WHY A CHRONIC CONDITIONS STRATEGY?

Aboriginal and Torres Strait Islander people living in Cape York experience higher rates of chronic conditions and related risk factors than the rest of Queensland.[1] Many chronic conditions can be prevented. However, the underlying risk factors are interrelated and complex to address.[2] Apunipima provides a comprehensive model of primary health care, with a focus on empowering Cape York communities and families to address these underlying risk factors.

The Chronic Conditions Strategy 2016–2026 details the organisational approach Apunipima will take to work with Cape York communities in the prevention, detection, treatment and management of chronic conditions. The strategy reflects current evidence-based best practice and is in line with national and other jurisdictional approaches. Subsequent Action Plans will outline how Apunipima will coordinate effort and measure progress in addressing the burden of chronic conditions.

AIM OF THE CHRONIC CONDITIONS STRATEGY

The strategy aims to improve the health and wellbeing of all Aboriginal and Torres Strait Islander peoples living in Cape York by reducing the incidence and impact of chronic conditions. In this context 'health' refers to the physical, social, emotional and cultural wellbeing of individuals, families and communities.[3]

This will be achieved by:

- Supporting better access to primary health care across Cape York communities
- Improving the patient's journey through the health system
- Improving collaboration between teams and with external partners
- Promoting more efficient and effective use of health resources
- Supporting local solutions and responses to identified needs
- Improving local chronic condition interventions and processes
- Avoiding service duplication and fragmentation and improving coordination in the prevention, treatment and management of chronic conditions

BURDEN OF CHRONIC CONDITIONS

Aboriginal and Torres Strait Islander people living in remote areas experience higher rates of chronic conditions and related risk factors than Indigenous people living in urban or regional areas of Queensland. Prevalence in remote areas is:

- 2.5 times higher for diabetes
- 2.8 times higher for chronic kidney disease
- Twice as high for asthma
- 30% higher for dyslipidaemia
- 25% higher for daily smoking
- 8% higher for overweight and obesity
- 42% lower for the consumption of recommended daily serves of vegetables[1]

STRATEGY SCOPE

The principles employed in the Chronic Conditions Strategy can be applied to all chronic conditions. However, the Strategy targets the following conditions and risk factors:

- Cardiovascular disease
- Type 2 diabetes
- Airway diseases
- Chronic kidney disease
- Mental illness
- Cancer (associated with risk factors common to other chronic conditions)
- Rheumatic heart disease*[6]

These conditions have been prioritised because they:

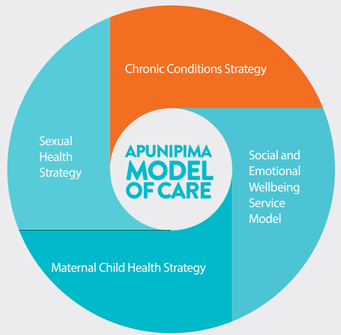
- Cause the greatest burden of disease in Cape York
- Share common risk factors
- Have complex causes
- Have a gradual onset but are long term and persistent
- Occur across the life cycle, although they are more prevalent in ageing adults in line with increased life expectancy
- Are usually not immediately life threatening but can compromise quality of life through physical limitations and disability
- Are in line with current national priorities[6]

* Apunipima is actively involved in rheumatic heart health through the maternal child health team despite Queensland Health being the sole recipient for rheumatic heart disease funding.

HOW THE STRATEGY FITS WITH OTHER GUIDING DOCUMENTS

The Chronic Conditions Strategy and Action Plans will form the basis for how chronic conditions are addressed, support resolution of health issues identified through community health plans and assist in meeting Apunipima's strategic goals. The development of the strategy has been guided by state and national planning documents, including Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 and the Implementation Plan for National Aboriginal and Torres Strait Islander Health Plan 2013–2023.[1,3,6,7]

The Chronic Conditions Strategy is one of four strategic documents operationalising the Apunipima Model of Care and links to activities outlined in the Social and Emotional Wellbeing Service Model, the Maternal Child Health Strategy and the Sexual Health Strategy.



HOW WILL PROGRESS BE MEASURED?

Apunipima monitors program performance using three main approaches:

- Delivery of strategic actions
- Clinical outputs and outcomes
- Evaluation and research

Long and short-term performance indicators will be measured. Long-term indicators will be measured using National and Apunipima Key Performance Indicators. Short-term measures will be detailed in the two year Action Plans.

