstitial nephritis
Renal	N11	Chronic tubulo-interstitial nephritis
Renal	N12	Tubulo-interstitial nephritis not specified as acute or chronic
Renal	N13	Obstructive and reflux uropathy
Renal	N14	Drug- and heavy-metal-induced tubulo-interstitial and tubular conditions
Renal	N15	Other renal tubulo-interstitial diseases
Renal	N16	Renal tubulo-interstitial disorders in diseases classified elsewhere
Renal	N17	Acute renal failure
Renal	N18	Chronic renal failure
Renal	N19	Unspecified renal failure
Renal	N20	Calculus of kidney and ureter
Renal	N21	Calculus of lower urinary tract
Renal	N22	Calculus of urinary tract in diseases classified elsewhere
Renal	N23	Unspecified renal colic
Renal	N25	Disorders resulting from impaired renal tubular function
Renal	N26	Unspecified contracted kidney
Renal	N27	Small kidney of unknown cause
Renal	N28	Other disorders of kidney and ureter, not elsewhere classified
Renal	N29	Other disorders of kidney and ureter in diseases classified elsewhere

## Position Description

Clinical  
**COMMUNITY CHRONIC CARE CLINICIAN**  
Chronic Care for Aboriginal People  
<Insert Name of Organisation>

<Insert Date>

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### *POSITION DETAILS*

Position No: <Insert Position Number>

Position Title: Community Chronic Care Clinician (Clinical position)

Employment Type: <Temporary – full-time (2yrs)>

Classification: <Insert Classification>

Location: < insert Organisation>

Contact: <Insert Contacts Name>

Phone: <Insert Number>

Closing Date: <Insert Closing Date>

### **MAIN PURPOSE OF POSITION**

To provide ongoing support and expertise through comprehensive assessment, planning, implementation and overall evaluation of individual patient needs using the Model of Care for Aboriginal People 15 years and over (younger clients at there discretion) with or at risk of a chronic disease. Advise and support chronic care for Aboriginal people team to provide culturally appropriate services and to work effectively with Aboriginal communities. Accountability for the care, coordination, discharge navigation and planning of all patients. Have a through knowledge of Aboriginal policies and protocols. Extensive knowledge of available service providers in both health and social service providers. This position is accountable to <Insert Name of Manager, Division or Program>.

### **DESCRIPTION**

Provide the clinical expertise across hospital, community and specialist settings to ensure that the Aboriginal patient progresses through the continuum of care as identified in the model of care for Aboriginal people with a chronic disease. Coordinate and support the integration of the social service functions into patient care. Support the clinical components of Chronic Disease management in a holistic manner that responds to local identified need. Adhere to departmental goals, objectives, standards of performance, and policies and procedures. Ensure compliance with quality patient care and regulatory compliance.

### **ESSENTIAL CRITERIA:**

1. Demonstrated capacity to engage with Aboriginal people, families and communities
2. Post-registration qualifications in Chronic Diseases and at least three years experience working in the clinical area of their specified postgraduate qualification.
3. Experience in clinical practice and service delivery in Aboriginal Health.
4. Proven ability to contribute to clinical research, quality improvement and clinical governance activities
5. Ability to develop, implement and evaluate health projects
6. Demonstrated capacity to provide clinical leadership and act as a resource person in the field of Chronic Care.
7. Demonstrated ability to work as part of a team member with excellent written and verbal communication skills.

8. Demonstrated problem solving abilities and commitment to champion, promote and educate Aboriginal Health issues.
9. Computer literacy and ability to use computer applications CERNER, IIMS, and Microsoft applications such as Word, Excel and PowerPoint for data entry, reporting and presenting.
10. Demonstrated knowledge and experience in Quality Improvement practices, methodologies and the Accreditation Process.
11. Current unrestricted Class A unrestricted NSW Drivers Licence and willingness to travel.

## **DESIRABLE**

Priority will be given to applicants of Aboriginal and Torres Strait Islander descent.

## **KEY ROLES AND RESPONSIBILITIES**

### **Screening**

- ☐ Conduct and promote health checks for clinical indicators
- ☐ Develop tailored comprehensive screening to improve access for Aboriginal patients
- ☐ Assist in develop a strategies to assist AMS & GP's to increase Adult Health checks
- ☐ Include non medical tools to conduct comprehensive screening such as QoL tools
- ☐ Conduct opportunistic screening where appropriate
- ☐ Use of algorithms/decision trees for those with identified risk factors or early markers of disease
- ☐ Data collection and reporting of information
- ☐ Ensure there is a recall system following screening

### **Assessment**

- ☐ Comprehensive Assessment (medical and non-medical) in partnership with family/carer
- ☐ Include risk factors both clinical & non clinical such as lifestyle risk factors
- ☐ Long and short term goal setting
- ☐ Develop comprehensive care plans with the client & or carer

### **Treatment**

- ☐ Provide evidence based treatment in accordance with National guidelines
- ☐ Ongoing monitoring of the effectiveness of treatment
- ☐ Include priority of medications (compliance and access to medications)
- ☐ Collaborative care planning (with implementation and review) in partnership with patient and family.

