



NSW Aboriginal Chronic Conditions Area Health Service Standards

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

E X E C U T I V E S U M M A R Y

Background

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

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

Risk factors for chronic conditions such as high blood pressure, smoking, physical inactivity and poor nutrition continue to occur at higher rates in Aboriginal populations. In addition Aboriginal people have had a consistently poor level of access to appropriate health care services. Early intervention and population health mechanisms are failing to prevent poor health in Aboriginal communities. Primary health care services are under-utilised for a complex range of reasons, including lack of bulk billing, transport issues and discrimination. As a consequence many Aboriginal people are presenting to health services late in the course of their

diseases and experience significantly higher rates of preventable complications and death. Aboriginal people are also not receiving the same level and quality of care for the diagnosis and treatment of illness as the rest of the Australian population.

Improvement in health outcomes for Aboriginal people is contingent upon effective action in all of the domains influencing health and well being, including employment, housing and education. Collaboration with intersectoral organisations impacts significantly on the determinants of health. Health services, for their part, including government and non-government services such as Aboriginal Community Controlled Health Services, general practitioners and professional organisations, play a significant role in both treating and preventing ill health for the Aboriginal population. There have been a number of relevant initiatives and frameworks that have provided scaffolding for the *NSW Aboriginal Chronic Conditions Area Health Service Standards* (see Figure 1 on page 2).

NSW Aboriginal Chronic Conditions Area Health Service Standards

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

The Standards aim to:

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

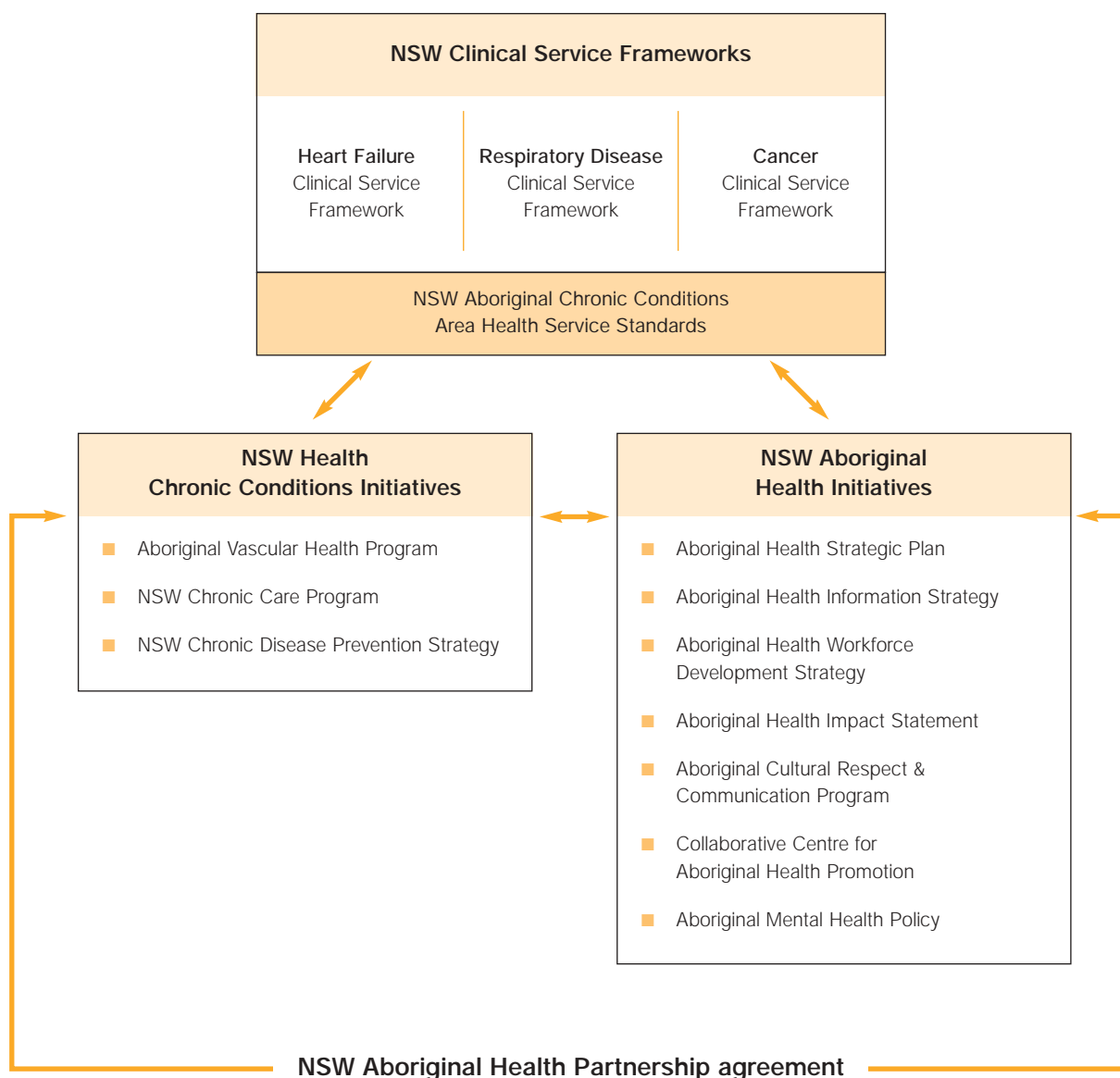
The *NSW Aboriginal Chronic Conditions Area Health Service Standards* are based on the available evidence of effectiveness or principles of best practice for chronic

conditions interventions for Aboriginal populations.

They are designed to assist health service providers enhance their current services through incorporating evidence based approaches. The Standards incorporate the principles of:

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

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



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

Implementation

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

Key steps in effective implementation

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

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

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

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

NSW DEPARTMENT OF HEALTH

73 Miller Street
North Sydney NSW 2060
Tel. (02) 9391 9000, Fax. (02) 9391 9101, TTY. (02) 9391 9900
www.health.nsw.gov.au

This work is copyright. It may be reproduced in whole or in part for study training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above, requires written permission from the NSW Department of Health.

© NSW Department of Health 2005

SHPN (OSB) 050013

For further copies of this document please contact:
Better Health Centre – Publications Warehouse
Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452, Fax. (02) 9816 0492

Further copies of this document can also be downloaded from the NSW Health website: www.health.nsw.gov.au

March 2005