Apunipima works in partnership with other health and non-health service providers, contributing directly and indirectly to improved health outcomes. Progress against the Action Plans will be communicated every two years to Apunipima staff, Cape York communities, and partner organisations.

TIME FRAMES

The Apunipima Chronic Conditions Strategy 2016–2026 projects a ten year outlook, with review biannually and evaluation occurring after the first 5 years.

The Action Plans will guide work across two year periods and monitoring will occur every 6 months.

DEFINING CHRONIC CONDITIONS

Chronic conditions are long-lasting and persistent in their symptoms or development. The term is applied to conditions such as heart disease, type 2 diabetes, cancer and other non-communicable diseases.[3] The causes of many chronic conditions are well known. To reduce the incidence of people developing chronic conditions, interventions need to target behavioural and biomedical risk factors along with social and cultural determinants of health.2

Behavioural risk factors include: smoking, poor nutrition, gambling harmful or hazardous alcohol consumption, inadequate physical activity and social and emotional wellbeing.[2]

Biomedical risk factors include: excess weight (overweight and obesity), high blood pressure, high blood cholesterol, impaired glucose regulation, inadequate nutrition, low birth weight, genetic and epigenetic factors.[2]

Social determinants of health include: housing, employment, education, food security, addiction, and access to services.[4]

Cultural determinants of health include, but are not limited to: identity, traditional cultural practice, kinship, connection to land and nature, language, healing, spirituality, empowerment, ancestry and belonging and Aboriginal and Torres Strait Islander knowledge.[3]

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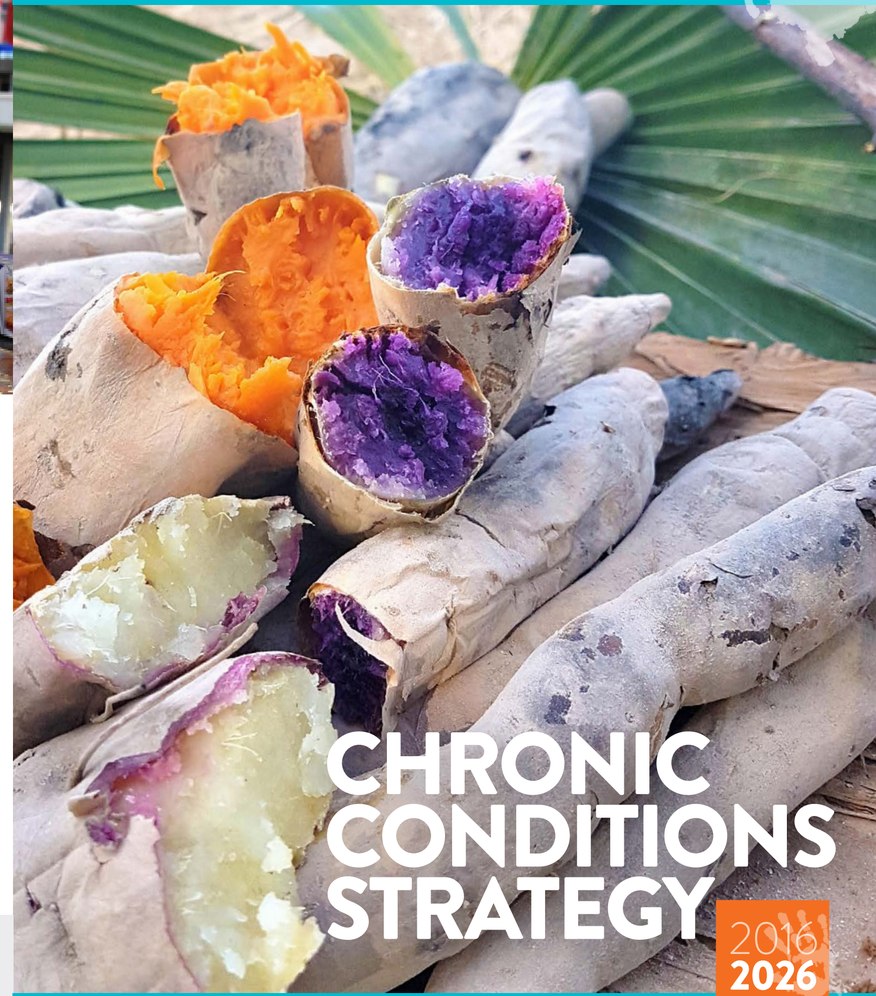
our health in our hands



CHRONIC CONDITIONS STRATEGY

2016 2026

ACTION AREAS

TO ADDRESS CHRONIC CONDITIONS IN CAPE YORK

SCREENING AND EARLY DETECTION

Provide culturally appropriate assessment and early detection of biomedical and behavioural risk factors for chronic conditions.