### **Referral**

- ☐ Develop priority referrals for Aboriginal people medical (Specialists) and non medical (Rehab etc)
- ☐ Local knowledge of GP's and specialists who bulk bill
- ☐ Timely referrals to appropriate rehabilitation and allied health and health promotion services

### **Follow up**

- ☐ 48 hour follow up post discharge from hospital
- ☐ Provide transport where necessary or access to other forms of transport
- ☐ Link up with services that screen for clinical indicators
- ☐ Communicate with other providers known to the patient & or carer
- ☐ Handover to other service providers outside of the AHS where necessary
- ☐ Follow up with patients after appointments
- ☐ Home visits where appropriate

### **Trust**

- ☐ Provide informal visits where appropriate
- ☐ Ability to earn credibility from other Aboriginal clients



- ❑ Consider timing of earning trust, perseverance is a key element in gaining trust
- ❑ Always follow through with any arrangements or notify client well in advance with alternatives
- ❑ Acknowledge time taken to develop rapport with the patient
- ❑ Attend community events
- ❑ Develop network with Aboriginal staff and services
- ❑ Be sensitive to community and family politics
- ❑ Take the lead from Aboriginal colleagues
- ❑ Maintain confidentiality
- ❑ Acknowledge men and women's business where appropriate
- ❑ Acknowledge and respect the role of elders in the community
- ❑ Assist to develop & deliver programs in community and clinic settings

#### **Education**

- ❑ Provide appropriate education on disease and its progression
- ❑ Be mindful of the clients health literacy & adapt education to suit
- ❑ Individualised education may sometimes be more appropriate (1:1)
- ❑ Identify the best person to provide education
- ❑ Consider the methods or tools used in education
- ❑ Be guided in part by the Aboriginal client
- ❑ Seek community consultation as part of planning education programs
- ❑ Provide self management support
- ❑ Celebrate their achieved success

#### **Other**

- ❑ Work as part of a team
- ❑ Partnerships with other health service providers
- ❑ Provide advice for any service level agreements
- ❑ Basic computer literacy to use variety of IT systems
- ❑ Collection of clinical data and progress notes
- ❑ Reporting of clinical indicators
- ❑ Evaluation of service provision
- ❑ Liaise with non health service providers depending on patient's needs
- ❑ Communicate with all providers involved in patient's care

### **KEY INTERNAL AND EXTERNAL RELATIONSHIPS**

Aboriginal Community Controlled Health Services

General Practices

Aboriginal Health Workers

Local Area Health Services

Non Government Organisations

Local Government Agencies

NSW Department of Health

Aboriginal Community

### **CHALLENGES/ PROBLEM SOLVING**

The most significant challenge facing the position holder is managing and providing leadership within a small team and across a broad range of services within health and the community sector.

Acquiring the "unwritten" skills to (if not Aboriginal) become culturally sensitive to only their medical but also their spiritual needs that have impacted in their lives in the past and present and to be guided by their actions or communication on how best to deliver care.

## **DECISION MAKING**

There is an expectation that you will be involved in the decision making process about project planning and activities to further improve health outcomes of Aboriginal people in consultation with relevant key stakeholders.

## **VERIFICATION**

This section verifies that the position holder and supervisor have read the above position description and are satisfied that it accurately describes the position.

### **POSITION HOLDER**

Signature..... Date.....

### **SUPERVISOR**

Signature..... Date.....

# Position Description

**Non-Clinical**  
**Community Chronic Care Coordinator**  
**Chronic Care for Aboriginal People**  
**<Insert Name of Organisation>**

**<Insert Date>**

### *POSITION DETAILS*

Position No: <Insert Position Number>

Position Title: Community Chronic Care Coordinator

Employment Type: Temporary – full-time

Classification: <Insert Classification>

Location: <Insert Organisation including name of site and location>

Contact: <Insert Contact Name>

Phone: <Insert Number>

Closing Date: <Insert Date>

### **MAIN PURPOSE OF POSITION**

The purpose of the position is to work within a chronic care team to implement the Chronic Disease for Aboriginal People Model of Care using a shared care approach to manage the care of Aboriginal people with or at risk of developing a chronic disease.

To facilitate actions and communication between Aboriginal clients and service providers and to advocate for the rights and needs of Aboriginal community members.