OBJECTIVE: To increase the proportion of the Cape York population that attends annual health checks and other screening services.

PRIORITY ACTIVITIES:

- Enhance Primary Health Care capacity to implement a coordinated, systematic approach to opportunistic screening and early detection of disease markers (MSB 715)
- Increase access to screening and early detection of chronic conditions and complications of pre-existing conditions
- Identify and address barriers to participation in screening
- Deliver culturally appropriate brief interventions
- Encourage early detection

WHY IS THIS ACTION AREA IMPORTANT?

Culturally appropriate approaches to early detection and follow-up of disease markers result in better health outcomes for families and communities[5]

CLINICAL CARE

Provide holistic clinical care that encompasses prevention, early detection, treatment, and management of chronic conditions. Embed a culturally appropriate, family-centred approach with services delivered in clinic, home and community settings.

OBJECTIVE: Increase the early detection and management of disease markers to delay or halt the progression of chronic conditions through the delivery of comprehensive clinical care to individuals and families, in clinic, home and community settings.

PRIORITY ACTIVITIES:

- Enhance Primary Health Care capacity to implement chronic condition care plans
- Ensure the availability of core clinical services for the Aboriginal and Torres Strait Islander peoples of Cape York, including access to specialist and allied health services
- Ensure chronic condition management plans are regularly reviewed
- Conduct brief interventions to address risk factors for chronic conditions
- Provide integrated delivery of multi-disciplinary chronic condition care and ensure evidence-based guidelines underpin clinical care provision (eg Chronic Conditions Manual)
- Encourage and support self-care and self-management of chronic conditions
- Provide intensive support to pregnant women with gestational diabetes to reduce the risk of mother and child developing type 2 diabetes in later life
- Provide opportunities for families and carers of people with chronic conditions to be involved, informed, supported and enabled

WHY IS THIS ACTION AREA IMPORTANT?

Clinical care must be culturally safe, high quality, responsive and accessible to Aboriginal and Torres Strait Islander peoples in Cape York. Frequent ongoing personalised support is needed to encourage self-management of lifestyle risk factors and prevent chronic conditions[5]

HEALTH PROMOTION AND DISEASE PREVENTION

A healthy family and community has the knowledge and skills to make healthy lifestyle choices and have control over their own health and wellbeing. Culturally and community appropriate messages encourage and empower families and communities to live healthy lifestyles. Empowered community leadership can develop or adapt policies and infrastructure to better support a healthy lifestyle.

OBJECTIVE: To increase community awareness, knowledge and understanding of the risk factors and protective behaviours related to chronic conditions and increase self-efficacy to manage chronic conditions by delivering culturally appropriate social marketing and information and education sessions to families, small groups, and the community. To increase the number of initiatives in Cape York communities that create supportive environments (healthy places) for healthy living.

PRIORITY ACTIVITIES:

- Assess and prioritise environmental conditions that can be influenced by policy, regulatory, or infrastructure initiatives that will identify gaps, address determinants of health in the local environment and subsequently support healthier lifestyles.
- Provide group education and skill development sessions on behavioural and lifestyle risk factors (smoking, nutrition, alcohol, physical activity and social and emotional wellbeing), where possible linking with existing activities such as community events or information days, community camps and other activities on country
- Deliver healthy lifestyle programs and/or enhance existing programs to provide education and information on risk factors for chronic conditions
- Develop referral pathways and systems to direct clients to healthy lifestyle programs
- Ensure language and literacy issues are considered in the development and delivery of health messages and education materials
- Engage communities in the design, development and implementation of social marketing campaigns that target specific population groups and develop culturally appropriate information and resources that complement the mediums used
- Extend the reach of appropriate national and state social marketing campaigns that promote consistent messages about smoking, nutrition, alcohol, physical activity, and social and emotional wellbeing

- Identify local interpretations of current lifestyle risk factors and create locally-based solutions that uniquely represent the community and environment
- Assess and prioritise environmental conditions that can be influenced by policy, regulatory, or infrastructure initiatives that will identify gaps, address determinants of health in the local environment, and subsequently support healthier lifestyles

WHY IS THIS ACTION AREA IMPORTANT?