To implement and monitor the strategies and initiatives to address chronic diseases and to ensure the on-going provision and access of professional and culturally appropriate health services to Aboriginal communities in New South Wales.

### **DESCRIPTION**

Facilitate access to the appropriate health and social services for Aboriginal people with or at risk of developing a chronic disease. Working as part of a chronic care team assist with basic health screening and assessments; Plan and implement basic health care; Provide information and education about chronic disease and support services; appropriately refer and follow up patients in the community and hospital setting; Establish and monitor care plans;

Identify community health issues, needs and strategies to improve health outcomes; Contribute to OH&S processes; Comply with infection control policies and procedures in health work; Process and maintain workplace information;

### **ESSENTIAL CRITERIA**

1. Demonstrated experience of engaging and working with Aboriginal people, families and communities.
2. Demonstrated experience in negotiating with a diverse range of health and social services to meet the needs of Aboriginal people with a chronic disease
3. Demonstrate effective communication skills and the necessary inter-personal skills to develop rapport and trust with Aboriginal people carer's and families

4. An effective team player in a multidisciplinary environment that fosters mutual respect in a cross cultural environment;
5. Demonstrated understanding of and commitment to the principles of holistic health care and how this applies to service delivery to Aboriginal communities and chronic disease;
6. Competent with the willingness and ability to undertake further skill development programs as needs to fulfill this position;
7. Ability to maintain confidentiality and respect.
8. Basic computer skills to use MS Word, Outlook, Excel and the ability to learn other IT applications;
9. Current unrestricted Class C NSW Driver License and willingness to travel;
10. Ability to exercise good judgment and cultural appropriateness in relating to the Aboriginal community, health care providers & beneficiaries;
11. Ability to establish and maintain effective and cooperative working relationships with health staff and others contacted in the course of the work;
12. Ability to accurately complete tasks within established timeframes;
13. Demonstrate organisational skills and an ability to effectively prioritise multiple tasks and deadlines.

## **DESIRABLE**

Priority will be given to applications from Aboriginal and Torres Strait Islander people.

## **KEY ROLES AND RESPONSIBILITIES**

### **Identification**

- ☐ Data sourcing for Aboriginal people with or at risk of developing a chronic disease & mapping available services
- ☐ Deliver training (or assist in delivery) to staff on how to “Ask the question on Identification” including a rollout strategy
- ☐ Ensure recording of Aboriginality in all services and settings
- ☐ Develop community education strategy to promote the benefits of self identification
- ☐ Work with facilities to develop local process following identification to imbed this until it is BAU

### **Screening**

- ☐ Assist in develop a strategies to assist AMS & GP's to increase Adult Health checks
- ☐ Include non medical tools to conduct comprehensive screening such as QoL tools
- ☐ Data collection and reporting of information
- ☐ Ensure there is a recall system following screening
- ☐ Undertake opportunistic screening as appropriate

### **Assessment**

- ☐ Include both social and health assessment
- ☐ Include realistic goal setting in line with self management strategies
- ☐ Develop comprehensive care plans with the client & or carer

### **Treatment**

- ☐ Facilitate treatment in a timely manner
- ☐ Collaborative care planning (with implementation and review) in partnership with patient and family.

### **Referrals**

- ☐ Develop priority referrals for Aboriginal people medical (Specialists) and non medical (Rehab etc)
- ☐ Local knowledge of GP's and specialists who bulk bill
- ☐ Timely referrals to appropriate rehabilitation and allied health and health promotion services



**Follow up**

- ☐ 48 hour follow up post discharge from hospital
- ☐ Provide transport where necessary or access to other forms of transport
- ☐ Link up with services that screen for clinical indicators
- ☐ Communicate with other providers known to the patient & or carer
- ☐ Handover to other service providers outside of the AHS where necessary
- ☐ Follow up with patients after appointments
- ☐ Home visits where appropriate

**Trust**

- ☐ Provide informal visits where appropriate
- ☐ Ability to earn credibility from other Aboriginal clients
- ☐ Consider timing of earning trust, perseverance is a key element in gaining trust
- ☐ Always follow through with any arrangements or notify client well in advance with alternatives
- ☐ Acknowledge time taken to develop rapport with the patient
- ☐ Attend community events
- ☐ Develop network with Aboriginal staff and services
- ☐ Be sensitive to community and family politics
- ☐ Take the lead from Aboriginal colleagues
- ☐ Maintain confidentiality
- ☐ Acknowledge men and women's business where appropriate
- ☐ Acknowledge and respect the role of elders in the community
- ☐ Assist to develop & deliver programs in community and clinic settings

**Education**

- ☐ Individualised education may sometimes be more appropriate (1:1)
- ☐ Identify the best person to provide education
- ☐ Consider the methods or tools used in education
- ☐ Be guided in part by the Aboriginal client
- ☐ Seek community consultation as part of planning education programs
- ☐ Provide self management support
- ☐ Celebrate their achieved success

**Other**

- ☐ Work as part of a team
- ☐ Partnerships with other health service providers
- ☐ Provide advice for any service level agreements
- ☐ Basic computer literacy to use variety of IT systems
- ☐ Collection of clinical data and progress notes
- ☐ Reporting of clinical indicators
- ☐ Evaluation of service provision
- ☐ Liaise with non health service providers depending on patient's needs
- ☐ Communicate with all providers involved in patient's care
- ☐ Performs other duties as assigned.

**KEY INTERNAL AND EXTERNAL RELATIONSHIPS**

Aboriginal Community Controlled Health Services

General Practices

Aboriginal Health Workers

Local Area Health Services

Non Government Organisations

Local Government Agencies

NSW Department of Health

Aboriginal Community

### **CHALLENGES/ PROBLEM SOLVING**

This worker will be expected to be flexible in sometimes challenging situations, you may be required to assume a variety of roles and undertake a broad range of tasks that require a timely and coordinated approach to meet the needs of the client under the supervision of the registered nurse.

### **DECISION MAKING**

There is an expectation that you will be involved in the decision making process about project planning and activities to further improve health outcomes of Aboriginal people in consultation with relevant key stakeholders.

### **VERIFICATION**

This section verifies that the position holder and supervisor have read the above position description and are satisfied that it accurately describes the position.

#### **POSITION HOLDER**

Signature..... Date.....

#### **SUPERVISOR**

Signature..... Date.....

## **LIST OF ACRONYMS**

<b>Acronym</b>	<b>Abbreviation</b>
ABS	Australian Bureau of Statistics
ACCAG	Aboriginal Chronic Care Advisory Group
ACCAHSS	Aboriginal Chronic Conditions Area Health Service Standards
ACCHS	Aboriginal Community Controlled Health Services
AH&MRC	Aboriginal Health and Medical Research Council
AHS	Area Health Service
AMAH	Area Manager Aboriginal Health
AMS	Aboriginal Medical Service
AHW	Aboriginal Health Worker
CAH	Centre for Aboriginal Health, NSW Department of Health
CCAP	Chronic Care for Aboriginal People
CHIME	Community Health Information Management Enterprise
DCO	Director Clinical Operations
DPPP	Director of Population Health, Planning and Performance
ED	Emergency Department
eMR	Electronic Medical Record
GP	General Practitioner
GSAHS	Greater Southern Area Health Service
GWAHS	Greater Western Area Health Service
HNEAHS	Hunter New England Area Health Service
HSPiB	Health Services Performance Improvement Branch, NSW Department of Health
HSNet	Human Services Network
IT	Information Technology
JH	Justice Health
KPI	Key Performance Indicator
LGA	Local Government Area
MBS	Medical Benefits Scheme
MoC	Model of Care
NCAHS	North Coast Area Health Service
NSCCAHS	Northern Sydney Central Coast Area Health Service
NSW	New South Wales
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
SESAHS	South Eastern Sydney & Illawarra Area Health Service
SSWAHS	Sydney South West Area Health Service
SWAHS	Sydney West Area Health Service

## **ACKNOWLEDGEMENTS**

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Chronic Care for Aboriginal People Steering  
Committee – Including Dr Tracey McCosker –  
Director Clinical Operations HNEAHS

Robyn Speerin  
Musculoskeletal Network Manager  
Greater Metropolitan Clinical Taskforce

## **Site Visits and Consultations**

- Armajun Aboriginal Health Services
- Aunty Jean's Chronic Disease Rehab Program  
Nowra
- Blacktown Hospital – Care Navigation
- Booroonegen Djugen Aboriginal Corporation
- Broken Hill Base Hospital
- Casino Aboriginal Medical Services
- Condobolin Hospital
- Griffith Base Hospital
- GWAHS Aboriginal Health Worker Forum
- HNEAHS Aboriginal Health Worker Forum
- Inverell Base Hospital
- La Perouse ("Lapa") Aboriginal Community  
Centre

- Lismore Hospital
- Maari Ma Primary Health Service
- Maari Ma Aboriginal Corporation
- Menindee Health Service
- Mootang Tarimi Outreach – Blacktown
- Moruya Health Services
- North West Aboriginal Community Options  
/ComPacks
- Nunyara Aboriginal Health Unit Gosford
- Queanbeyan District Hospital
- Wagga Wagga Base Hospital
- Western Sydney Aboriginal Medical Service
- Aboriginal Health & Medical Research Council