Making informed choices is important in reducing risk factors. Targeted social marketing campaigns are effective in encouraging individuals and families to assess their behaviour. Education and healthy lifestyle programs embed knowledge and skills development, encourage self-efficacy, and assist individuals to apply healthy behaviours in practice. The creation of policy environments that promote health in the primary health care service and the local community complements clinical care efforts.

PARTNERSHIPS, RESEARCH AND ADVOCACY

Support communities to lead partnerships with health professionals and other local and external stakeholders to address the health priorities identified in their communities.

OBJECTIVE: To engage in, support and lead activities that influence better health outcomes in Cape York communities.

PRIORITY ACTIVITIES:

- Work with communities to find local solutions to address health needs
- Establish and foster partnerships and networks with key stakeholders (including community members) to strengthen our capacity to address health disparities and social determinants of health
- Strengthen partnerships with Hospital and Health Services to reduce hospital admissions and re-admissions
- Provide leadership to government, non-government and private providers regarding prevention and management of chronic conditions in Cape York
- Ensure that research is relevant to and supported by community members and that research findings can be translated into meaningful outcomes for community members
- Identify opportunities for and participate in public health advocacy at the local, regional and national level to support better health outcomes for Cape York communities
- Advocate further development of community-controlled health services in Cape York
- Advocate policy, regulatory and infrastructure activities that can influence smoking, nutrition, alcohol, physical activity and social and emotional wellbeing at the community level

WHY IS THIS ACTION AREA IMPORTANT?

Apunipima must build and facilitate relationships with the community and state and national organisations to foster innovative solutions, strong networks, informed and enhanced advocacy and best practice research.

WORKFORCE AND CAPACITY BUILDING

OBJECTIVE: To attract, train, and retain an appropriately skilled workforce.

PRIORITY ACTIVITIES:

- Commit to the recruitment of Aboriginal and Torres Strait Islander community-based staff who are central to addressing chronic conditions in Cape York communities
- Identify workforce strengths and gaps in relation to the prevention, treatment, and management of chronic conditions including cultural competencies and community development approaches
- Advocate adequate staffing levels for the disease burden against Apunipima Cape York Health Council best practice standards
- Increase workforce capacity (number and skill set) to deliver chronic condition prevention and intervention initiatives
- Establish resources for both clinical and non-clinical prevention work
- Improve recruitment and retention of staff and encourage employment of local community members
- Provide and ensure access to timely training and support for staff to participate in service improvements
- Provide professional development and clinical supervision of staff where appropriate, and support staff to apply evidence-based chronic condition practice in their work
- Integrate healthy workplace principles into organisational policies and practices to create a healthy workplace for staff and clients.

WHY IS THIS ACTION AREA IMPORTANT?

A skilled workforce is essential to implement this strategy. It is important to attract, train and retain skilled health professionals and to bolster the Aboriginal and Torres Strait Islander workforce, including community members, to take on roles to support the implementation of the strategy.

MONITORING, EVALUATION & COMMUNITY FEEDBACK

OBJECTIVE: To provide full and continued access to Apunipima health data, service performance and program outcomes to empower communities to fully participate in health service planning (setting priorities, making decisions and planning and implementing strategies to achieve better health).

PRIORITY ACTIVITIES:

- Support and promote involvement of the local community in the identification of health needs and in prioritising and planning processes that will impact on the prevention and management of chronic conditions
- Establish mechanisms for regular feedback to the community on health service performance and program outcomes
- Utilise national, state, regional and community health data to inform ongoing program development
- Ensure data collection systems allow for appropriate recording of indicators and performance measures and that staff are trained to record these details
- Evaluate social marketing campaigns
- Implement continuous quality improvement initiatives to strengthen consistent chronic condition practice across the continuum of prevention, treatment and management
- Build individual and organisational evaluation capacity, both to conduct evaluations and to use evaluation findings to inform the quality of future program delivery

WHY IS THIS ACTION AREA IMPORTANT?

Monitoring and evaluation are critical to the development of a robust evidence base that informs policy and practice, resulting in efficient use of resources to achieve improved health outcomes.